

Executive Summary

We Can Do Better:

**Oregon Team Report on Western Europe's
Successful Approaches to Adolescent Sexuality**

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Rights, Respect, Responsibility® is an innovative and bold initiative.

Its mission is to help Oregon youth develop healthy sexual attitudes and behaviors supported by proven public health strategies that reduce teen pregnancies, births, abortions and sexually transmitted infection

Despite substantial declines during the 1990's, teen pregnancy rates for 15-19 year-olds in the United States are among the highest in the industrialized world – an unfortunate tradition that has continued for decades. Similarly, teen birth and abortion rates as well as the incidence of sexually transmitted infections in this country – and in our own state of Oregon – are dramatically higher than those in most other developed nations.

<u>1999 Pregnancy, Birth and Abortion Rates (per thousand)</u> <u>for Young Women, Ages 15-19</u>			
Country	Pregnancy	Birth	Abortion
Netherlands	12.2	8.2	4.0
Germany	16.1	12.5	3.6
France	20.2	10.0	10.2
United States	83.4	49.6	25.0
(Oregon)	68.6	46.6	22.0

Sources: Family Planning Perspectives, 2000, 32(1): 14-23; Centers for Disease Control & Prevention; Advocates for Youth fact sheet, 2001: European /USA Comparison; Oregon Health Division Vital

With pragmatism and unyielding commitment, western European countries including Germany, France and the Netherlands have successfully shaped an approach to adolescent sexuality that has proven remarkably effective. What are they doing? Can we learn from them... and does it make sense to adapt any of these strategies to our teen pregnancy prevention efforts in Oregon?

With these questions in mind, a team of 16 Oregonians embarked on the 2001 European Study Tour sponsored by Advocates for Youth, a Washington, D. C.-based organization "... dedicated to creating programs and promoting policies that help young people make informed and responsible decisions about their sexual and reproductive health." (Advocates for Youth, 2001) This annual fact-finding mission to Germany, France and the Netherlands offers an intensive look into the comprehensive and

complementary approaches that have established these countries as leaders in the field of adolescent sexual health.

Members of the Oregon team included: Coleen Belisle, former county health nurse and sexuality educator; Jon Benson, education & training program manager; Alicia Cardenas, program supervisor at Centro Latino Americano / Healthy Start; Diane Duke, administrator at Planned Parenthood Health Services of Southwestern Oregon (PPHSSO); Ginny Ehrlich, Team Leader, Coordinated School Health Initiative at Oregon Dept. of Education; Frank Gibson, attorney; Mary Gossart, Director of Education & Training at PPHSSO; Toby Hill-Meyer, high school student; JoAnn Miller, Director of Benton County Commission on Children and Families; Jan Oliver, administrator at University of Oregon; Kitty Piercy, Director of Public Affairs at PPHSSO and former state representative; Paul Robinson, minister at Congregational United Church of Christ; Wendy Shelden, family nurse practitioner and program administrator; John Sulzman, consultant and trainer in the field of sexuality education; Ingrid Tyson, family nurse practitioner and program coordinator; and Teresa Westmoreland, middle school health teacher.

This executive summary provides key findings from the Oregon Team Report and reflects study tour research and team members' personal / professional experience with adolescent sexual health programs and policies in the state of Oregon.

Endnotes:

1. "A New Paradigm for the Future." Advocates for Youth, 2001.

There are a number of factors that influence the significant differences in sexual health indicators for youth in Germany, France, and the Netherlands as compared to those in the United States:

- public health policies grounded in pragmatism and research
- sexuality information characterized by open, honest dialogue
- readily available, affordable family planning services
- sustained, realistic media campaigns

Along with a common sense approach toward adolescent sexuality, the importance placed on ethical behavior and personal responsibility in the area of sexual health is profoundly evident in the three countries we visited. *It is incumbent upon each person, regardless of his or her age, to act in good conscience and with accountability in making sexual decisions.* The vision embraced by Rights, Respect, Responsibility[®] clearly reflects this philosophy:

Rights: Young people have the right to accurate, realistic information and confidential health services.

Respect: Young people deserve to be respected as valued members of the community with much to offer.

Responsibility: Young people are expected to act responsibly to safeguard their health. Society must provide young people with the tools they need to act responsibly: accurate information, confidential health services, and a secure stake in the future.

Honoring these values creates a society in which the community ensures all members, youth and adult, have the knowledge and health services they need to make responsible sexual choices. To complement effective sexuality education in schools, the European countries we visited emphasize parent/child communication, guidance from one's personal faith community, mass media campaigns, clinic services, and public policy based on research... all of which support clear and consistent messages around responsible, healthy sexuality.

Philosophically, many European countries accept that often, older adolescents choose to have a sexual

relationship. Consequently, programs and policies focus on protective services, knowledge, behaviors and skills. In the United States, programs, policies and national initiatives focus on delaying sex as long as possible. Yet the reality is that U.S. teens experience first intercourse one to two years *earlier* than their European peers.

Despite the lack of evidence that abstinence-only programs are effective, Congress has appropriated more than \$500 million for abstinence-only-until-marriage education since 1997. The state of Oregon receives and utilizes these federal dollars for three programs: STARS (Students Today Are Not Ready for Sex), Stop and Think, and FACTS (Family Accountability Communicating Teen Sexuality). In addition, the Oregon legislature allocated \$526,083 in state matching funds for abstinence-only education for the 2001-2003 biennium.

To be eligible for the federal abstinence-only funding, programs must teach that “sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.” (Welfare Reform Act) Yet, according to the findings of nationally representative surveys, (Kaiser Family Foundation, 2000) ***this federal mandate for abstinence-only-until-marriage education is out of step with public thinking:*** (Advocates for Youth: *Transitions*, 2001)

- 85% of parents want schools to teach how to use condoms, and 84% want schools to teach about other forms of birth control;
- 88% of parents want schools to teach young people how to communicate with partners;
- 45% of students in grades 7–12 want to know what to do in case of rape or sexual assault;
- 46% of students in grades 7–12 want to know how to deal with the emotional consequences of sexual activity and how to talk with a partner about birth control and sexually transmitted infections; and
- 46% of students in grades 7–12 want to know how and where to get birth control.

Technically, Oregon's laws and administrative rules provide a supportive climate for comprehensive sexuality education. Specifically, Oregon Administrative Rule (OAR) 581-22-1440 requires school districts to incorporate age-appropriate instruction on infectious disease, including HIV/AIDS and Hepatitis B, as an integral part of the health education curriculum, as well as in other subject areas. This OAR requires that school districts' plans of instruction include:

- scientifically accurate information;
- discussion of risk behaviors associated with HIV and Hepatitis B;
- discussion of abstinence from sexual activity and drug use as the safest way of preventing HIV and Hepatitis B; and
- effective strategies (including the use of latex condoms) that reduce the risk of sexual transmission of HIV.

Oregon Revised Statute (ORS) 336.455 requires that all sexuality education in public elementary and secondary schools must be comprehensive, scientifically accurate, and must include the following key concepts:

- Discussion of sexuality as a normal, healthy aspect of human development;
- Information about responsible sexual behaviors that reduce the risks of HIV, sexually transmitted infections (STI), unintended pregnancy;
- Promotion of abstinence from sexual intercourse as the safest and best choice for school-aged youth;
- Instruction on contraceptive and disease prevention strategies as a means of risk reduction for HIV, STI and pregnancy; instruction must include possible health benefits and side effects for each method;
- Discussion of possible physical, psychological and emotional effects of early sexual activity and pregnancy;
- Discussion of the importance of respect, responsibility and honesty in human relationships;
- Sharing of laws pertaining to statutory rape and the financial responsibilities of parenthood; and

- Opportunities for students to develop and practice skills related to negotiating and maintaining their sexual limits.

Nevertheless, the 2000-01 Oregon Sexuality Education Assurance Survey designed to monitor local implementation of ORS 336.455 and OAR 581-22-1440 and the School Health Policy and Programs Study suggest there are still significant gaps in implementation. The majority of comprehensive instruction occurs at the high school level, with only one in three middle schools addressing issues pertaining to disease and pregnancy prevention strategies and less than half of elementary schools specifically addressing the issue of sexual activity. *And while the vast majority of Oregon’s secondary health educators report that they teach sexuality and HIV prevention education in their classrooms, only about 9% report using a proven, effective curriculum; over half indicate that they use abstinence-only programs that have yet to be found effective in changing students’ sexual risk behaviors.* Additionally, 58% do not include a discussion about the correct use of latex condoms as part of classroom instruction.

Several key factors contribute to the effectiveness of sexuality education programs in Germany, France and the Netherlands as compared to Oregon:

- Each European country has developed research-based education programs that are effective and deliver a consistent message.
- Western Europe emphasizes how sexual intercourse fits into a larger continuum of sexual expression and a loving relationship while Oregon focuses on disease prevention.
- In the Netherlands, Germany and France, all students are provided accurate and comprehensive instruction in the area of human sexuality at the equivalent of the U.S. middle school level. Oregon state-level policies do not specify the ages or grade levels at which students should receive certain instruction. In keeping with the tradition of “local control” in Oregon, school

boards, administrators and teachers decide if and when students receive vital information and skills pertaining to negotiation and communication in romantic relationships, and contraceptive/disease risk-reduction strategies.

Oregon's implementation of comprehensive sexuality education varies greatly from community to community. Some have solid K-12 comprehensive sexuality education programs that utilize proven, effective programs. Many have solid high school programs. Some focus solely on abstinence and use programs with no evidence of success, and some have little or no sexuality education.

Oregon's School Health Policy and Programs Study also points to the need for ongoing professional development opportunities in order to keep educators current on issues related to human sexuality. In the past two years, only about one-quarter of secondary health educators have reported receiving professional development on human sexuality and less than half on the prevention of HIV and sexually transmitted infections. Over half of health educators cited the need for additional professional development on HIV prevention and over 40% identified staff development needs in the areas of human sexuality and pregnancy prevention.

While the quality and consistency of comprehensive sexuality education programs decline in Oregon, rates of sexual activity among middle school youth are increasing at an alarming rate. The 2001 Oregon Healthy Teens Survey results show that 16.1 % of Oregon 8th graders have had sexual intercourse with 70% reporting latex condom use at last intercourse. Of those 8th graders who had sexual intercourse in the last three months, 40% had multiple partners. A significant number of Oregon middle school youth are at risk of pregnancy and sexually transmitted infections. The data suggests a need for more consistent implementation of effective sexuality education in Oregon schools, particularly at the middle school levels where an unacceptable number of students are putting themselves at risk due to lack of appropriate information and skills.

Recommendations for Improving Sexuality Education in Oregon

- Allocate resources, including funds for teacher training, to implement comprehensive sexuality education in all public schools;
- Allocate class time to implement sexuality education;
- Require the use of sexuality education programs and materials that research has proven to be effective; and
- Develop a clear, consistent, nonjudgmental message about healthy human sexuality that all educators will deliver.

A key component of the European approach to adolescent sexuality is education, much of which is communicated through mass media campaigns. These campaigns provide positive, accurate and effective messages about the prevention of sexually transmitted infections and unintended pregnancies. They also help shape social norms that reinforce healthy sexual attitudes and behaviors among the general population.

The messages and delivery strategies have been developed by professionals over several years, using research and evaluation to test their effectiveness in changing behaviors, then applying research results to craft the next generation of campaigns. A consistent, focused, and frank sexual health message is provided, using a variety of media. These public information campaigns, which are heavily funded by the government, are well received by the viewing public.

In all three countries, mass media campaigns (Berne et al, 1999):

- stimulate open discussion
- exhibit a positive approach to sexuality
- do not stigmatize or discriminate
- change behavior by persuasion

- avoid fear-based tactics
- acknowledge and respect the diversity of values
- create a message to which people easily relate
- use appropriate, moderate humor
- integrate messages about HIV/AIDS, STI, and pregnancy prevention
- promote condom use for those who are sexually active
- represent the diversity of relationships
- communicate practical skills
- provide an umbrella for activities targeting specific groups and interventions at local and regional levels
- change and evolve as a result of research and evaluation of the previous campaign

After learning how western Europe's effective mass media campaigns developed over time, our study tour group was encouraged and enthusiastic. Certainly, here in Oregon, as we face our own struggles against ever-burgeoning numbers of STI cases and unintended pregnancies, we can do better. Certainly, here in Oregon, we want to respond to the very real public health concerns of sexually transmitted infections and unintended pregnancies with an appealing, research-based approach that will change attitudes and behaviors. We must insist on being sensitive, clever, persistent and persuasive to create effective public information campaigns that support healthy sexual attitudes and behaviors.



In order for young people to develop the capacity to make healthy decisions about a myriad of life issues including sex, they must be guided by a blend of accurate information, personal values and family support. Parents *are* the initial and primary source of sexuality messages for their children, whether they do it consciously, thoughtfully, carefully... or not. Talking with children about sexual issues presents some of life's awkward moments for European and American parents alike. Many feel ill-equipped, unprepared, and at times overwhelmed.

While research shows that most U. S. parents believe sex education should begin at home, studies also tell us that much of the education offered is too little, too late. As part of its *Talking With Kids About Tough Issues* national campaign, the Kaiser Family Foundation conducted a survey that indicated there are significant gaps in parent-child communication. Many parents were surprised to find that the issues they are not talking about, as well as some they believe they *have* already discussed, are the very issues their children want to know more about. (Kaiser Family Foundation, 1998)

Of the young people ages 10-12 interviewed in the Kaiser Survey,

- 50% wanted more information about how to protect against HIV and AIDS (62% of parents surveyed have *not* talked about this);
- 44% wanted more information about how to handle pressure to have sex (46% of parents surveyed have *not* talked about this); and
- 43% wanted more information about how to know when you're ready for sex (50% of the parents surveyed have *not* talked about this).

Ongoing parent/child discussions about sexuality occur in only 10% of American families, and the majority of young people *and* parents report that they are dissatisfied with the quality and quantity of family discussions about sexual issues. (Berne et al, 1999)

In contrast, while the European parents we met on the study tour admitted to feeling challenged when it comes to family conversations about sex, they nevertheless claim their responsibility and work hard to communicate openly and honestly with their children. ***Family and faith are expected to be the primary sources of values, morals and beliefs surrounding sexuality and sexual choices.***

Recommendations for Supporting Parent–Child Communication About Sexuality

On June 28, 2001, the Surgeon General of the United States, Dr. David Satcher, released a Call to Action to all Americans urging us to promote sexual health and responsible sexual behavior. He

recommended that Americans begin a dialogue about the importance of living a sexually healthy life. He urged us to recognize that parents are the child's first sexuality educators and acknowledged that families differ in their level of knowledge, as well as their emotional capability to discuss sexual issues. (Office of Surgeon General, 2001)

Parents need to become informed so they can talk with their children about sex... and the community must help them by providing opportunities to learn through:

- parent education classes – through schools, places of worship, community organizations and lunchtime on-site programs for working parents;
- access to resource materials including books, pamphlets, fact sheets, and videos; placement of sexuality education resources for parents in video stores and public libraries;
- websites featuring information on topic-specific information related to sexuality and/or parent strategies; to name a few:

www.advocatesforyouth.org

www.siecus.org

www.teenpregnancy.org

www.wecandobetter.org

www.pphsso.org

www.plannedparenthood.org

www.teenwire.com

- collaboration with local media to produce special programming in support of parent/child communication about sexuality.

In western Europe, it was refreshing to witness the religious community's overall endorsement of the values embedded in Rights, Respect, Responsibility[®] and its pragmatic regard toward adolescent sexuality. What has ultimately evolved is an understanding that 1) the church cannot dictate morality for

all people, and 2) everyone's ability to reason for themselves should be honored. These prevailing attitudes helped the religious community stand aside and allow the health care professionals decide the most effective way of handling the changing sexual scene created by the introduction of the birth control pill in the 1960's.

In contrast, the religious climate in Oregon – and across the United States – differs substantially from that of the three countries we visited. Conservative religious elements influence what is and is not taught in the public schools regarding sexuality, sexually transmitted infections, HIV/AIDS and related issues. The “religious right” is a political force that is committed to permeating the public education scene with its own strongly conservative religious agenda. The fruits of its labor can be seen in the creation of abstinence-only until marriage curricula and programs funded by federal and state monies – despite the fact that there is no research showing such programs to be effective in changing the sexual risk-taking behaviors of youth.

Additionally, this conservative, politically-focused religious force is relentless in its blatant attempts to shape legislation around health care policy. This mixing of religion and public policy not only doesn't exist in Germany, France and the Netherlands – it would not be tolerated. Public health policy is based upon research, not upon any one set of religious dictates.

This should not be interpreted as disregard or disrespect for religious values. The Dutch, German and French people consider the values of individual freedom and responsibility in sexual behavior extremely important. “In these countries, the morality of sexual behavior is weighed through an individual ethic that includes the values of responsibility, love, respect, tolerance and equity... The values that are incorporated into the individual ethic align well with the ethical teachings of Christianity and Judaism.” (Berne et al, 1999)

During the European Study Tour, we experienced a climate in which religious institutions support programs and policies to improve the sexual health of adults and adolescents. These institutions do so through quiet acknowledgement or at least by maintaining a position of neutrality. Some move beyond this to provide medically accurate, respectful and effective sexuality education within their own faith-based schools.

Recommendations for Enhancing the Role of Faith Community in Supporting Healthy Sexuality

- Organize clergy/faith-based groups throughout the state to challenge the extremist voice in the public policy arena;
- Give these clergy/faith-based groups full and adequate information, training and resources to be effective;
- Support people of faith in making their presence felt wherever these issues are discussed, and work to create a presence on a pro-active basis; and
- Equip religious communities to teach responsible sexual behavior and sexuality awareness utilizing supportive curriculum such as “Our Whole Lives.” (Unitarian Church et al, 2001).

We need to find ways to change a culture that has accepted the “taboo” of sex... a culture that approaches sex and sexuality with fear, shame and ignorance. At the very least, we need to break the agreement that has allowed fear, shame, ignorance – and in many cases, a particular religious viewpoint – to dictate public policy around sexual health.

In the European countries we visited, one of the major public health goals is to ensure access to confidential reproductive health services for adolescents and adults alike. Healthy sexual outcomes and the reduction of sexually transmitted infections and unintended pregnancies (particularly among teens) are a national priority. National health care covers the cost of most contraceptive methods, emergency contraception, abortion, counseling services, medical exams and screening/treatment of sexually

transmitted infections. Young people grow up with a consciousness that supports the use of sexual protection and contraception. The mantra of “safe sex or no sex” is quite familiar. It would be incorrect to assume that this implies or promotes “promiscuity” however, for *equally familiar is the lesson of sex within the context of a loving, committed, respectful, responsible relationship.*

In the United States, abortion is thrust into the middle of the conversation about reproductive health services while in western Europe it has become but a small piece. The reason: because they are so successful at prevention, people in Germany, France and the Netherlands experience far fewer abortions. Even though these countries have more restrictions around abortion, those restrictions are not based upon particular religious perspectives. Western Europe views abortion as a social failure, not a moral one.

As a general rule, reproductive health clinics in Germany, France and the Netherlands are located near schools or along public transportation lines, and are open during hours that make sense for teens. These clinics appeal to young people by: (Berne et al, 1999)

- accepting teen sexuality and sexual behavior
- guaranteeing anonymity and confidentiality
- waiving the Pap smear and pelvic exam as prerequisites to contraception
- providing non-judgmental service
- requiring minimal paperwork
- requiring no parental consent

All of these pieces work in tandem to support sexually active youth in accessing sexual health services.

Oregon law allows all people to receive confidential family planning services and testing/treatment for sexually transmitted infections, regardless of their age. (ORS 109.640 and 109.610) The state has a unique program called the Oregon Health Plan (OHP) that provides insurance coverage for qualifying

low income Oregonians, and this plan includes reproductive health services. Additionally, Oregon is a pilot site for a program called the Family Planning Expansion Project (FPEP), a five-year state- and federally-funded demonstration project to reduce unintended pregnancy.

In 2000, just over 65,000 people of moderate income received free services through FPEP. Birth control services and supplies are included as is screening for sexually transmitted infections. Abortion is not covered under FPEP. County health departments, Planned Parenthood clinics, university health centers, and a number of community clinics provide services. However access in rural communities is inadequate. A major concern is that the decision around renewing this effective program will essentially be a political one, rather than a decision driven by proven outcomes.

Recommendations to Enhance Utilization of Reproductive Health Services:

- Work with health care providers to accept that youth are sexual beings and deserve age- and experience-appropriate, accurate information as well as family planning and sexually transmitted infection services based on established standards of care;
- Mandate that all health insurance packages available in Oregon cover complete reproductive health services, contraceptive methods and abortion services without conscience clause exemptions;
- Increase publicity around reproductive health clinics and how to access them;
- Add contraceptive methods, including condoms and emergency contraception, to services available in school-based health centers;
- Ensure access to reproductive health clinics in all 36 Oregon counties;
- Educate parents and community partners about the availability of reproductive health clinics and resources and the needs of youth who utilize them;
- Make abortion services accessible to all those who need them;
- Promote a zero-tolerance policy of harassment and violence towards abortion providers and their clients; and
- Focus on preventing the need for abortion in the first place. This must rise to the top of everyone's

agenda, including clinics that provide abortions and organizations that advocate for reproductive rights.



When it comes to developing public policy around sexual health services, education, and government supported mass-media efforts, western Europeans approach human sexuality as a public health issue, not a moral one. That's not to say that personal beliefs, morals, and values are unimportant or have no place in the realm of sexual decision-making. But they are just that – personal – and are best left to be addressed within the family. Even in France, which is over 90% Roman Catholic, the bishops have far less influence on reproductive health issues than is the case in the United States. When establishing regulations around sexual health issues including education, availability of reproductive health care, and public information campaigns, western Europeans trust and rely on their experts... and the experts in turn rely on sound scientific research and ongoing, rigorous evaluation of what has proven to be effective.

In his presentation to the European Study Tour participants, Mr. Robert Simon, from the French Ministry of Health, remarked that in developing strategies to combat unintended teen pregnancies, births, abortions, and transmission of sexually transmitted infections and HIV, the French rely heavily on research conducted in the United States to determine what works. Looking rather perplexed, he added, “But in France, we pay attention to the results of the research... and cannot understand why your country does not.”

Rather than paying attention to the evidence, utilizing programs that have been proven successful, and influencing outcomes through the use of effective regulation, the U.S. inclines toward prohibition: abstinence-only-until-marriage education, barriers to school-based clinical services, and the unwillingness of the media to run frank and effective public education campaigns. The American approach does not come from our experts, whom the Europeans candidly acknowledge produce the best

research in the world. Neither does it come from the majority of American citizens. Recent polling shows there is widespread support for comprehensive sexuality education, contraceptive insurance coverage, and access to emergency contraception. (Lake et al, 2001) Yet we do not see the reflection of this support in public policy and programming.

U. S. public policy around human sexuality changes with the administration in office. Currently, policy is shaped by those with strong notions of what they believe should be so, but a weak understanding of what *is* so. A small group of committed moralists can and do convince our politicians to act without the slightest bit of empirical evidence to back them up. This does not and would not happen in the parliaments of the three countries visited by our Oregon team.

Recommendations for Enhancing Public Policy in Support of Healthy Sexuality

- Monitor and ensure compliance with existing law that requires sexuality education courses offered in Oregon public schools to be comprehensive;
- Make teacher training broadly accessible. Currently, the Oregon Department of Education offers training in research-based sexuality curricula that have been proven effective in changing sexual risk-taking behaviors among youth. This is offered at no charge to participants, however school districts must provide release time and substitutes. These requirements have presented a significant barrier for teachers;
- Change Oregon Benchmarks to reflect progress in positive sexual health outcomes including a reduction in the rates of teen pregnancy, births, sexually transmitted infections and HIV disease;
- Pursue the legal changes necessary to ensure that health insurance policies in Oregon treat coverage for birth control methods on a par with other prescription drugs and devices;
- Persuade policy makers to base their decisions on sound research in the area of sexuality; and
- Avoid participation in the “abstinence wars.” Build bridges with social conservatives, especially at the grassroots level, where there are common goals – prevention of unintended pregnancy,

reduction in the number of abortions, and ensuring that young people are safe from sexually transmitted infections.

As a whole, Oregon, along with the rest of the nation, continues to spin its wheels around the issue of teen sexual behavior. If we continue to do what we've always done, we'll continue to get what we've always gotten: premature and unprotected sex among youth, unacceptable teen pregnancy rates, children having children, and epidemic numbers of sexually transmitted infections.

The lessons learned from the European approach to adolescent sexuality are incredibly compelling and offer great insight and promise as we struggle Oregon and around the country to formulate our own plan of action. Oregon is ripe for bringing this issue to the next level. We have a number of pieces already in place. A public understanding of the European experience can provide a significant boost to move our state forward. We have an opportunity to reframe the debate into a cooperative discussion that embraces the “three Rs” of adolescent sexual health: rights, respect, responsibility – *where youth are supported in developing attitudes, making decisions, and choosing behaviors that safeguard their sexual health; where parents, clergy, teachers, government and media work together with youth to create a climate that supports sexual health; where a “fourth R” – research – is the basis for selecting programs and strategies that have been proven effective.*

This is the vision behind Oregon's Rights, Respect, Responsibility® (RRR®) initiative.

Endnotes:

1. Welfare Reform Act of 1996 (P. L. 104-193).
2. Advocates for Youth. “The Future of Sexuality Education: Science or Politics.” *Transitions*: Vol12 #3. March, 2001.
3. Oregon Administrative Rules. Salem, Oregon, 2000.
4. Oregon Revised Statutes. Salem, Oregon, 2000.
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7. Oregon Healthy Teens Survey. Department of Human Services – Health Services. Portland, Oregon, 2001.
8. Berne, Linda and Huberman, Barbara. Aimer Sans Puer: (To Love Without Fear) European Approaches to Adolescent Sexual Behavior and Responsibility. Advocates for Youth, 1999.

9. Kaiser Family Foundation / Children Now. "Talking With Kids About Tough Issues: A National Survey of Parents and Kids." Princeton Survey Research Associates, 1998.
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