THE DUTCH METHOD: BETTER SEX EDUCATION

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ABSTRACT

This inquiry project studied Dutch curriculum, pedagogy and practice in sexuality education, seeking to identify ways that schools and teachers in the United States can improve programming, instruction, and outcomes. The Netherlands leads the world in measures of sexual health and related issues, with low rates of adolescent pregnancy, disease, abortion, sexual assault, and teen sexual activity. Comprehensive education embedded in science curricula and as a social norm supports Dutch adolescents in developing healthy attitudes and expectations, as well as behaviors, regarding intimacy and respect.

Extensive research on the impact of different approaches to sexuality education, both in the Netherlands and in the United States, shows that a comprehensive and pragmatic approach to educating teens about sexuality results in markedly better public health outcomes. In the academic literature, this is a definitive conclusion, but it remains controversial in education circles in the United States due to cultural prohibitions on talking about aspects of sex. The Dutch model, within a less restrictive socio-religious context, exemplifies the logical implementation of the scientific findings. Researchers and educators agree that cultural context plays a crucial role in the potential success of any program, and caution against drag-and-drop curriculum implementation.

In order to improve the quality of sexuality education for American adolescents, schools must evaluate community priorities, engage with stakeholders, review evidence-based protocols and best practices, and design and implement programs that meet the needs of their communities.

Because of the cultural difficulties involved in discussing teen sexual health in the United States, it is imperative that school decision-makers understand the body of evidence that supports comprehensive sexuality education. This project explores the underlying research and effective methodologies for improving programs in adolescent development and sexuality, and encourages schools to take deliberate actions to address this topic.

Introduction

Schools, and the relationships that teens have with schools, [also] influence teens' sexual behavior. Attachment to school and success in school reduce the chances that teens will engage in unprotected sex and become pregnant. When teens feel close to their schools, believe that academic achievement is important, earn good grades, do not drop out of school, or have plans for higher education beyond high school, they initiate sex later, use contraception more effectively, and are less likely to become pregnant or bear children. In short, such positive feelings increase motivation to avoid risky sexual behavior. (Kirby, 2012)

The motto of my alma mater is, in Latin, *Non satis scire;* in English it reads "To know is not enough". As a college student, I gave it not a passing thought, but now that I work daily with fledging students, the phrase seems more than prescient—it's directive. It calls for one, for me, to take action as needed. When one knows something, one becomes responsible for it.

I know that my students are ill-equipped for the adult world of sexuality.

I know they are interested in sex.

I know they have a variety of sexual experiences, many near-disastrous.

I know that an ounce of prevention is worth a pound of cure, and that a stitch in time saves nine.

I know that nobody wants to talk about it.

After college, in North Carolina, I learned that when people say “Well, tell us what you really think!” it isn’t an invitation. It’s pejorative, and enforces social norms, pointing out my myriad conversational violations and the consequences of speaking my mind.

What I really think is that young people need, and deserve, information, support, and guidance as they grow up. This is a fundamental point of parenting, and teaching, that I might have once thought would go without saying. What I know is that parents, and teachers, often raise babies to adulthood without saying very much at all about how that even comes about. And young people develop adult identities, including sexual aspects, with little information, support, or guidance.

I also know that young people desire more information, more support, and more guidance as they navigate the changeable waters of adolescence. They seek those things as they seek intimacy, independence, and individuality.

What I really think is that we need to talk about sex.

Talking about sex with teens is so awkward for adults that typically they just don’t do it. Teens have sex anyway. I make a logical leap. We really need to talk about sex with teens. I know they need it.

One of my colleagues pointed out that I “don’t even teach sex ed,” a rebuke for bringing up the subject, and true! I do, though, teach people—young people, who I know need information, support and guidance.

To know is not enough.

What’s the problem?

Family culture, curricula and social norms dictate the information that students receive about their biology, relationships, and behavior, and vary dramatically from state to state and school to school. The United States has no national expectation about what is taught or learned, and traditionally the responsibility has rested, at least nominally, with parents and PE teachers. That manifests in young people learning whatever the school board determines, or a particular teacher believes, or a distant administrator mandates, or what the "vocal minority" advocates for, rather carefully evaluated and validated content grounded in pedagogical best practices.

In my state, North Carolina, "local education agencies maintain control over sexuality education curricula and may expand on minimum requirements without public hearing" (NC Healthy Youth Act, 2009), so the content and quality of education varies widely and is often subject to influence by religious beliefs or other personal perspectives. Such factors shape the discourse and the information that is available to young people in different schools.

It's not a secret that talking about sex is a vital element of health care. Health experts and researchers commonly (from the APA, AMA, CDC, UNESCO, WHO and more) advocate for accessibility and dissemination of information about sexual health (Peter, 2015) and researchers have examined the recommendations, protocols, consequences, and resulting programs from every angle. Multiple studies have been conducted in schools and with curricular programs to evaluate the efficacy and outcomes of approaches ranging from the federally-funded abstinence-only programs of the 1990s to the comprehensive sexuality education models used in Europe, Australia, New Zealand, Canada, and some parts of the US. Findings consistently support access to information and quality sex education in schools as the

best means of improving sexual and reproductive health, mental health, awareness, and socio-economic outcomes. (APHA, 2014; Brindis, 2006; Kirby et al., 2006).

We can do better.

Watching things go badly

Sometimes the less clinical narratives are more compelling. High school teachers cultivate selective hearing, and high school students can be quite undiscerning about who can hear them. It's not uncommon to hear about breakups, hookups, condom failures, birth control pills, and pregnancy tests "on the reg". More acute instances involve pregnancies, abortions, and assaults, the confidences of students who seek counsel. In a small and tight-knit school community, teachers are often the “trusted adults” who young people turn to in times of difficulty. These trusted adults then assume a share of the burden, becoming responsible for providing support, direction, and reassurance.

Things I didn’t want to hear:

A hooked up with a stranger at a nightclub*
B lost their virginity with C* in a closet during a party*
D is having a baby at 17*
E sent dick pics to a bunch of the girls in class*
F, age 15, has a 24-year-old boyfriend*
G is having another baby at 20*
H, I* and J* went in the woods, and the boys pushed her down and felt her boobs*
K has a history of incest and sexual abuse*
L had an abortion*
M is late for class because she had to go buy a pregnancy test during lunch*
N was giving O* a blowjob in the bathroom*
P assaulted Q* during a church lock-in*

R’s step-brother raped her in his dorm*
S called T* a slut because she rejected his advances*
U asked V* for nude photos*
W shared nude selfies with a classmate*
X is scared but doesn’t know how to get tested for STIs*
Y pressured Z* into sex, and everyone knows*

This is only a sampling of student experiences, gleaned from the daily life of a classroom teacher *who doesn’t even teach sex ed*.

Student voices: ****** School**

Students at my school are used to being heard, respected, and responded to. They care about fairness, well-being, each other. They expect to analyze, discuss, seek solutions and debate all kinds of issues, and that their teachers are in charge. Except there’s that one subject (...sex...) that elicits a different response, bewildering students who turn to a trusted adult for information, support, and guidance.

In recent years at this highly-regarded K12 charter school, student discourse on the need for improved sex ed has become clamorous and action-oriented. As students experience sexual assault, witness harassment, and engage with their online communities, the issue becomes more pressing. At the same time, the education provided on these topics strikes students as incomplete. Student inquiries conducted for a college-level research methods class (Smith, 2016; Kauftheil, 2017) describe both the demonstrated need for more information about sexual and reproductive health and stakeholder interest in improved quality of education. Student leaders have recognized a problem, and they don’t rest there. To know is not enough—they want to create change. Smith’s white paper outlines the need for

"restructuring" of sexuality education provided by ******** School, and Kauftheil's comparative analysis of US and North Carolina standards suggests the need for revision of the program to align with commonly-accepted educational best practices. Their surveys of sexuality education awareness and attitudes in the community reveal a plurality of thought, and student persistence is what motivates me to examine this problem and seek to resolve it.

Smith (2016) produced a white paper outlining a proposed restructuring of the sex education program at ******** School based on 2012 National Sexuality Education Standards and the results of an in-house test of vocabulary related to anatomy, reproduction, and STIs. Students in both basic high school biology and AP Biology scored less than 50% accuracy, proving that ******** School students lack a full understanding of these subjects and supporting survey results that indicate inadequate instructional investment in sexuality education. Smith's survey results also indicate that an overwhelming majority of students and parents consider sexuality education very or somewhat important, and that the responsibility for providing such lies with both schools and parents.

A 2017 student survey by Kauftheil had a 52% response rate from a population of 184 high school students.

Some of the results:

Q. Was something missing in your sex education?
A. 34.4 % maybe; 43.8% yes

Q. What was missing?
A. 54 optional responses described a range of topics, perspectives, and facts that students felt *should* have been included, like gender identity, LGBTQ+ concerns, contraceptive options, accessing teen-friendly health care, and responding to crisis.

Q. Should sex ed be mandatory?
A. 70.8% yes; 17.7% maybe

Q. Who should teach sex education?
A. An outside specialist not affiliated with the church 65.6%

Q. Did this form make you uncomfortable?
A. 16% yes; 32% maybe; 52% no

Kauftheil's findings indicated widespread commitment to increased access to information within the school, and was presented to the administration with the recommendation for consideration.

These student surveys may not withstand scientific validity testing, but represent authentic, earnest inquiry and justify the suggested actions. As the facilitator of these successful problem-based learning projects, I must regard the results as having integrity that matches the process of inquiry. The respect we accord students for their academic efforts must match the respect we accord their conclusions. The results provide food for thought, and for responsive educators, the next step is to listen to what our students say.

Students seek more than information about STIs and pregnancy avoidance in their sex ed courses. Many educational perspectives focus on avoiding negative outcomes, whereas students engage with the content as "sexual subjects"—invested in their own well-being and experience. Lacking other sources of information, they turn to pornography and unreliable online content providers for answers. Allen, discussing a 2005 study of adolescents in New Zealand, posits that the "effectiveness" typically measured in sexuality education programs is defined by adult expectations rather than student perceptions. Programs may or may not include student views or aims. This gap can result in divergent assessments of effectiveness, as well as missed opportunities for improved learning.

Kirby (2012) examined 83 studies to determine what primary factors causes teen sex, contraceptive use, and pregnancy in the US. The results indicate many factors, interrelated, with no one main cause. Parental values, family structure, economy, faith, education, history of abuse, romantic involvement, drugs and alcohol, peers, beliefs, maturity, social norms, and more were all significant factors in adolescent sexual behavior. Kirby also notes that "...nearly all youth experience some pressures, either internal or external, to have sex…" regardless of income, gender, race, or other socio-economic or cultural factors. Sexual development and the onset of sexual interactions are universal and warrant a practical, effective approach.

What are "good outcomes"?

Comparative studies of measures of adolescent sexual and reproductive health in the US and Germany, France, and the Netherlands show a pattern of positive outcomes in the European countries, including lower rates of pregnancy, STIs, and abortion, and higher rate of condom use. (Advocates for Youth, 2008. See graphs) Associated outcomes like delayed onset of sexual activity and diminished sexual harassment and assault are more prevalent in the Netherlands as well, according to *Sex under the age of 25*, a 2017 large-scale representative study of the sexual health of young people aged 12 to 25 in the Netherlands conducted by STI/AIDS Netherlands.

While it may seem counterintuitive, increased access to information and education about sex leads to less risky behavior, fewer partners, and later initiation of sexual behavior. Many of the problems related to teen sex can be avoided with pre-emptive sexuality education, and this investment will benefit our young people as they grow up and move into the world as confident, healthy adults.

In a nutshell:

NO	YES
No undesired sexual contact	Personal responsibility
No unintended pregnancies	Informed practices
No sexually-transmitted infections	Healthy behaviors
No sexual coercion or harassment	Interpersonal respect
No inappropriate relationships	Supportive community response

Why "comprehensive sexuality education"?

Comprehensive sexuality education expands the abstinence-only perspective to include "scientifically accurate information about human development, anatomy and reproductive health, as well as information about contraception, childbirth and sexually transmitted infections (STIs), including HIV" (UNFPA, 2016). Institutions that promote public health, such as the Centers for Disease Control and Prevention, the World Health Organization, the American Public Health Association, the United Nations, the National Institute of Child Health and Human Development, the American Academy of Family Physicians, and many more support evidence- and information-based sexuality education. The academic literature offers a wealth of evidence related to various aspects of adolescent sexual health, illustrating extensive and credible research from institutions and academics around the world. The scientific community supports sexuality education for adolescents that acknowledges sexual behavior beyond abstinence and provides information about related subjects like consent and harassment, contraception, relationships, and health.

The American Public Health Association also asserts "that all young people need the knowledge, attitudes, and skills necessary to avoid HIV, other sexually transmitted infections (STIs), and unintended pregnancy so that they can become sexually healthy adults." The APHA

calls for schools, among other agencies and groups, "to implement effective sexuality education programs that are developmentally and culturally appropriate; foster equality and respect; support the elimination of health disparities, sexual assault, and intimate partner violence; and are based on sound science and proven principles of instruction."

Kirby's 2007 meta-review of 83 studies from around the world, measuring impact of curriculum-based sex ed and HIV-reduction programs, described evidence-based characteristics of effective sex ed programs. Two-thirds had "significant positive effects" including:

- Delayed onset of sexual activity
- Increased condom use
- Increased contraceptive use
- Refusal of unwanted sex
- Decreased number of sexual partners
- Increased abstinence
- Increased communication with trusted adults about sex
- Increased knowledge about sexual risks [STI/HIV]

These outcomes align with widely desired goals and contribute to improved well-being in adolescents. The findings contrast with abstinence-promotion program outcomes, which Kantor (2008) found do not result in increased abstinence, delay in onset of sexual activity, reduced numbers of sexual partners, or increased contraceptive use. A follow-up review of US policies and programs in 2017 by Santelli, et al. reinforces the conclusion that abstinence-only approaches "...are not effective, violate adolescents rights, stigmatize and exclude many youth" and that "Adolescent sexual and reproductive health promotion should be based on scientific

evidence and understanding…" These studies reveal a significant disconnect between the presumed goals of abstinence-based programs and actual sexual behavior, as well as best practices in sexuality education and sexual and reproductive health.

Weaver (2005) compares school-based sex ed practices and policies between the US, the Netherlands, Australia, and France, noting that "Regulation of sex is a central concern of all societies." This acknowledges the ongoing tension between those who accept or tolerate sex between young people and those who don't, which remains influential in the US. However, Weaver concludes that as "...young people engage in sexual intercourse," and pre-marital sex is statistically more normal than not, comprehensive sex education "empower[s] youth against the negative consequences of sexual activity". A long-term review of adolescent sexual behavior by Cox et al. (2014), revealed that between 1991-2012, over 80% of US females ages 15-17 who engaged in sexual activity had no prior sexuality education, so lacked resources and support for making informed decisions about consent and safe practices, as well as the benefits of abstinence.

Empirical health information, public health data and patterns of adolescent behaviors point incontrovertibly towards the efficacy of evidence-based comprehensive sexuality education. Policy and legal recommendations draw on the evidence as well. The information, though, has not become ingrained in the social fabric of family life or educational practices in the United States, resulting in a needless and perilous incongruity that fails to serve the well-being of young people. People and groups who oppose comprehensive sexual education on moral or religious grounds prioritize those views over the pragmatic approach of the public health field. When non-marital sex is discouraged by abstinence-focused education, young

people do not have access to information that would inform decision-making in the context of intimate relationships. Weaver (2005) explains that "The goal of all sexuality education programs is to non-judgmentally equip students with a capacity to behave responsibly if they decide to have sex", which some proponents of abstinence see as a "mixed message". Adolescents armed with knowledge make better decisions and communicate more effectively within their relationships, which leads to more positive outcomes, as described above, in sexual contexts.

In Allen's study, participants expressed that the information typically provided is sex ed programs was too basic (they already knew it) and was introduced too late. This presages Kauftheil's 2017 poll results and may be due to the selection of a narrow range of topics, excluding others that would be helpful for young people to be informed about, like transgender issues, homosexuality, emotions, consent and harassment. Avoiding the subject of sexuality, or providing information that is "too little, too late," does not serve the best interests of youth. The promotion of sexual abstinence as the central feature of health education programs disguises the dearth of practical information that youth seek.

In the US, the history of promotion of abstinence is tied to the moral virtues of chastity and self-discipline, as well as pregnancy prevention and abortion-avoidance. Faith-based political activism resulted in the passage of Title V, [*Act to promote abstinence-based sex ed in schools*] in the US in 1996. The promotion of abstinence education 1996-2010 in the US did not result in increased abstinence or decreased sexual activity, nor increase rates of sexual activity in young people (Weaver, 2005). Many teens, balancing social expectations and their own

experiences, engage in sexual activity but maintain a virginal persona with family or other parties (Mollborn, 2015).

Required abstinence or the view of sex as risk-taking frames adolescent sexuality in conflict within community, linking it to undesirable behavior and outcomes (Schalet, 2011). American cultural history has prized purity for youth and marital monogamy for adults, as as the demographic reality shifts, the social ideal has been slower to evolve in many circles. This contributes to the prevalent mixed-message that young people shouldn't have sex but young people who are cool have sex, brought to people of all ages by the various screens and media they engage with. While parental values and religious mores play important roles in families and cultures, those views do not reflect the larger context of adolescent sexual health research. Kirby (2012) proposes that "...it is the attachment to individuals or groups of people who express and model low-risk norms that is protective" rather than abstinence-based education. Families and groups that seek to promote or enforce teen abstinence may have greater power in cultivating that attachment than prohibiting access to comprehensive information about sexual development.

According to Schalet (2016), the majority of American youth lose their virginity in teen years, whether they tell their parents or not. Abstinence-only education proved ineffective in decreasing rates of teen sexual activity; Kantor found that even adolescents who took "virginity pledges" engaged in higher rates of anal and oral sex (2008). While adults may not want to acknowledge teen sexuality for fear of encouraging promiscuity, such conversation has the opposite effect. Family connections and sexual health information are both protective factors, supporting delayed initiation of sexual behavior, as well as other positive outcomes. (APHA,

2015) Knowing this, it is incumbent upon people who work with adolescents to strive to support them through this stage of their development armed with information and agency.

Since "[T]he communities that teens live in influence their sexual behavior" (Kirby, 2012), parents and organizations retain significant power in how young people experience and conceptualize these life transitions. Cultural norms, family values, religious mores, and other social expectations provide context for adolescent relationships. Educated students benefit from informed decision-making and understanding the "bigger picture" in which their actions play out. Rather than increasing promiscuity, comprehensive sexual education contributes to improved outcomes in terms of physical health, self-concept, social behavior, and economics. Communities influence teens and benefit when they are healthy and responsible.

Two things stand out. Teens have sex. Information is good.

What's so great about the Netherlands?

The Netherlands is internationally recognized as having exceptionally good outcomes in terms of youth sexuality education. Published research on the climate surrounding youth sexuality in the Netherlands demonstrates that the country's approach has positive effects on behavior and mental health, as well as public health and economic costs. The differences between outcomes in the US and the Netherlands is connected to the inclusion of comprehensive sexuality education as a national educational goal for the Dutch. The differences in the cultural attitudes towards sex create a distinctly more accepting and positive experience for Dutch young people. (Ferguson, 2008; Kantor, 2008) The underlying belief that sex is a normal, healthy part of life informs the decisions that families and schools make in communicating and teaching about sexuality. Within families, it is acknowledged that young

people are curious about sex, and they have a right to access to accurate and comprehensive information.

In the Netherlands, with its notable health statistics and uncontroversial sex ed practices, comprehensive sexuality education is considered a human rights issue; Kantor (2008) observes that people have a right to accurate information in order to protect their own health and well-being. With a cultural attitude that does not demonize the sexually-active, the Dutch social context is more positive and has fewer obstacles than many US settings (Mollborn, 2015). Comprehensive sexuality education is a component of national educational standards and all school curricula. *Long Live Love,* an evidence-based curriculum developed by researchers in the Netherlands, represents an investment in the education and development of youth and has led to improved outcomes over the last 25 years. The program has been updated several times and expanded to include units for elementary, middle, and secondary school-age students. As the most widely-used comprehensive sexuality education curriculum in the Netherlands, it has contributed to the improved and impressive statistics on youth sexual health and is a pedagogical model for instruction. (Schutte, 2017; Mevissen et al., 2018)

The unit consists of six lessons and moves through issues from puberty to choosing and using contraceptives in a sexual relationship, addressing intimacy, sexual experiences, identity, and “the first time” with straightforward discussion and information. Each lesson has been rigorously tested, evaluated, and revised to ensure efficacy and the program as a whole meets the national standards set by the Dutch Ministry of Education. Each Dutch school has curricular autonomy, and implementation of the goals varies, but the developers of *Long Live Love* specify that the research-based teaching pack, fully implemented, meets Ministry standards and

reflects evidence-based best practices around teaching about relationships and sexuality. (Mevissen, et al., 2018; SOA/AIDS Netherlands, 2017).

Review of program materials reveals the contrast between how Dutch and American schools present comprehensive sexuality education. While the content seems parallel, including relationships, health and disease information, pregnancy prevention, and the consent imperative, the divergence is apparent in tone and specificity. This is where cultural norms and values about nudity, shame, privacy, bodily functions, and gender roles differ in some significant ways that impact all of the other aspects of CSE delivery.

Typically, current US sex ed programs focus on public health issues like teen pregnancy, STI transmission, AIDS/HIV prevention, and risks of sexual activity. The more holistic approach in the Netherlands “accepts adolescent sexuality and teaches youth about sexual responsibility”. Dutch curricula use a more “comprehensive” definition of the word “comprehensive,” as well, and include subjects avoided in US materials as controversial, explicit, or inappropriate. Ferguson 2008, outlines four prominent themes in Dutch sexuality education materials: development and reproductive biology, relationships, safe sex, and *Weerbaarheid*, a concept that includes interactional competencies like communication, critical thinking, judgment, identifying personal values, and decision-making.[1] These elements, nominally included in US curricula, scaffold the development of attitudes and understanding that lead to the “positive outcomes” of Dutch sexuality education.

Kantor (2008) claims that Dutch acceptance of teen sexuality manifests in availability of information and consistent messages about responsibility, appropriateness, and relationships.

[1] According to van Duin, “webaarheid” implies resilience and also proactive preparedness for defense, and includes an inherent strength (personal interview)

Ferguson (2008) describes it as a “Positive, rights-based approach to adolescent sexuality and sexual health” with an emphasis on personal responsibility and autonomy. The use of contraception, including condoms to prevent disease, is widespread, normalized, and not controversial. In fact, condom and contraceptive use are expected among sexually active people.

In the Netherlands, the teen pregnancy rate is 8 times lower than US and the abortion rate is twice as low. School reports of sexual harassment and assault are negligible. (Advocates for Youth, 2011). Dutch teens delay sex until “ready,” thus avoiding regret and shame as well as having to defy family rules. Additionally, teens maintain connectedness with parents and caregivers who can provide support and perspective. In comparing this cultural scenario to the US, Schalet (2011) proposes a new paradigm that recognizes individual autonomy, growth, and personal context instead of prohibitions, limitations, and control. A distinctive element of the Dutch worldview is that the Dutch believe in love, and sex generally falls under that umbrella. Dutch teens who engage in sexual activity commonly decide to do so in the context of a committed, monogamous, and long-term relationship. This duality is addressed both within the family and in curricular content at school, and emphasizes relational consideration. In comparison to the Dutch approach, Schalet (2016) finds that many teens in the US want and miss love and intimacy in their relationships, but that sex often occurs without that connection. In addition, sexually active teens often lack support from caregivers. Besides other limitations, US sexuality education commonly de-couples the emotional from sex, undermining relational intimacy and leaving teens alone with the consequences.

Attitudinal preferences and beliefs shape educational norms, and in this regard the Dutch methods of CSE will not directly translate to most American settings. Latent historical influences as well as deliberate choice of values color the discourse around many aspects of science and politics, and the subject of sex is particularly fraught in the United States. The widespread practice of using sexuality in advertising, design, and entertainment masks the deep discomfort Americans feel when considering sex as something people do, even within the marital setting and for procreation. Whether it is considered sacred or inappropriate, actual, if not virtual, sex remains a subject divorced from public acknowledgment. This intensifies the conflict about CSE in schools and at the same time makes it educationally imperative that schools address sexual development as a normal element of life.

What are best practices?

In 2010, US federal funding for adolescent sexual health shifted away from abstinence-only-until-marriage to “evidence-based” programs, bringing its focus into agreement with the American Public Health Association 2006 statement that "Successful sexuality education programs use variety of teaching methods, personalize the information about risks and avoidance of unprotected intercourse, and provide opportunities to practice communication skills" (Brindis, APHA, 2006). Researchers and practitioners concur that to improve programming, outcomes, health and well-being, the structural paradigms around sex education need to be reassessed with input from stakeholders, including students (Allen, 2005; Dennehy, 2007; van Lieshout, 2017; Schalet, 2011).

Dennehy adds that "Education presented in a supportive, nonjudgmental environment will promote comfort and confidence in discussing issues relating to sexuality", prioritizing

student experience and receptivity as critical elements of educational efforts. Allen recommends "reconceptualising" effectiveness by involving students in all aspects of program design, implementation, and content selection. Smith (2016) would agree, with emphasis on needs determination and student satisfaction. Such a constructive approach will develop individual agency and autonomy rather than the enforcement of proscriptive rules for avoiding negative outcomes and controlling adolescent behavior.

Why is this hard?

All states mandate physical education, and this is typically the setting for instruction about "health" as well. Subjects like nutrition, stress management, drug and alcohol awareness, and sexual health intersect with fitness and sportsmanship. Sex ed in US schools is typically taught by teachers without training in sexual health (Weaver, 2005), as it falls under the purview of physical education teachers, or is outsourced to various agencies. While some outside experts may lend credibility (Allen, 2005), schools must evaluate such partnerships with care. Access to sex education has historically been limited by governmental support and funding, decisions of school personnel, and parental objection (Peter, 2015). Practices vary widely among states and districts, resulting in inconsistent education of American young people about a fundamental part of adulthood.

Parents, traditionally considered the sharers of information about "the birds and the bees," contribute to this inconsistency. Religious and moral views may inform how parents educate their children about sexuality, but the larger issue of parental discomfort with talking about sex limits the effectiveness of "the talk". The CDC's National Center for Health Statistics Morbidity and Mortality Weekly Report (vol. 63, April 8, 2014) reveals that more girls receive

sex education from formal programs than from parents. The Guttmacher Institute Fact Sheet *American Adolescents' Sources of Sexual Health Information* (2017) states that 45% of parents talked with their sons about condom use, and 36% of girls' parents. This single statistic indicates that over half of all US parents are not providing complete information about safe sex, leaving young people at risk of unprotected sex, unwanted pregnancies, and sexually transmitted infections. This also implies a "values vacuum"—teens without adult guidance construct their own set of values, which may or may not coincide with parental beliefs. Parents have a critical opportunity to engage with their children throughout this developmental period.

Peter's 2015 Illinois study found that parents broadly support comprehensive sex education in the public schools, although nearly half of them did not know whether or what form of sexuality education was offered at their children's schools. A 2016 national poll on children's health found that 70% of parents surveyed thought sex ed should definitely be included in middle and high school programs (National Poll on Children's Health (Rep.). Smith's (2016) survey in a single North Carolina school revealed that, of 94 parent responses, over 90% believe that the school bears responsibility for providing sexuality education. This reflects Ito's 2005 findings that about 90% of North Carolina parents preferred more comprehensive sexuality education.

Anecdotally, parents are sometimes perceived as barriers to CSE in schools based on assumptions or fear of backlash (Bryan, 2018, personal interview; Peter, 2015). This can be the result of activism by a vocal minority, skewing the perception of public opinion. For the minority of parents who do not support sex ed in schools, 36 states, including North Carolina, permit parents to "opt out," or remove their child from sex ed classes at will, though actual

rates of this are reportedly very low. (SIECUS, 2018) Schools committed to appropriate sexuality education will benefit from fostering relationships with their parent communities, and act as allies in supporting adolescent development.

What should we do?

While the topic of sex can engender emotional, even divisive, responses, our young people and our communities will benefit from a thoughtful examination of the priorities, goals, and stakeholders involved in sex education in our schools. What works in a particular setting, like the Netherlands, will not necessarily transfer to other settings. Stakeholder input and needs assessment are essential parts of laying a foundation for successful program continuation. (Mevissen et al., 2018)

According to researchers (Allen, 2005; van Lieshout et al., 2017; Mevissen et al., 2018; Schutte, 2016) teacher quality and commitment have definitive impacts on effectiveness. As with any adopted curriculum changes, changes to sex ed programs must engage teachers in structural and pedagogical decision-making. Teacher “buy-in” translates to the program fidelity, completeness, and continuation that make evidence-based programs like *Long Live Love* effective.

Community context, including beliefs and social preferences concerning youth, sexuality, and health, is an inextricable factor in sexuality education and adolescent development. (Allen, 2005; Global Education Monitoring Report. Education for people and planet: Creating sustainable futures for all", 2016) In the Netherlands, parental expectations of adolescent autonomy and maturing sexuality facilitate a cultural openness about sexuality that contributes to the demonstrated positive health outcomes discussed in the literature. For

communities with different social norms, it will be most beneficial to tailor the educational approach to sexuality to complement systemic expectations and initiate sustainable growth of sex ed programming within existing frameworks. That said, the wealth of academic research on comprehensive sexuality education identifies some imperatives that should be incorporated into any promising program.

The confluence of teaching methods, family connections, and communication between parties lends support to optimal adolescent development and the oft-cited “positive outcomes”. The American Public Health Association finds that “School connectedness [...] leads to improved sexual and reproductive health; for instance, according to the Centers for Disease Control and Prevention, “Research has shown that young people who feel connected to their school are less likely to engage in many risk behaviors, including early sexual initiation, alcohol, tobacco, and other drug use, and violence and gang involvement.” (Brindis, 2006) Educators and administrators commit daily to educating students in literacy, numeracy, and critical thought, “recognizing that while their core responsibility remains crucial, they must also reach beyond it”. (Steenkamp, 2018) A disinclination to do so results in a dereliction of the moral duty that responsible adults owe youth in their communities.

We know better, so we must do better.

But how?

Supporting resources available from the North Carolina Department of Public Instruction provide information and align with the legal obligations imposed by the 2009 NC Healthy Youth Act. Examination and integration of these resources will ensure alignment with the NC Standard Course of Study objectives, further solidifying the rationale for program

improvements. Tools of proven validity can guide and strengthen development, selection, implementation, and continuation of sexual health education programming. For example, the Health Education Curriculum Analysis Tool (HECAT), developed by the US CDC, is a vehicle for evaluating health education program development in school contexts. The framework outlines methods of curriculum evaluation, templates and scoring methodologies for program comparison, and appraisal materials for content, implementation, and continuation.

The principles of Intervention Mapping provide another protocol for developing evidence-based programs, and have been effectively used in developing and evaluating *Long Live Love,* among other health initiatives. (Bartholomew, Parcel, Kok, Gottlieb, & Fernandez, 2011; Mevissen, et al., 2018; Schutte, 2017) A systematic approach that considers stakeholders, goals, and priorities will contribute to the development of a program that meets the needs of the target community and has the potential for effective implementation and future growth. IM offers a concrete path towards integrating best practices, evidence-based strategies, and community needs, and can guide schools in designing, developing, or adopting comprehensive sexuality education plans in the interests of their students (see Appendix A).

Both approaches begin with a situational assessment that engages all parties. Investmentment in the foundational needs and goals of the constituents will identify potential disagreements or confusions and expedite the process of program selection and development. Schools and school systems will define guiding principles to focus the discussion on appropriate priorities. For instance, a free-standing charter school in North Carolina will look to state education standards and the Healthy Youth Act of 2009 as well as the mission statement of the school to clarify central values and desired outcomes. Acknowledging common definitions at

the outset of program consideration will aid in discernment throughout the process. With this shared understanding, further conversation at each stage will lead to decisions, assessments, and determinations that will be most effective in the selected community.

If this, then what?

The role of trusted adult involves both judgment and a suspension of judgment. It’s necessary both to be a confidential listener and a mandated reporter. As the receiver of personal secrets, stories, and emotional processing, I repeatedly lament that my students lack appropriate resources and support for some of the difficult situations in which they sometimes find themselves. In the classroom, teachers emphasize critical thought, reasoning, and seeking credible evidence to make informed decisions. The corollary, applying these academic paradigms to the emotional development of young people, requires that they have access to information and “trusted adults” to facilitate their understanding of the life-changing process of development. To grow up is to become a whole adult being, and access to information about the sexual aspect of development is a critical aspect.

Inspired by my students’ commitment to finding answers and speaking out about difficult issues, I’ve applied the same model for inquiry that we use in my high school AP Seminar course to identify, address, and resolve problems in community. As a teacher, I model and explain the process using the QUEST acronym provided by College Board (*Question, Understand, Explore, Synthesize, Team-transmit-transform*); I seek ways to demonstrate and clarify the process; I facilitate examination and encourage creative problem-solving. I challenge assumptions and require evidence in support of arguments. I talk the talk. By the third AP Seminar student inquiry project on sexuality education in public schools, I determined to walk

the walk. Students look to me for answers. I am the trusted adult. I must respond with integrity, model the behavior I want to see, and actively respect the learning process. I cannot just know about the problem. *Non satis scire.*

Next Steps: Building the bridge between research and practice

The extensive research findings on the results of effective sexuality education can benefit school populations only if the findings are incorporated into education practice. Between state law requiring sexuality education as part of the health curriculum for middle and high schools and the widespread and emphatic data-based conclusions from the scientific community, the case can be made that schools in North Carolina have the legal and ethical responsibility to provide comprehensive sexuality education. It is incumbent upon each school entity to do so with care and consideration.

The points below outline a plan for improving sexuality education and associated outcomes in a small, independent school setting in North Carolina. Based on research from the fields of education, public health, and behavioral science, these steps will lead the community through appropriate decision-making processes in considering, adopting or developing, implementing, and sustaining an enhanced program. A cohort of administrators, teachers, students, and parents should collaborate on the process. (Kok, 2015; Mevissen, et al., 2018; Schutte, 2017)

- **Meeting with key players in the school**
    - Identify interested parties and communicate about the scope of the conversation to reach out to potential participants
- **Parent/community forums**

    - Invite and inform parents so they can engage as they want to
    - Acknowledge role parents play in school and adolescent development
- **Needs assessment (HECAT/IM protocols)**
    - Target priority areas, consider involved parties, assess resources
- **Creation of position statement**
    - Define goals, values, and priorities with input from all parties; set focus for efforts
- **Action plan**
    - Determine what actions will be taken and by whom; select or design curriculum; identify outside resources, speakers, experts we can call on; set date for program evaluation
- **Implementation**
    - Incorporate plans into practice; facilitate learning in context; adjust as needed with goals in mind
- **Ongoing evaluation**
    - Solicit community input on process; evaluate results qualitatively; consider effectiveness; recalibrate as needed

The take-away

As Mevissen notes (personal interview), it is not realistic to assume that a particular curriculum will be applicable in all contexts (personal interview), so the findings point towards targeted program development that addresses local needs. This matches Mevissen's initial approach to the design of *Long Live Love*, planned for use in Dutch public education where it

aligns with the goals and priorities of the programs, as well as prevalent cultural attitudes and expectations. While *Long Live Love* is credited with public health success and is widely recognized as an excellent program in the Netherlands, US schools and systems must determine the most appropriate fit for their settings in selecting or building a program. The key tenets that contribute to the success of *Long Live Love* must be examined, and creative solutions sought for translation to more restrictive cultural settings.

However schools decide to approach the “problem”, it’s essential to question the framing of adolescent sexual development as a problem. This is the fundamental distinction between how schools, families, and society understand the role of sexuality education in the United States and the Netherlands, and a crucial determinant in public health outcomes and personal experience. Educators have a social responsibility to support healthy development in students and incorporate best practices into their teaching. Researchers and analysts provide and evaluate evidence on which schools and program designers should rely in adopting, adapting, or assessing curricular materials and school policies.

Beyond educational best practices and legal proscriptions, societal and religious attitudes have powerful influence on how people conceive sexuality. Personal values commonly impact the delivery of information and education about sexual development in public schools as well as in families, and may or may not align with the findings of scholarly research. Educators must balance respect for the values and beliefs of their communities with the practical and ethical demands of their duty to their students. This position arises from four key assumptions that guide my decisions and behaviors as an educator. Clear explication of these

assumptions outlines my motivations and priorities in working to improve sexuality education in my school community.

Science is valid. Science does not weigh in on morality, nor frame sexuality as a moral subject. We must accept scientific findings on and quantitative analysis of biology, physiology, dise*ase, health, and behavioral effects.*

State and Federal law provides valid and guiding directive. Though individual belief may differ, we must accept the rule of law within our communities and schools. Public schools in particular must be informed by legal decision-making.

Education is a valued social good. Educated constituents are fundamental for democracy; education provides choice, liberty, and access to resources and ideas; educating people is required for civil society.

Education includes, implicitly and explicitly, values. All education bears a moral charge towards goodness and what is right. Definitions of such concepts remain dynamic but underlie all movement towards education.

With that conceptual framework, judgment on about the morality of sex remains outside the schoolhouse door. Information about adolescent development and behavior can be taught and learned within the values of a democratic education and the legal and scientific structures of our society. This secular approach leaves room for family and religious values in the home and church while providing students knowledge with which they can make informed decisions about their bodies, health, future, values, and relationships.

As the beneficiary of an American education, I seek to understand both sides of an argument, to evaluate evidence, to ask clarifying questions, to make sense of information. I

know that many problems can be fixed, misunderstandings resolved, agreements reached. I know that knowledge is power, and power conveys “ability or capacity”. I know that those who can, do. As a teacher, I must lead by example--demonstrating the process of learning and being accountable to the higher moral standard expected of teachers. My students presented me with a question, or problem, when they looked to me for support and guidance in troubling situations. I had to think about how I could help, and look beyond the day-to-day resources to fully address their questions. I considered different perspectives, and how they might shed light on the situation. This paper is an effort to synthesize and communicate ways that educators in general and my school community in particular can better serve the needs of our students. We strive to prepare our students for life beyond graduation, endeavoring to equip them with skills and knowledge to thrive, in college or out. Information and awareness about sexual development, sexuality and relationships, whether we want to acknowledge it or not, plays a role in this. How we choose to deal with this is up to us.

To know is not enough.

Appendix A

Preliminary Needs Assessment at ******** School

Participatory planning group includes Adrienne Berg, Dena Floyd, Cotton Bryan, Bryan Matthews, Sarah Koppelkam, Lori Phillips

Needs

Flexible comprehensive curriculum to support teaching

Vertical alignment and age-appropriate materials

Integration of sexual diversity perspectives

Accurate information dissemination in PE/Health class

More access to information about health issues, relationships

Processing space for questions and reflection

Community capacity

Stakeholders include students, parents, teachers, administration, school board. Desire and capacity for improved education on sexual health and relationships varies with and across groups, with strong student interest in more accurate, advanced, and relevant information within a safe and respectful environment. Parent interest is mixed, reflecting the community demographics of liberal, conservative, and religious families. Teachers of high school students recognize the need for improved sex education curriculum and student support, with some more comfortable with engaging in the teaching of it. The health and biology teachers support reconsideration of the subject in their class content.

While administration and the school board have no direct involvement, they would necessarily receive potential negative community response. The principal has voiced concern about “blowback” from parents with any substantial changes to the curriculum. He was not aware that the health teachers introduce the sex ed unit with an “opt out” clause tag parents may sign; such a clause is at variance with all other curricular subjects, in which no curricular opt-out is permitted. The NC Healthy Youth Act provides student exemption from health curricula with a written parent request.

The ******** School Board is solely comprised of parents, who conduct an annual review of the principal prior to offering a contract for the following year. Members of the school board may or may not be inclined to engage with curricular matters around health and sexuality education. The adoption of curriculum in general falls outside of their purview.

Program goals for health and quality of life

Comprehensive revision of the health curriculum to include complete and accurate medical information about adolescent development and sexuality, including relationships, responsibility and consent, sexual diversity, reproduction, pregnancy prevention, sexually-transmitted infections, sexual harassment, and access to health care.

Integration of theory-based best practices for teaching adolescents, including current thinking in sexual education and health.

Community acceptance and support for program improvements; improved student outcomes and satisfaction with the education available.

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