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**Précis**

Sexual education is a very controversial topic in the United States right now. The goal of my research was to determine what method of sexual education produces the best results. Due to the debate over whether teaching teens about methods of contraception increases teen sexual activity, I felt it was necessary to investigate the countries that do teach teens about pregnancy prevention, and determine the actual effects.

The United States has the highest rate of teen pregnancy among any Western nation. The current rate in the United States is also higher than the teen pregnancy rate in almost fifty developing nations as well. With 43 teen pregnancies per 1,000 teens, the United States has roughly one million unplanned pregnancies every year. Determining why other nations are successful in preventing younger generations from bearing children would be useful information for the situation in the United States.

The current method of sexual education provided by public schools is a form of abstinence-only education. Abstinence-only education strictly promotes abstinence training to teenage students. The basic dogma these programs adhere to is that the only perfect method of pregnancy and disease prevention is abstinence. Unfortunately, these programs have not proven effective. The students that are enrolled in schools with abstinence-only education do not delay their age of first
intercourse, and their rates of pregnancy and sexually transmitted diseases are actually higher. Other Western nations are not having these problems, and I wanted to see if it was the sexual education that made the difference.

Sweden provided the best example of how knowledge empowers teens to make safer decisions. In the 1950's, Sweden had a sexual education plan similar to the abstinence-only plan in the United States. At this time their teen pregnancy rate was 50 teen pregnancies per 1,000 teens. In 1975 Sweden changed their program and decided to give teens information about sex, sexually transmitted diseases, pregnancy, and contraceptives. The government also made contraceptives available under the government health plan, and available to teens without parental consent. Within twenty-five years of these changes, Sweden was able to reduce their teen pregnancy rate by eighty percent, and the rate of STD transmission by forty percent.

Sweden was able to drastically change the rates of pregnancy and disease transmission by implementing comprehensive sex education. While the easily accessible contraceptives had an impact on Sweden's success, if the United States made a change in the form of sex education used in schools a similar success story could be seen here as well. It has been determined that abstinence training does not work, it is now time to use education that does work.
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ABSTRACT

Millions of teenagers internationally become pregnant every year. Most of these pregnancies are unintended, and many of the resulting children are not properly cared for. There are one million unintended teen pregnancies in the United States alone. Sexual education has significantly reduced the number of teen pregnancies in many Western nations. These successful school programs instruct teens about the methods of pregnancy and sexually transmitted disease prevention. The United States needs to reevaluate its own sexual education program and determine why so many nations have succeeded in this realm. The qualitative analysis of these programs is used to determine how these programs differ from the current programs in use in the United States, and how the United States could implement the same strategies that have been proven effective.
INTRODUCTION

The topic of sexual education tends to bring about either heated debate or general feelings of discomfort. Unfortunately, being passionate or uncomfortable does not change the need for sex education in schools. Today's teens are having sex at a young age, with the average age of first intercourse 15.8 years (Berne 1999). These teens are having sex without the knowledge they need to protect themselves. America's teens are at risk for contracting any one of the prevalent sexually transmitted diseases (STD), or becoming pregnant. Neither of these outcomes could enhance an individual's life, nor aid that individual's success in current society. A cure has not been discovered for many of the sexually transmitted diseases, thus making one act of unprotected sex a choice that maybe lived with for years to come. Many of the consequences of unprotected sex are life long.

If a teenager happens to become pregnant, the teen has a few choices in the United States. She may choose to have an abortion, which can be costly and painful, she can put the child up for adoption, where the teen would have to carry the child to term and then be faced with a potentially very emotional experience while giving up the child, or the teen can choose to keep the child. Not one of these choices is easy to make for anyone, and the consequences of each choice are different. Abortion and adoption have the potential for causing emotional trauma, while choosing to keep the child can place the parent at a disadvantage for the rest of her life.
Teen parents are often at a disadvantage in American society for a number of reasons. Teen parents are less likely to complete high school, and even less likely to complete any form of higher education. Without affordable childcare, even holding a steady job is difficult while trying to care for a young child. Education is necessary for children to learn how to succeed in all areas of life, just as adequate sex education is needed to prevent the disasters of uninformed sexual decision making.

Sexual education began in the early 1900's as discussing the anatomy and functions of reproductive organs. These sessions were usually a part of the biology lectures, and topics outside of reproduction were rarely elaborated on (Otto 1978). In the 1960's with the release of the birth control pill, sexual behavior began to change in America's adolescents and young adults. Fear of pregnancy was no longer a significant factor in deciding to abstain from sexual relations, now that pregnancy could now effectively be avoided. Single Americans now had choices when making decisions relating to their sexual behavior. The rebellious attitude of this era was only increased with the sexual freedom that young women had now been given with the release of the birth control pill. These medical advances required more knowledge to make an informed decision. There are so many forms of contraception to choose from, all providing different advantages and disadvantages. Sexual education needed some changes.
Sexual education gradually began including some contraceptive information, but there was no national standard in the United States. This left the sexual instruction at the discretion of the public school teachers, most of whom had no training in sexual education. This left many instructors very uncomfortable with teaching students about the subject, and so many teachers would avoid teaching areas outside of strict reproduction and physiology. It is difficult to expect a schoolteacher to instruct students in a subject on which they have had no formal training. These public school teachers were not instructed how to approach sexual topics, nor were many of these teachers provided with adequate teaching materials. Teachers needed some assistance before sexual education had a chance of succeeding.

No national standard for sex education was even thought of until the 1980's. In the 1980's traditional family values became more and more attractive in the aftermath of the sexual revolution of the 1960's. Ronald Reagan had used this change in attitudes to his advantage during his presidential campaign, but he was not the only politician lobbying for traditional family values. In 1981, Senator Jeremiah Denton of Alabama, proposed the Adolescent Family Life Act (AFLA). The AFLA funded programs in schools and community centers promoting self-restraint and discipline to counteract the number of both teen pregnancies and abortions. Senator Denton felt that teen sexual activity and abortions had a strong correlation, and felt that his plan could remove both of these evils from society at the same time (Levine 2002). While it does make sense that
sex and abortion rates are correlated, it definitely takes more than a few lectures to overcome a natural drive like sex in teenagers.

AFLA was not the only law to be passed promoting the use of abstinence training and banning comprehensive sexual education. In 1996, as part of the Welfare Reform Act, 250 million US dollars were to be spent over the next five years on sexual education programs around the country that promoted abstinence-only education. This was along the same lines as AFLA, and had the same motivations as well, to reduce teen sexual activity. Most public school districts accepted the money, and since that time the average school has been promoting abstinence among its students.

Schools that are funded by the 1996 bill are not permitted to discuss forms of birth control, safer sex, and especially not permitted to discuss abortion as a choice that can be made by pregnant teens. These programs are only permitted to discuss the failures of birth control methods, and the failures of condoms in preventing STD transmission. There are so many choices that today's teens can make about their sexual health, and preventing teens from obtaining information is only going to increase the number of teens devastated by the consequences of unprotected sex each year.

Medical research has given this population many choices regarding the prevention of pregnancy and sexually transmitted diseases. Until the release of the birth control pill in the sixties, in the United States there were only barrier methods of contraception available, like the condom and cervical cap. The diaphragm and cervical
cap need to be fitted by a physician, and the birth control pill requires a prescription, causing most conversations about birth control choice to be conducted with a physician. Today, sexually active teens have a number of hormonal contraceptive choices, as well as the traditional barrier contraceptive methods. Unfortunately, despite the increased knowledge that teens need to determine the right method for their lifestyle, the average school is still not teaching students about birth control methods.

Sexually transmitted diseases are being studied in many laboratories to provide the public with more accurate information to use to protect themselves. The Human Immunodeficiency Virus, for instance, was not identified until the eighties when the general public believed that it was a disease only homosexuals were susceptible to. Medical scientists later learned that HIV is not sexual orientation specific, nor can it be passed through kissing, hugging, or breathing the same air as an infected person. STDs are all easily prevented with the use of condoms and regular testing for these infections, but sexually active young adults are not being taught this information. The information is available at medical facilities, but the average person is not likely to ask their physician about such topics. While the correct information is available, many myths about each of these diseases are also easily overheard and discussed with peers. The vast amount of misinformation about birth control and sexually transmitted diseases being circulated aids the case to increase what is taught in sexual education courses.
Teaching sexual education brings about the moral debate over what exactly is appropriate to be taught to teenagers. Currently in the United States there are two sides to this debate. There are those that feel that information is necessary to protect America's youth from the dangers of unprotected sex. The opposing view is that giving teens information about safer sex actually encourages premarital sex. This group feels that this would increase the current rate of teen pregnancy through an increase in the number of teens having sex. These sects of people believe that sexual education puts sexual thoughts into these teenagers' minds, thus increasing the number of sexually active teenagers. Consequently, these people believe that the best solution to the teen pregnancy rate would be to teach sexual abstinence to students, so as to not encourage premarital sexual behavior. Both sides feel that a solution is needed, and both sides also believe that they have found the solution. Determining a solution and implementing it is in the best interest of all Americans.

Abstinence education involves very little discussion outside of teaching abstinence. These programs teach students that abstinence is the moral standard, which students must adhere to. These programs do not delve in to the different forms of birth control, and very rarely discuss sexually transmitted diseases. STDs, if included in the lesson plans, are used as added reasons to abstain from any sexual encounters. These programs are well supported, for example by religious groups that disapprove of premarital sex, and parents scared by the rates of STD transmission. While promoting
abstinence has its merits, others feel that teaching teens the information they need to protect themselves without promoting a way of life would be more effective.

Comprehensive education, or abstinence plus education, teaches students about both abstinence and birth control methods. The many forms of hormonal birth control (i.e. the Pill) and barrier methods (i.e. condoms) are discussed along side a discussion of abstinence as a form of family planning and birth control. Sexually transmitted diseases are also explained in depth. Students are taught how to prevent contracting an STD, what the symptoms of the various diseases are, and how each disease is either cured or treated. These programs give teenagers all the information they would need in order to protect themselves if they do decide to engage in sexual behaviors (Donahoe 2002). While some feel that these programs promote sexual activity in adolescents, many researchers feel those suspicions are unfounded and are not supported by fact. Fortunately, many other countries have found the need for sexual education and have employed a number of different teaching methods for this controversial topic. Examining these methods and their success rates, in the form of rates of teen pregnancy, could end this moral debate in the United States.

The United States currently has the highest rate of teen pregnancy among any Western nation. According to the Center for Disease Control and Prevention (CDC), for every 1,000 teens in America there is an average of 43 pregnancies. Comparatively, the Netherlands experiences 6.9 pregnancies per 1,000 teens, and France has only 9.1
pregnancies per 1,000. While some argue that these lower rates are due to an increased acceptance and prevalence of abortion in these countries, this is not the case. The United States also has the highest rate of abortions preformed per 1,000 teens with 20.1 abortions, while the Netherlands, France, Germany, and Sweden are all fewer than ten abortions per 1,000 teens. If these lower rates of pregnancy and teen abortion can be related to the forms of sexual education in use in these countries, then it would be beneficial to the United States to determine how to implement these programs in public schools.

Determining an effective method for sexual education could have a significant impact on many facets of American society. There are over one million teen pregnancies every year in the United States. Unfortunately the average teen is not financially stable enough to care for a child, and consequently many of these teens eventually seek out government assistance to care for their children. Studies completed by UNICEF have discovered that the combined cost of welfare and medical care costs for these teen mothers and their children is over $7 billion every year. Many of these pregnancies will end in abortion. Despite the debate over the morality of abortions, abortion is a painful procedure and avoiding the pregnancy would have been much easier. If pro-life groups really want to prevent abortions, preventing unintended pregnancies would be one step toward reducing the rate of abortions in the United States. Making abortions illegal
would not be necessary if unwanted pregnancies were avoided, because abortions are rarely the result of a planned pregnancy.

Governments and teen mothers are not the only victims to this situation. According to UNICEF, the infant mortality rate is fifty percent higher among infants born to mothers under the age of twenty. These infants are less likely to have access to adequate health care, given that teen parents rarely have health insurance. The lack of health care increases the mortality rate. UNICEF has also found that women currently living in poverty are three times more likely to remain in poverty after having children in their teens. Many activist groups are attempting to reduce the number of Americans living under the poverty line, and sex education could at least lessen the number of children living in poverty. American teens could have so many opportunities if they were practicing safer sex instead of teen parenthood. It would be in the best interest of society if the most effective method of sexual education were determined and implemented in American public schools.

RESEARCH QUESTION

The sexual education of the United States is severely lacking the ability to prevent the consequences of unprotected sex. There are many countries not experiencing the same level of difficulty, and discovering what factors contribute to their success could possibly help the United States recover from the high rates of teen pregnancy. It also needs to be determined which method could logistically be
implemented in the United States. Sexuality is a very culturally determined topic, and when determining the ability to employ a given sex education method, this factor needs to be taken into consideration.

**APPROACH**

Now that the issue of teen pregnancy has been identified, a method to determine how each country's programs differ and how successful each method is was created. To examine the differences between the various methods of sexual education, ten different variables were selected to compare the programs to one another. After each variable was examined, the success of the programs was inferred from the country's rates of teen pregnancy, teen abortion, and STD transmission rates.

The first variable to be compared was how each program approached the topic of abstinence. How abstinence was presented in the program was examined. It was then determined if abstinence was the main focus of the program as in abstinence-only education, if it was presented as a choice that each individual makes for himself or herself, or if abstinence was omitted entirely from training. This has been a large issue of current debate, since the omission of abstinence training from sexual education is seen as promoting premarital sexuality.

Contraception and condom use instruction were also investigated. There is a wide range of variability of how programs compared on these subjects, because while some programs simply did not include these subjects in the curriculum, others briefly
explained what each method entailed, and some programs instructed on the use and application of condoms and other contraceptives. In this same area, it was also determined how easily teenagers could obtain contraceptives. It was determined if there was government assistance for the cost of birth control, due to the high cost of hormonal birth control, and whether parental consent was necessary to obtain contraceptives. Requiring parental consent for a teenager to obtain birth control could change the likelihood of some teens seeking contraceptives.

Sexually transmitted disease coverage was determined next. Did the program explain the transmission of each disease, did they explain if the disease was curable or just treatable, and the accuracy of the information presented in the program were all factors in this dimension of sexual education. Again there was a wide range of information being distributed, everything from teaching inaccurate ways to contract these diseases, to teaching the newest medical information was found among the programs I looked at. Human Immunodeficiency Virus (HIV) coverage was examined more closely than the coverage of the other diseases. HIV causes such a deadly disease that looking at the accuracy of the information relating to HIV was important. Finally, the accuracy of information presented in general was examined. This has recently been a criticism of abstinence-only programs, so the accuracy of the information used in all of the programs was investigated. It was definitely possible that if one form of sexual
education was spreading false information, that another program of sexual education was also spreading false information.

Each program was then examined to see if alcohol and drug use information were included in instruction. Although the coverage of these topics does not immediately seem applicable to the study of sex education, drugs and alcohol do have an impact on sexuality. The intoxication caused by alcohol or drugs has a detrimental effect on general decision-making ability, thereby affecting a teenager's ability to make appropriate sexual decisions for themselves. So each program was then looked at to see if these issues were even discussed, and if so how was the situation approached was looked at as well.

The last three variables to be investigated were the length of the program, the general structure of the program, and the tactics used in the program. The duration of the program showed large differences among the different programs. Some begin when students are around the age of seven and continue through high school, while others only last for a few class sessions over one year in high school. The general structure was examined to determine if a lecture based class would be more effective than a discussion and activity based program or vice versa. These methods of teaching vary in effectiveness among other academic subjects, so it needed to be determined which method was most effective for this subject. Finally the tactics used in the classroom were looked into. Some programs were using STD coverage and the lack of a one
hundred percent effective birth control method to scare students into pledging abstinence until marriage. Most programs were providing students with accurate information to empower the teens to make their own decisions. Information needs to be portrayed accurately, and the programs using scare tactics were not portraying accurate information much of the time.

The information on each program was researched through a variety of sources. Sweden, for example, is very proud of their sexual education program and the successes they have had with their program in the last thirty years. Sweden has donated one percent of their gross national product to sexual education in developing nations every year for roughly the past twenty years. Consequently, their program is well documented, and there is ample literature describing the Swedish program. Other countries were not as easy to research, but teen pregnancy is a worldwide issue and many journals have included information about how the Dutch and Danish societies, for example, have managed to produce a teen pregnancy rate as low as that of Sweden.

Teen pregnancy rates and the rates of STD transmission for various nations were gathered from the Center for Disease Control and Prevention, the United Nations, and the United Nations Children's Fund. Data concerning abstinence-only and abstinence-plus programs was easily found from sources like Planned Parenthood, as well as at the websites promoting each type of program. While these sources did post inaccurate information about the opposing method of sex education, these sites did
provide the curriculum for their own program. Both approaches are campaigning to be included in American schools right now, so information was easily found. There has also been information on the political debate over this issue, so various news-broadcasting companies have also provided information for this topic. The United States House of Representatives recently released a report on the current government funded abstinence-only education programs, which also proved to be very useful. Through the combination of these sources I was able to determine how the methods of sex education differed from one another, and see the general effect on teen pregnancy in each respective country.

RESULTS

The results of the rubric variable comparisons follow. Abstinence-only and abstinence-plus methods from the United States, along with the programs from Sweden, the Netherlands, Germany, France, and the United Kingdom were investigated. These programs were qualitatively analyzed using the ten variables discussed.

Abstinence-Only

Abstinence-only education is currently the form of sexual education being funded by the United States government to be provided in public high schools. Since each state has the opportunity to create a curriculum for sex education, what is actually taught across the country varies. Until 1996, there were no federal policies for sexual
education, except abstinence groups funded by the Adolescent Family Life Act. These groups were not a significant part of the American public school system, however. Part of the Welfare Reform Act of 1996 appropriated $250 million to be given to states willing to adhere to an abstinence-only education program. Teaching students to wait until marriage before beginning a sexual relationship and the negative consequences of engaging in a sexual relationship were the standards of these programs. Forty-eight states have accepted abstinence-only funds since 1996. The guidelines to qualify for the grants include promoting abstinence, while birth control and abortion are to be omitted from lectures. To compensate for the variability I found among the thirteen most common abstinence-only programs, I will show the range I have found for each variable being discussed.

Abstinence-only education has a very strong opinion favoring abstinence in youth. These programs explicitly promote abstinence, often presenting abstinence as the only choice in reference to sexual relations before marriage. Often involved in these programs are virginity or abstinence pledges that the students take, vowing that they will not engage in premarital sex. These programs will either omit information about condoms and other forms of contraception, or explain how ineffective these methods are referring back to explaining that abstinence is the only one hundred percent effective method of both birth control and STD prevention. The promoters of abstinence-only education would prefer that contraceptives were only available to teens...
with parental consent, if at all. Currently in the United States, contraceptives, like the
birth control pill, are available to teens without parental consent. Some states, including
Washington State, provide free contraceptives to women unable to afford such
expensive hormonal methods. In the states that do not subsidize contraception, clinics,
such as Planned Parenthood, will provide birth control at a lower cost for those who
cannot afford it. Some health insurance plans do provide coverage for contraceptives.
However, a large percentage of Americans do not have adequate health insurance.

Abstinence-only programs are not required to cover information about
sexually transmitted diseases. Those that do often times distort the facts about
transmission and prevention, sometimes teaching completely incorrect information. In a
report recently released by the United States House of Representatives Committee on
Government Reform, eleven of the thirteen federally funded abstinence-only
curriculums contain errors in discussing STD transmission, HIV transmission, and the
ability of condoms to prevent these diseases. Many of these programs cite an erroneous
study completed in 1993 by Dr. Susan Weller, who had determined the effectiveness of
condoms in preventing the transmission of HIV to be less than 69%. This study
contradicts the studies that the Center for Disease Control and Prevention have
completed, as well as other studies published in the New England Journal of Medicine,
which show that condoms have an average effectiveness rate upwards of 85%, which is
improved to about 97% effective with perfect use.
The general accuracy of information among the abstinence-only programs is low. Not only is condom effectiveness misrepresented, the risk of pregnancy for other forms of sexual behavior are inaccurate. According to the same report from the United States House of Representatives, one program explains to students that simply touching another person's genitalia can result in a pregnancy. Pregnancy could only result from that situation if there was ejaculate transferred from the penis to the vagina via a hand; otherwise the touching of another's genitalia could not result in pregnancy. Another abstinence-only program states tears and sweat as bodily fluids that can transmit HIV, but according to the CDC, the exchange of tears, sweat, and saliva has never resulted in a case of HIV transmission. One program that did include instruction on condom use taught students to examine the condoms for holes, and after intercourse, both partners should immediately wash their genitals with soap and either rubbing alcohol or diluted Lysol. Though an examination of the condom packaging for rips is necessary, examining the actual condom is not and could produce tears in the process. Many physicians suggest a general washing of the genitals after intercourse, especially when a partner is susceptible to bacterial infections, but physicians suggest washing with a mild soap only. Washing the genitals with either of those harsh chemicals could cause serious health problems.

Alcohol and drug use are generally not discussed in these programs. These programs are generally taught in high school, and alcohol and psychoactive drugs are
illegal for high school age students in all fifty states. This fact tends to negate the need to discuss how alcohol can effect sexual decision making in these programs.

Unfortunately, roughly thirty percent of high school age teenagers drink on a weekly basis (CDC 1995). If these topics are approached, they are discussed as immoral and contributing factors that lead teens to participating in sexual activities.

The lengths of abstinence-only programs vary from a couple class sessions in high school to a few class sessions every other year through middle school and high school. These programs are usually a mix of lecture and discussion. Their main activity is the virginity pledges that are signed by students. These pledges are discussed among the class, and then signed. These pledges have shown to delay the first act of intercourse among teenagers, but only for a few months.

The distorted information used in these programs seems to represent the use of scare tactics in recruiting teens to an abstinent way of life. Misrepresenting STD transmission and the facts about conception are simply ways to frighten teens into believing that abstaining from sex is the only way to prevent pregnancy and prevent the contraction of a deadly STD.

Unfortunately for abstinence-only supporters, these types of programs have not proven very effective (Yudt 2004). These programs have been in use since the 1980's, and teen pregnancy rates have only declined slightly. This decline is not due to an increase in abstinence practicing teens, but instead to an increase in effective use of
contraceptives according to the CDC. The United States still has the highest rate of unintended pregnancies among Western nations, with a rate of 43 pregnancies per 1000 teens.

**Abstinence-Plus**

Abstinence-plus education, also known as comprehensive education, is not currently being supported by the United States government, and thus isn't being taught in enough schools to determine the exact effectiveness of the program on a large scale. The basic curriculum that is being promoted by supporters, like Planned Parenthood, will be examined in this section.

Abstinence is covered in the abstinence-plus programs as well as contraceptives. The name of these programs changed from comprehensive to abstinence-plus to make it known that these programs do not promote premarital sex, but rather individual choice. Abstinence among America's teens has become the ideal situation most parents hope their children will strive for. Abstinence is one of many choices about sexuality that is discussed in these programs. Unlike abstinence-only programs, abstinence is not the only choice teens are taught about, and teens are not asked to make a pledge to remain abstinent either. Other choices about sexuality are also presented, such as intimate activities not leading to sex. Teens not only have the choice between safe sex and complete abstinence, but also given options for remaining a virgin while still being intimate with their partner.
Choices about contraceptives and condoms are also included. There are many different types of contraceptives, and not each one will be appropriate for each person. Abstinence-plus programs instruct teens on the advantages and disadvantages of each method, along with the effectiveness of each method. These programs are based on the principle that choices should be based on information, so the information taught is accurate. It is often discussed how to obtain contraceptives and condoms in these courses, so that teens can implement the method of birth control they find most appealing. Condoms are also discussed in detail. Instruction pertaining to the application of condoms may or may not be included in actual training, but their effectiveness, advantages, and disadvantages are usually part of the program. Condoms are essential for disease prevention in premarital sex, due to the fact that hormonal methods of birth control do not provide protection against the transmission of STDs.

Sexually transmitted diseases are a large unit in abstinence-plus education. These programs try to give the latest statistical information on transmission, as well as the most recent medical knowledge of how these diseases are transmitted, prevented, treated, and whether or not a specific disease is curable. I was unable to find a program teaching inaccurate STD information to its students. These programs usually have extensive lessons on HIV and AIDS. It is important to these programs that teens know how they can and cannot contract these diseases so they can effectively protect themselves.
Each program varies, but alcohol and drug use are discussed in some programs. It is discussed how the ability to make decisions is impaired while intoxicated, which also impairs the teen's ability to make responsible sexual decisions. In certain programs, sexual assault is also discussed during the alcohol unit. Alcohol and drug use are associated with between 40% and 50% of all rape and sexual assault cases. Informing teens of these dangers is important for their safety as well.

The length of each program varies. The general consensus is that the longer the program, and the earlier it begins, the more effective the program will eventually be in preventing teen pregnancies. These programs also vary in structure, but most involve some lecture material and are largely discussion based. Activities in these programs vary from role-plays, or games, to general question and answer sessions. I was also unable to find a curriculum involving the use of scare tactics to persuade teens to not have sex, or scare them into using condoms.

Since these programs are not in widespread use in America, the general rate of teen pregnancy in the United States would not be an appropriate basis for evaluation. The few studies published have shown an increase in use of contraceptives, condoms, and abstinence among teens involved in these programs, thus showing a lower rate of pregnancy in that population (Donahoe 2002).
Sweden

Sweden has had mandatory sexual education since 1956. The sole purpose of this education was to decrease the numbers of teen pregnancies. This goal was realized through an increase in use of free abortions. Though legal in Sweden, abortion is not condoned, which brought about the need for sexual education reform in 1975. In 1975 sexuality education began earlier in the student’s lives and no longer included any moral judgment about premarital sex. Since 1975 both the STD transmission rates and unintended pregnancy rates have fallen drastically.

Sweden removed all aspects of abstinence training from its curriculum in 1975. Their program no longer insists that abstinence is the key to a healthy life. Abstinence is discussed, but as a very minor point of the total education program. Sweden also stopped emphasizing that intercourse should only occur within a marriage. Though sexual activity is not encouraged, neither is abstinence.

Instruction involving contraception and condom use is an essential part of Sweden's program. Contraceptives are seen as the solution to reducing the teen abortion rate. Sweden discusses the effectiveness and proper use of contraceptives in an open, unbiased fashion, while portraying accurate information about contraceptives. Condoms are also seen as disease and HIV prevention. Instructing on where to obtain condoms, as well as how to use a condom properly are very important to this program. Condoms are available at most grocery and drug stores, as well as in vending machines.
in most public restrooms. Free condoms are available at some hospitals and family planning clinics. Hormonal contraceptives are subsidized by the government so that all Swedes have access to effective methods of birth control. Parental consent is not necessary for receiving contraceptives.

The Swedish program covers HIV and sexually transmitted diseases in great detail. Providing the public with accurate information about disease transmission is essential for reducing the number of citizens infected with a sexually transmitted disease. Preventing the spread of STDs is far less expensive than treatment of STDs for a government that provides healthcare for its citizens. These programs distribute accurate information to prevent the transmission of diseases.

Sweden's program begins when children start school at the age of seven. In the first few years of school, children openly discuss where their younger siblings came from, how their mothers carried them for nine months, and general reproduction information. Sexual education is integrated into all subjects, rather than being limited to a biology or health class. At the age of thirteen, Swedish students begin learning about contraception, condom use, and sexually transmitted diseases. These sessions are rarely lectured, but rather instructor led discussions where students can freely share experiences and curiosities. These topics are brought up in numerous subjects, everything from discussing the HIV virus in biology to discussing fidelity related to a piece of literature.
Sweden's program has proven to be very effective. Sweden's unintended pregnancy rate was about 50 per 1,000 teens before the 1950's, but since the implementation of the current program in 1975, Sweden's teen pregnancy and teen abortion rates have dropped to roughly six pregnancies per 1,000 teens, one of the lowest in the world (Stopes 2004). This was done without the moralization of teen sex, and without the use of scare tactics to frighten teens into abstinence methods.

Netherlands

Sexual education in the Netherlands varies from school to school. There is no mandated sexual education program in the Netherlands, and no preferred text and curriculum to follow. Despite the lack of governmental requirements, more than ninety percent of Dutch students receive sexual education in school.

Unlike the abstinence-only programs, the Dutch model rarely discusses the negative consequences of sexual encounters. With sex being presented in a positive light, abstinence, if discussed at all, is presented as an individual's choice, rather than a social standard to adhere to. The Netherlands, despite a lack of abstinence training, has the highest average age of first sexual encounter among western nations, with an average age of 17.7 years. Sweden and the United States, for comparison, both have an average age of first sexual encounter around the age of fifteen.

The use of contraceptives and condoms are taught in most schools. This became a focus of sexual education with the discovery of AIDS. Condoms are available
in most stores, clinics, hospitals, and public restrooms. Instruction on the use of condoms is a part of most Dutch curriculums, as is instruction on where to obtain other contraceptives and how they are used. Condoms are the only contraceptive not covered by the national health insurance. Diaphragms, oral contraceptives, intrauterine devices, and emergency contraceptives are all covered by the national health plan (Berne 1999). Teens are able to receive these methods of birth control without parental consent, thus reducing the number of steps a teen must complete before being given access to contraceptives.

Because sexually transmitted diseases were the main driving force in promoting sexual education, STDs are extensively covered in these programs. The Netherlands's national health plan provides free STD testing, HIV testing, pre-test and post-test counseling, as well as STD treatment at many clinics around the country. Not only is information provided in the school curriculum, but the government displays sexual health information in various forms of mass media. Obtaining accurate STD information is not difficult. The HIV pandemic caused fear in the government, and continues to be a reason sexual education is still important in Dutch schools.

Sexuality education begins in the Netherlands at around the age of twelve for most students. This program is incorporated into most school subjects, as was Sweden's program. The general approach to sexual education is to talk with students as opposed to teaching at the students (Berne 1999). The questions arising from students tend to
direct the class discussions. Teachers are free to teach the students whatever it is that the students want to learn about human sexuality. The government does not ban certain subjects from the classrooms, thus giving teachers freedom to teach what they deem appropriate for the individual class and age group. In addition to believing that information empowers young teenagers, the Dutch also believe that sexual behavior is an individual decision that should be assisted by an open accepting community. The Dutch system also includes discussions and activities based on improving communication skills so that relationships can be more fulfilling, and so each partner understands the wants and needs of the other.

The Dutch model does seem to have proven itself effective, given that the rate of both unintended pregnancies and teen abortions are at a rate less than one third of the rates in the United States, with a rate of 6.9 pregnancies per 1,000 teens (De Vroome 1991). Improving the sexual education helped the Netherlands decrease their rate of HIV transmission to one of the lowest in the world.

**Germany**

Germany views human sexuality as part of a physically and psychologically healthy lifestyle. Consequently, their sexual education is very accepting of premarital sex among teenagers. While open about sexuality, abortion is not condoned as a method of birth control, so other forms of contraceptives are made easily accessible to prevent large numbers of teen abortions.
Abstinence is generally not part of the German sexuality education instruction. Abstinence is certainly not promoted as in abstinence-only programs. Contraception and condoms, on the other hand, are promoted extensively. Information regarding how the many forms of birth control work, are used, and effectiveness is discussed. The program is designed to motivate students to use birth control correctly and for every sexual act. Contraception is provided free of charge to all women under 20 years old, and is available at many clinics and pharmacies (Berne 1999). Parental consent is not necessary for a teen to obtain contraceptives.

There is vast coverage of sexually transmitted diseases and HIV among German schools. Germany feels that prevention is key in ending the HIV pandemic, and freely administers information regarding the transmission and prevention of all STDs. Students are taught about the symptoms of many STDs, how they are contracted, and the course each disease eventually takes. Schools discuss behaviors that put students at risk for contracting these diseases, including intravenous drug use. When discussing the risks involved in these behaviors, German schools also explain how to decrease the risk of participating in these activities. Using a condom for every sexual act would be an example of reducing the risk of contracting a disease from a potentially risky behavior.

Germany has a program that is well integrated into the German school system. Sexual education is taught in the early teenage years, so that prevention information is distributed before the average teen becomes sexually active. The German program is
largely discussion based, where the instructor answers students’ questions when they are asked. The instructor may lead the discussion into an area of sexual education that needs to be addressed, but always answering students’ questions and facilitating discussion sessions. Sexual education also provides instruction on sexual communication, sexual development, and relationship skills. German sexual education prepares students for the intimate relationships that will be significant parts of each student’s life.

Germany's open and accepting social atmosphere, combined with an effective sexual education program, and easy access to contraceptives has allowed Germany to maintain low rates of teen pregnancy.

France

Sexual education in France was almost nonexistent in schools until HIV was discovered in the 1980's. Sexual education usually takes the form of disease prevention in France. France is a predominately Catholic culture, and thus does not condone abortion; nonetheless abortion is still legal in France. To prevent abortions, preventative measures are taught in schools. The French schools try to be creative in their instruction, include the input of teens on sexual education policies, and try to make contraceptives easy to obtain.

France did not mandate sexual education to delay sexual relationships in teens, but rather to inform teens about preventative measures to take to ensure a healthy
sexual experience. Abstinence is not exclusively taught in French schools, while condom use and contraceptive uses are. Contraceptives are available at no cost for teens 18 years of age and younger. For older teens, the national health insurance subsidizes most of the cost of contraceptives. Parental consent is required for teens under fifteen, but is overlooked by many physicians if it is in the best interest of the teenager.

Since sexual education began as disease prevention, STDs and HIV are a main portion of the program. Distributing accurate information to all ages and demographic groups is important to the French government. Students are taught the basics of transmission, symptoms, and treatment in school.

The mandated program begins at age thirteen, where between 30 and 40 hours of instruction are required per year until students reach high school. Most schools include sexual education beginning around the age of nine, starting by teaching simpler topics, such as how babies are born. Once the student turns thirteen, parents are no longer allowed to remove their child from these courses, because the French government believes that public health is endangered by students not learning pertinent information about engaging in safer sexual practices (Berne 1999). Teens are often included in the distribution of information, and have the opportunity to discuss how information should be presented with those that distribute sexual information on a larger scale.
The sexual education and government policies pertaining to sexual health have had some success in France. While France does not have the lowest rates of teen pregnancy and STD transmission, their rates are still less than half of the rates experienced in the United States currently.

**United Kingdom**

The United Kingdom is in a similar situation as the United States regarding sexual education. There is currently a debate over what methods of sexual education should be implemented to counteract the high rates of teen pregnancy being experienced in the United Kingdom. While some officials are looking to the Netherlands for answers, others are following their religious beliefs and hoping to restrict what is taught in schools to family values and abstinence training. Prime Minister Tony Blair is currently asking Parliament to initiate sexual education reform. The current system of sexual education is examined in this section, but since British schools have almost no national guidelines to follow, each region's programs are different.

Abstinence is currently a major part of the British sexual education program. To aid the abstinence instruction in British schools, American fundamentalist groups have been promoting abstinence-only education in Britain as well. Contraceptives and condoms are taught in some schools, but are not emphasized to the degree that Britain's neighbors, like Germany, emphasize contraception. Contraceptives are available for
teens, though information on how to obtain contraceptives was harder to find. It was more difficult to research, so chances are that inexperienced teens looking for information would have similar difficulties. Britain does have national health care, and contraceptives are offered at a subsidized cost.

Sexually transmitted diseases are minimally covered in British schools. Some schools provide no training on prevention, while others do promote the use of condoms during sexual encounters to protect one from contracting STDs. The general structure of these programs involves lecture and some discussion. The programs are substantially shorter than their European neighbors, with some schools providing only a couple hours of instruction per year. The accuracy of the information discussed in classes was difficult to ascertain, but I was also unable to find any evidence of complaints about inaccurate information either.

The United Kingdom has a very poor track record for its sexual education programs. The lack of guidelines provided by a national committee could not help the fact that most schools do not have a set standard for sexual education. Britain's teen pregnancy rate has been recorded at around 30 pregnancies per 1,000 teens, a rate similar to the rate in the United States.

Analysis

While there were many differences in what these seven programs taught, how each program was implemented, and social services accompanying the program, there
were a few main differences. There are large differences between the information provided between all of the programs and the abstinence-only programs. Not only do abstinence-only programs omit information about birth control, these programs often teach inaccurate information to students. The other six models all seem to be based on the basic theory that providing information to teens and enabling them make their own decisions will be in the best interest of the teens.

The European programs differed even more from the abstinence-only programs than the American abstinence-plus model. The European models almost completely omitted discussion of abstinence, with the exception of the United Kingdom. These programs were also different from the abstinence-plus programs in that respect.

The other major difference between the United States and Europe is that all of the European countries examined provided free birth control to teenagers without parental consent. This can contribute a lot to the number of teens using contraceptives, and consequently the number of teen pregnancies.

The United States and the United Kingdom have the two highest rates of teen pregnancy among Western nation by a large margin. The US stands at around 43 per 1,000, and the UK has remained at around 30 per 1,000 teenagers. Each of the other countries looked at had rates varying around 10 births per 1,000 teens.

Sweden’s experience with sexual education and its effect on unintended pregnancy rate was the most insightful. While Sweden implemented an abstinence-
until-marriage program in 1956, there was no substantial change in teen pregnancy. In the almost twenty years that plan was in effect, the pregnancy rates did not change enough for Sweden's government to deem it a success. In 1975, Sweden removed abstinence training, and increased instruction of contraceptives, and in the last thirty years has decreased the rate of teen pregnancy by eighty percent.

The programs that had success also had class structure and program duration in common. These programs begin sexual education with an informal format when children start school. These programs then continued on through high school, and provide teens with contraceptive information before the average age that teens become sexually active. The classroom sessions are usually discussion and activity based. These programs are very interactive, which appeals to multiple student learning styles in the program.

DISCUSSION

Sexual education is a critical component of reducing unintended pregnancies, reducing teen abortions, and reducing the transmission of sexually transmitted diseases. It has been shown that the countries that employ a comprehensive method of sexual education tend to have lower rates of teen pregnancy and teen abortion. Countries, such as Sweden and the Netherlands, have successfully lowered their rates of teen pregnancy through an education program that teaches students accurate information about birth control practices, the transmission of STDs, and provides
preventative measures to teens at low or no cost. Sweden lowered its rate of teen pregnancy by 80% since its education reform in 1975. If Sweden can accomplish such a feat, it would be in the best interest of the United States to try and follow suit.

The main differences between the sexual education programs that worked and those that have not provided promising results can be simplified into those that allowed teens to make their own choices and those that attempted to make the decision for the teen population. The programs that found success in reducing pregnancies, did not moralize the sexual decisions being made by teenagers. Instead the successful programs tended to promote learning about protecting oneself from the consequences of unprotected sex. Sweden's rate of teen pregnancy was comparable to the United States before the 1970's, at which time an open and accepting form of education was implemented. This program aided Sweden not only in reducing teen pregnancies by eighty percent, but decreasing STD transmission by forty percent. Sweden had an abstinence-until-marriage program in the 1950's, but it did not provide the success that their current program has provided.

The programs that were unsuccessful in preventing teen pregnancy had a few common characteristics. These programs taught teens that the only way to prevent pregnancy effectively was through abstinence. Abstinence is the most effective way of preventing pregnancy, but that does not mean that the many other forms of contraception available are completely ineffective. These programs also attempted to
make these sexual decisions for the teens by setting abstinence as the moral standard all teens should strive for. The successful programs give teens the information necessary to make an informed decision about their individual sexual activity levels.

For the United States to implement one of these models a few things would most likely need to change before any program could succeed. First, the information being taught needs to be accurate information, so that teens are really learning how to protect themselves. If teens are going to be expected to follow the advice of their instructors, then teens need to be able to trust that the information being given to them is accurate. Teens need information about contraceptives, how to make sexual decisions, and the dangers of unprotected sex. Teens also need to be given choices regarding these topics. There should be a national standard that schools should adhere to so that all teenagers are getting the information they need from the public school system. Parents are not a reliable source of information for teens, due to the fact than many parents prefer not to discuss the sexual activity levels of their children.

Teachers also need help in these areas. Providing training to teachers that will be teaching sexual education is necessary to help the teacher feel comfortable with the subject, which in turn helps students become comfortable with sexuality. Increasing the subsidization of contraceptives would also aid in decreasing the number of teen pregnancies every year. For once teens are given all the information, many still will not be able to afford expensive hormonal birth control. This would be the ideal situation for
implementing a new form of sexual education, but any changes in this direction would be a good start.

Abstinence until marriage programs hope that by scaring teens with the dangers of unprotected sex, the basic Christian values of chastity will be adhered to. While it is true that abstinence is the only completely effective method of prevention, telling teens that the other methods are not effective does not increase their likelihood of actually abstaining from sex until they do get married. Teens involved in these programs are just as likely to have sex before marriage as teens that do not receive this sexual education. The only difference is that the teens having received abstinence training are less likely to use contraception when they inevitably do engage in sexual behaviors. These teens were taught by teachers they trusted, how ineffective birth control methods were in preventing pregnancy and STDs, and consequently do not believe that it is worth the time, effort, or money to use these methods. So not only do abstinence programs not reduce the number of sexually active teens, these methods decrease the number of teens that are using contraception effectively.

The United States House of Representatives Committee on Government Reform recently prepared a report for Representative Henry Waxman. Rep. Waxman has been a long time promoter of comprehensive sexual education in public schools. He believes that giving teens the knowledge to protect themselves is the easiest way to reduce the number of teens affected by the dangers of unprotected intercourse. Recently
he has been accusing the abstinence-only programs of teaching inaccurate information during class sessions. The US Committee found that Rep. Waxman's suspicions were in fact correct. Many of these programs cite inaccurate or outdated studies to exaggerate the dangers of sex, failure rating of condoms and birth control, and distribute inaccurate information on how STDs are transmitted. Teaching inaccurate information does not seem appropriate for a highly developed nation like the United States. What is it that Americans value that condones teaching incorrect information? For a country that prides itself on being on the front line of discovery in many fields of science and engineering, how is teaching that oral sex leads to pregnancy appropriate? These seemingly misguided values could potentially cause damage on a much grander scale than a few teenagers believing that a person can contract HIV from kissing someone.

The United States has a very high rate of teen pregnancies compared to other Western nations. The reasons that the United States has for not implementing better forms of sexual education do not even compare with the many reasons for the United States increasing the scope of sexual education. Many conservative groups and politicians fear that allowing sexual education to include contraceptives and condom instruction will be seen by teens as permission to engage in premarital sex. Unfortunately for these groups, these fears have not been proven by any scientific fact. The countries that do employ a comprehensive sexual education have rates similar to the United States in regards to the percentage of sexually active teenagers. The type of
sexual education does not seem to affect the number of teens that will engage in sexual behaviors before marriage, but these differences do have an effect on the number of teens practicing safer sex during their premarital relations. Teens that have taken the virginity or abstinence pledges, for instance, are less likely to use contraceptives, or even know where these products can be obtained. If the same numbers of teens are having sex, but one form of education increases the use of protection among these teens, it seems logical that the teens using protection would have a lower rate of pregnancy.

Abstinence training supporters also claim that the programs in place in the European countries will not be successful in the United States because their cultures are so overly sexual that those teens were inevitably going to have sex. While culture may make a difference in how the information is taught, it does not mean that the program is completely doomed to fail. The main culture issue that may actually pose a problem is the lack of national health care in the United States. While the government in Europe provides STD testing and counseling, as well as contraceptives, teens have to find a way to finance their contraceptive choices in the United States. These cultural issues can be dealt with; they need to be if the negative consequences of unprotected sex are ever going to be stopped.

Poor sexual and reproductive health is a common cause of female death and disability around the world. Women that do not have sterile conditions or qualified help (i.e. a midwife) during the birthing process put themselves at risk for disease,
infection, sterility, and even death. Teen mothers are often in this category, since most do not have the financial resources to consult medical practitioners. Teens are also less likely to follow proper prenatal care, and often do not know that proper prenatal care is necessary for the birth of a healthy child. Consequently, infant mortality is fifty percent higher among infants born to women under the age of twenty. It was already discussed that the United States spends about $7 billion on welfare and health costs for teens that never intended to become pregnant. Teen pregnancies lead to children that cannot be supported by their parents. These families then either live in poverty, or in the case of developed nations, are living off government support. If this could be avoided in all nations, developed and developing, the level of poverty could be decreased and developed nations could decrease the amount of money spent on welfare programs.

The United Kingdom recently discovered that teen pregnancies increased the social exclusion experienced by lower class citizens. The majority of unintended pregnancies occurred in Britain's lower class, which increased the number of citizens in the lower class. Teens that get pregnant complete school with lower qualifications and often do not finish school, therefore decreasing their opportunity to succeed in British society. This is similar to the situation in the United States, where many teenage parents are forced to drop out of high school or college classes. Unfortunately, teen pregnancy does not just affect the teen mother and her child; there are much larger social ramifications.
Reducing unintended pregnancies could have many positive consequences. In developing nations where the average person does not have access to family planning information or birth control, families often have many more children that the parents can support. Educating these populations on methods of birth control and HIV prevention could significantly reduce the health care costs in these regions. Many developed nations have donated money to these areas to help these countries that have been on the front line of the AIDS epidemic. Had more funds been donated for the purpose of preventing the spread of HIV, many more lives could have been saved.

Many of the people contracting this virus are unaware that it could have been prevented, others are not even aware that the disease is not a spiritual curse. Educating world populations about this devastating disease might be a daunting task, but caring for the many millions of people afflicted by this disease already is even more difficult. As stated by the United Nations Secretary General, Kofi Annan, in 2004, “The eradication of extreme poverty and hunger cannot be achieved if questions of sexual and reproductive health are not squarely addressed.”

Medical scientists are currently working on a vaccine for the HIV virus. When this vaccine is finally created, thousands of lives can be saved. Unfortunately, this is a very rapidly mutating virus, thus making it difficult to create a vaccine. Multiple vaccines have been tested, but each one was only effective for one mutant strain of the virus, thus leaving patients susceptible to the many other mutant strains of the virus.
Even if a successful vaccine formula was discovered today, the testing and approval process take an average fifteen years before the vaccine can be released to the public. The vaccine for HIV is many years away, and the government needs to implement a way to protect the population soon.

United States foreign aid policy has changed drastically in the last few years. In 1994 at the International Conference on Population Development, the United States promised to donate funds to developing nations for family planning and contraception education. This could have been effective around the world, but funding to a lot of these nations was cut. The United States added to its policy that aid would only be given to organizations promising to promote abstinence and to omit any information about abortion in their programs. The government keeps forcing these Christian values on other nations and current US citizens, even though these abstinence programs have failed multiple times. Not only did these programs fail in Sweden, these programs are currently failing in both the United States and United Kingdom. President Bush had campaigned exclusively for these programs while governor of Texas. Texas teaches abstinence-only programs exclusively, despite their poor record. In 1998 Texas had an extremely high rate of teen pregnancies, with 123 per 1,000 teens. Texas has the ninth highest incidence of chlamydia, and the forth-highest rate of HIV transmission in the nation. At this point the government needs to realize that the current measures being take to prevent the consequences of unprotected sex are not producing positive results.
The countries chosen for comparison were done so for a number of reasons. Sweden and the Netherlands, for example, were chosen because their national rates of teen pregnancy are the lowest among western nations. Examining why these nations have had success could be potentially useful information. Western nations in general serve as a better comparison for the United States because the cultures are similar enough that programs instituted in those countries could possibly be used in the United States as well. Japan also has a very low rate of teen pregnancy and STD transmission, but the Japanese culture is significantly different, and these results could be a combination of education and culture. To illustrate if abstinence-only education is theoretically flawed, causing the lack of positive results, then observing another country currently using the program and experiencing similar failures would be a useful comparison. Which was the reason for choosing the United Kingdom as a comparison. While their program does include more information on contraceptives and sexually transmitted diseases, abstinence is a large part of the program. Programs that cease to mention abstinence have had the most success (i.e. Sweden after 1975). France and Germany were included in the research to provide multiple examples of how different cultures have had similar successes with comprehensive sexual education. For example, while France is a predominately Catholic culture, Germany has had a very strong Lutheran heritage. Despite these differences, and the differences
of these countries from Sweden and the Netherlands, all of these countries were able
to implement a comprehensive sexual education program and find success.

This research process did begin with the original assumption that abstinence-
only education is not an effective method of preventing teen pregnancy. While doing
research, I was pleased with the results that I had found, but I do not feel that
researching these countries again would produce a completely different outcome.
Researching these topics again would not change the fact that most of the countries
examined have low rates of STDs and pregnancy, and that they all follow a basic
comprehensive model of sex education. There were limitations in the literature
available. Sweden and the Netherlands promote world sex education, so there was
ample literature on their respective programs. Finding accurate information about the
plans in place for the United States and the United Kingdom were more difficult since
both countries are currently debating what form sexual education should take.

CONCLUSIONS

Through the research completed, I have discovered that the most effective form
of sexual education is a program that promotes the use of contraceptives and condoms.
These programs promote teens having safer sex and making responsible sexual
decisions for themselves. The countries that have employed these techniques in their
classrooms have had the highest rates of success in decreases unintended pregnancies,
abortions, and the transmission of sexually transmitted diseases.
Although the United States is currently debating whether or not abstinence should be the only concept taught in public schools, Sweden discovered first hand that focus on abstinence training decreases the success a program can achieve. Sweden experiences first hand that abstinence training did not decrease the number of teens that were sexually active. Abstinence also does not increase the age at first sexual encounter, nor does comprehensive education decrease this age. Once Sweden deleted the promotion of abstinence and increased the coverage of contraceptives, the rate of teen pregnancy began to fall.

There are many factors that contribute to how effective a program will be in preventing teen pregnancy. Programs need to be supported by the government, through the government subsidizing the cost of effective contraceptives. These programs also should be largely discussion based, where students will feel free to ask questions they may have. Including units on contraceptive use also showed a correlation with the programs that were successful. Finally, the longer the duration of the program, the more effective it proved to be.

Implementing an effective form of sexual education in the United States needs to be done. The United States can no longer suffer the consequences of unprepared sexually active teens. There are many social as well as monetary costs that the United States is currently paying for, because the majority of legislators believe in family values as opposed to scientific fact. Once the morality is taken out of this issue, and adults
realize that teens need help, an answer might finally be agreed upon. American teens have so many opportunities to succeed in life, most of which are taken away when unprotected sex catches up with them.

So, no abstinence preaching as one of the choices of all?

A table on teen sex facts would be helpful/ useful.

American teens
1st to 10th grade
12th grade 67% have engaged
1/4 act. act. teens get STD's

not only the Bush admin, but also the Clinton sense needs telling 1990's

Sueder, Germany, France, Netherland -> teach abstinence plus educated.

(Abstinence is not usually practiced, if so, its not a moral position, but an choices.

Age of 1st intercourse table was very interesting.
REFERENCES


