Chapter

4

Provide Universal Access to Comprehensive Sexuality Education and Information

*To achieve sexual health, all individuals, including youth, must have access to comprehensive sexuality education and sexual health information and services throughout the life cycle.**

Introduction

As noted at various points in this document, improving, maintaining and promoting sexual health will play a significant and indispensable role in achieving many of the Millennium Development Goals (MDGs). The eight goals outlined in Sexual Health for the Millennium declaration statement are highly inter-related. Universal access to comprehensive sexuality education is closely related, and indispensable to the other sexual health objectives stated in the declaration all of which have educational components. Individual and community awareness as well as knowledge and acceptance of sexual health issues are pre-requisites for positive change. Universal access to comprehensive and consistent sexuality education is an essential component in the development of any successful strategy to promote sexual health in the new millennium.

*This chapter was informed by the WAS Expert Consultation in Oaxaca, Mexico, a thorough review of the literature, and the background paper written by Doortje Braeken and Melissa Cardinal (see Appendix IV and V).

As affirmed in the declaration statement, comprehensive sexuality education is a process which ought to occur over the life-span. Our need for sexuality education does not begin or cease with puberty. The life course developmental periods of childhood, adolescence, young adulthood, middle age, and later life are all characterized by different but equally important sexuality related developmental tasks and sexuality education needs (Delamater & Friedrich, 2002). Youth however, warrant special emphasis in our call for universal access to comprehensive sexuality education, particularly with respect to the proposition that wide-spread implementation of sexuality education programming will make a meaningful contribution to the MDGs. It is also important because the provision of high quality sexuality education to children and youth offers a foundation for knowledge, attitudes and skills that are essential to the attainment of optimal sexual health, which can evolve with their changing needs through out the life span.

Due to nearly universal access to schooling for youth in the developed world, schools are often viewed as the ideal forum for implementing sexuality education. In the developing world, on the other hand, access to schooling has traditionally been severely limited with unequal opportunity according to gender, income and geographic location. School-based sexuality education, therefore, held little promise of reaching a plurality of youth in many communities. However, this is changing. As documented by Loyd (2006), in her background paper for the U.N. Millennium Project, more and more young people in developing countries, especially females, are attending school up to and through the pubertal years. As Loyd illustrates, school attendance in-it-self can have beneficial implications for sexual and reproductive health. Just as importantly, the rapid growth of school attendance, although access is still far from universal, presents a tremendous opportunity to scale up comprehensive sexuality education. It is crucial that as school systems are created and expanded, renewed and reformed, comprehensive sexuality education takes place as throughout the curriculum and is a core component of it. Justification for inclusion will rest, in part, upon demonstrating the links between sexuality education and sexual and reproductive health and community development as envisaged by the MDGs.

With respect to general education, the primary purpose of educating children is to prepare them for life. Hence, we teach them to read, write, problem solve, think creatively etc. These are the skills they will use throughout their life times. With respect to sexuality education more specifically, the information, attitudes and skills people acquire as children and youth will influence their choices and impact on their general sexual health as adults. Childhood, puberty and adolescence are critical periods for the development of sexuality. Basic knowledge, formative attitudes, and healthy practices that are learned before or as sexual activity begins are much more likely to be carried forward consistently and into adulthood. For example, there is evidence to suggest that young people who use condoms the first time they have intercourse are significantly more likely to use condoms when they are older compared to those who have first intercourse without condoms (Klavs, Rodrigues, Wellings, et al., 2005; Shafii, Stovel, Davis et al., 2004). Thus, it is vital that youth be reached with comprehensive sexuality

education before becoming sexually active because for many youth around the world, first sexual intercourse, if it is voluntary or not, can and does occur anytime after the onset of puberty. It is also important that school-based comprehensive sexuality education is linked to informal and complementary education that occurs in the community and in the home.

Comprehensive Sexuality Education in the Context of Global Sexual Diversity

To say that the global community is far from unified with respect to sexual values, beliefs customs, and patterns of behavior is to state the obvious. This diversity warrants sustained recognition and consideration in the formulation of strategy and policy directed towards developing and implementing comprehensive sexuality education programs that contribute on a global scale to the attainment of the MDGs.

> Matters related to sex and reproduction are sensitive – enmeshed in issues of culture and ideology of social institutions and personal identities. In many countries, various cultural groups have different understandings and positions on SRH (and on associated service provision). Public discussion and attention may be limited so political divisions can be avoided or because there is stigma attached. SHR has only become a fit topic for international discussion and consensus within the last 10-15 years (UN Millennium Project, 2006, p. 4).

This observation gives us just a taste of the unique culturally specific contexts in which sexuality education programs for youth occur – or don't occur – across the globe. The substance and character of these programs, or the lack of them, are often a very clear and precise reflection of the cultural beliefs towards sexuality that exist in the community. Clearly, religious, political, and social-moral stances on sexuality divide the global community and this is a fundamental obstacle to a unified, shared approach to the development and implementation of the comprehensive sexuality education that would contribute to impact on not only the HIV/AIDS epidemic but on a host of other issues such as gender equality and family planning. A very basic international unity of approach and recognition of the need for comprehensive sexuality education is required to underpin international agreements pertaining to sexual and reproductive health and rights, to secure funding for programs, to share expertise, and to ensure community engagement, active participation and ownership of programming. Given the vast cultural diversity of beliefs related to sexuality, where do we begin in developing a global strategy for comprehensive sexuality education?

Germain and Woods (2005) in writing about the need for an integrated approach to HIV prevention note that "Global politics do not make HIV prevention strategies easy

or straightforward to operationalize" (p. 59). They propose, following the lead of the 2005 UNAIDS Prevention Strategy, that prevention programs be grounded in the components of human rights, comprehensiveness, and an evidence base. A platform incorporating these three components for proposing universal access to high quality, comprehensive sexuality education follows.

Human and Sexual Rights

Existing commitments by governments to human rights and non-governmental agencies to sexual rights as human rights provides us with a substantive and workable beginning point to advocate for universal access to comprehensive sexuality education within a broader framework of sexual health promotion. As noted elsewhere in this document, the WHO (2002; 2006) Working Definition of Sexual Rights states that sexual rights based upon already recognized national laws and international human rights documents includes the right of all persons, free of coercion, discrimination and violence to, among other things, obtain information about sexuality and receive sexuality education.

The call for universal access to comprehensive sexuality education is inseparable from, and a key component of the demand to respect and promote human and sexual rights. It is the recognition of basic human and sexual rights that must provide the philosophical foundation for a global perspective on comprehensive sexuality education. As discussed in more detail below, care must be taken to not inject external presumptions concerning either the meaning and purpose of human sexuality or the precise definition of comprehensive sexuality education that go beyond the basic rights that have been the basis for international agreement. These conceptions must be internally derived within the specific ethno-cultural communities in which sexuality education is to be provided.

Comprehensiveness

In describing comprehensive sexuality education, SIECUS (2001) specifies a number of key concepts such as human development, relationships, personal skills, sexual behavior, sexual health and society and culture. Very often the term comprehensive sexuality education suggests that programs aimed at sexual risk reduction address both delay of first intercourse or abstinence and condom/contraceptive use as viable preventive measures. In this sense, the term comprehensive sexuality education is simply used as a way of distinguishing such programs from so-called "abstinence-only" programs which only promote refraining from sexual activity and do not address other options, such as condom use, for people who are or who will become sexually active. However, comprehensive sexuality education is a much broader term which implies a rights-based approach that takes into account gender and is culture sensitive.

Together, the rights articulated in the WHO (2002; 2006) Working Definition of Sexual Rights emphasize access to sexuality information and autonomous decision-making. As stated above, and for the purpose of this section, the concept of

comprehensive sexuality education is one which includes and respects basic human rights, provides broad based and accurate information and enables motivational and skill building opportunities which enable individuals to make autonomous, informed decisions about their sexual and reproductive health. In many western countries and some developing nations these ideas and what they imply for the specifics of sexuality education programs are well articulated and suitable for those cultures (see, for example, SIECUS, 1991; Health Canada, 2003; Ministerio de Educacion, Chile, 2002).

The Pan American Health Organization (PAHO, 2000) has made the provision of comprehensive sexuality education to the population at large one of its stated goals in promoting sexual health. The PAHO recommendations include a specific nine-point outline of the meaning and purpose of comprehensive sexuality education that are consistent with a human and sexual rights perspective and can be effectively applied to that region. In many other countries and regions, culturally specific and appropriate conceptions of comprehensive sexuality education have yet to be specified as the foundation for programming that reach large numbers of youth. Initiatives to do so will be essential in establishing universal access to comprehensive sexuality education.

In some countries, but most particularly in the United States, ample funding and advocacy for abstinence-only sexuality education programs is widespread. If we agree that the ethical foundation of comprehensive sexuality education is rooted in basic human rights and sexual rights that confer to each individual the indisputable right to autonomous and informed decision making, it is evident that abstinence-only programs fall out side this basic ethical perspective.

Programs that, by design, withhold the information necessary for individuals to make voluntary, informed decisions are unethical and from the perspective of sexuality education presented here, a violation of human rights.

Abstinence-only programs have been repeatedly shown to be ineffective in promoting and sustaining behavioral change. In addition a large majority of abstinence-only sex education programs have been shown to be ineffective in preventing sexual activity or in reducing HIV/STI or unintended pregnancy. While a few abstinence-only programs have been shown to modify attitudes towards abstinence and sexual behavior over short periods of time (up to six months), no evaluated abstinence-only program has resulted in delayed intercourse among abstinence program participants over longer periods of time compared to control groups or groups receiving broad-based sexual health education (Bennett & Assefi, 2005).

Despite U.S. federal government backing, including hundreds of millions of dollars in funding, a recent review of program evaluations designed to measure the impact of abstinence-only interventions implemented in the United States shows that they are not only ineffective but potentially detrimental to public heath.

> Abstinence-only programs show little evidence of sustained (long-term) impact on attitudes and intentions. Worse, they show some negative impacts on youth's willingness to use contraception, including condoms, to prevent negative sexual health outcomes related to sexual intercourse. Importantly, only in one state did any program demonstrate short-term success in delaying the initiation of sex; none of these programs demonstrates evidence of long-term success in delaying sexual initiation among youth exposed to the programs or any evidence of success in reducing other sexual risk-taking behaviors Abstinence-only programs show little evidence of sustained (long-term) impact on among participants (Hauser, 2004, p. 4).

Given the evidence noted above, funding and implementing abstinence-only programs should be considered as a poor use of valuable human and financial resources which could be deployed to the planning, implementation and evaluation of coordinated, cost-effective, evidence based programming. The abstinence-only approach restricts the provision of information to one specific strategy for HIV/STI and unintended pregnancy prevention, purposefully excluding information that can be utilized by those who are or inevitably will become sexually active. Thus, the abstinence-only approach is exclusionary, reflecting a narrow and specific point of view. The comprehensive approach, on the other hand, is conceptually inclusive rather than exclusive, presenting information on multiple strategies (including abstaining from sexual activity, delaying first intercourse, reducing the number of sexual partners, as well as practicing safer sex) for HIV/STI and pregnancy prevention.

In contrast to abstinence-only programs, comprehensive sexuality education programs ensure that decisions about whether to have sex or not, decisions about if and when to have children, and decisions about how to protect oneself and one's partner from HIV/STI are informed decisions based on choices that all people, including youth, have a right to make based on their own self-defined values as well as the values of their families and communities.

As opposed to the ineffectiveness of abstinence-only programs in reaching their behavioral objectives, there is evidence to suggest that more comprehensive sexuality education programs are able to help youth who have not been sexually active, to delay first intercourse (e.g., Jemmott, Jemmott & Fong, 1998). That comprehensive sexuality education is likely to be more effective than abstinence-only programming in enabling youth to delay first intercourse may well be due to the fact that well developed comprehensive sexuality education programs engage youth in the process of informed decision making, enabling them to actively make choices to protect and enhance their sexual health. Abstinence-only programs discourage youth from weighing alternatives and making choices based on their own realities, needs, traditions, and values.

The objectives of HIV/STI prevention and unplanned pregnancy prevention are included in all conceptualizations of comprehensive sexuality education programs for youth across the globe. Certainly, it is in meeting these objectives that universal access to comprehensive sexuality education contributes most significantly to attaining the MDGs.

There is growing and unequivocal evidence derived from peer-reviewed published studies evaluating the behavioral impact of well designed sexual health interventions that leads to the definitive conclusion that such programs are capable of significantly reducing sexual risk behavior among youth (For reviews of this literature see Alford, 2003; Bennett & Assefi, 2005, Jemmott & Jemmott, 2000; Kirby, 2000; 2001; 2005).

With respect to HIV/AIDS prevention specifically, there is also clear definitive evidence that educational interventions have the potential to significantly reduce high risk sexual behaviour among individuals, including youth.

Albarracin, Gillete, Earl et al. (2005) conducted a comprehensive review and meta-analysis of 354 HIV prevention interventions implemented from 1985 to 2003 in 33 different countries. Collectively, the interventions were shown to have increased knowledge of HIV, as well as increase positive attitudes toward condom use, change norms and intentions, improve behavioral skills, and increase actual condom use. The Albarracin et al., analysis also revealed effective prevention education strategies for different groups including youth.

More generally, there is an extensive body of HIV/STI prevention evaluation research indicating positive behavioral outcomes for interventions targeting adolescents, street youth, STI clinic patients, women, heterosexually active men, men who have sex with men, and communities (CDC, 2001; McKay, 2000).

The vast majority of the HIV/STI and pregnancy prevention evaluation literature concerning youth examines interventions implemented in the developed world (i.e., United States and Europe).

However, evidence of the effectiveness of prevention interventions from the developing world is growing. In a recent review of controlled studies in both the developed and developing world that employed experimental or quasi-experimental designs to evaluate the impact of sexual health and HIV education programs on the sexual behavior of youth, Kirby, Laris, & Rolleri (2005) identified programs from Brazil, Thailand, Kenya, Nigeria, Belize, Mexico, Chile, Tanzania, and Nambia that either helped individuals delay first intercourse, reduce their number of sexual partners, or increase condom use. Wang, Hertog, Meir, et al. (2005) reported on a comprehensive sexuality education program in China that resulted in increased condom and contraceptive use.

The literature providing evidence of the effectiveness of comprehensive sexuality education is compelling but it should not be construed as suggesting that all existing or prospective programs will be effective in reaching their objectives. One of the crucial lessons that we must learn from past experience is that there is no generic form of all-purpose sexuality education that can be effectively applied to all audiences or contexts. We must learn from both our successes and failures in order to create the most effective programs possible. Fortunately, we have already learned a great deal about the necessary ingredients of effective sexuality education. For example, a review and analysis of the existing literature (e.g., Albarracin et al., 2005; Fisher & Fisher, 1998; Kirby, 2005) suggests that programs are most likely to reach their behavioral objectives if they contain the following ten key components:

1. Include a realistic and **sufficient allocation of instructional time and financial resources**.
2. Provide educators with **the necessary training and administrative support** to deliver the program effectively.
3. Employ **sound teaching methods including the utilization of theoretical models** to develop and implement programming (e.g., IMB Model, Social Cognitive Theory, Transtheoretical Model, Theory of Reasoned Action).
4. **Use elicitation research to ascertain student characteristics, needs, and optimal learning styles**. This includes tailoring instruction to student's ethnocultural background, sexual orientation, and developmental stage.
5. **Specifically target negative sexual health outcomes** such as HIV/STI infection and unintended pregnancy.
6. Deliver and consistently reinforce **prevention messages related to sexual limit setting** (e.g., delaying first intercourse, abstinence), consistent condom use and other forms of contraception.
7. Include program activities that **address the individual's social and environmental context** including social pressures to engage in unhealthy sexual behaviors.
8. **Incorporate the necessary information, motivation, and skills** to effectively enact and maintain healthy sexual behaviors.
9. Provide **clear examples of and opportunities to practice (e.g., role plays) sexual limit setting, condom negotiation, and other communication skills**. In effective programs, individuals are active participants, not passive recipients.
10. Employ **appropriate evaluation tools** to assess program strengths and weaknesses in order to enhance subsequent programming.

Necessary Actions

4.1 Mandate comprehensive rights-based, gender sensitive, and culturally appropriate sexuality education as a required component of the school curricula at all levels and provide the required resources.

4.2 Work with community agencies to reach out of school youth and other high risk populations with comprehensive sexuality education.

4.3 Issue guidelines to ensure that sexuality education programs and services are grounded in the principle of fully informed, autonomous decision-making.

4.4 Ensure that sexuality education programs are evidence-based and include the characteristics that have been shown to contribute to effectiveness. This should be done in a way that allows for creativity and community specific needs in the development and evaluation of innovative programs.

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