

We Can Do Better:
**Oregon Team Report on Western Europe's
Successful Approaches to Adolescent Sexuality**

Contributors:

Coleen Belisle
Jon Benson
Alicia Cardenas
Diane Duke
Ginny Ehrlich
Frank Gibson
Mary Gossart
Toby Hill-Meyer
JoAnn Miller
Kitty Piercy
Paul Robinson
Wendy Shelden
John Sulzman
Ingrid Tyson
Teresa Westmoreland

Cover Design and Website: Brandon Baxter

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Additional copies available online at www.wecandobetter.org
or through Planned Parenthood Health Services of Southwestern Oregon
(541) 344-1611 x 13 or mary@pphsso.org

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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 infections.

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Preface

Submitted by Mary Gossart

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 Statistics, 1999

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 June 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, family planning 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.

Oregon Team Members on the 2001 European Study Tour

Oregon team members have prepared this report based upon their study tour experience, observations and research. This is a reflection of the personal impressions and

perspectives of 16 Oregonians – people who work with youth, who care about youth, and who are strongly committed to advocating for the health and well being of young people.

For a more detailed monograph on the European Study Tour experience and European strategies around issues related to adolescent sexuality, refer to **Aimer Sans Puer: European Approaches To Adolescent Sexual Behavior and Responsibility** by Linda Berne and Barbara Huberman. This can be obtained by contacting Advocates for Youth: (phone) 202/347-5700 (website) www.advocatesforyouth.org.

Endnotes:

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

Foreword

In his Foreword to **Aimer Sans Peur (To Love Without Fear) European Approaches to Adolescent Sexual Behavior and Responsibility**, James Wagoner, President of Advocates for Youth, eloquently captures the spirit and promise which inspire Oregon's Rights, Respect, Responsibility® initiative. His words are reprinted here: (Berne et al, 1999)

A New Vision for Adolescent Sexual Health

James Wagoner

Rights, Responsibility, Respect. This trilogy of values underpins a social philosophy of adolescent sexual and reproductive health in the Netherlands, Germany and France.

In these countries, government and society view accurate information and confidential services, not merely as needs, but as rights of adolescents. These rights, in turn, depend upon societal openness and acceptance of adolescent sexuality. In short, the Dutch, the Germans, and the French expend less time and effort trying to *prevent* young people from having sex and more time and effort in *educating* and *empowering* young people to behave responsibly when they decide to have sex. Each of these nations appears to have an unwritten social contract which states, "We'll respect your rights to independence and privacy; in return, you'll take the steps you need to take to avoid pregnancy, HIV/AIDS, and other sexually transmitted diseases."

Is this a formula for lax morality and promiscuity? The young people in the countries we visited commence sexual intercourse a year or two *later* than do U.S. teenagers. Further, the Netherlands, Germany and France boast better public health outcomes – the teenage birth rate in the Netherlands for example is [more than 6] times *less* than in the United States. Germany's gonorrhea rate is nearly 25 times less than the U.S. rate.

So if Dutch, German, and French teens have better health outcomes *and* delay the onset of sexual activity longer than do U.S. youth, what's the secret? Do we have a 'silver bullet' solution for the United States that will reduce its three million new STD infections

among teens each year, or the 6,000 cases of HIV infection reported so far among those ages 13 to 24, or the 800,000 teen pregnancies each year?

Could the ‘silver bullet’ solution for the United States be a mass media campaign like those in Europe that boast a single, consistent message – *safe sex or no sex*? Is it a public health system that makes contraception available at little or no expense? Could it be the fact that public health policy is based on public health research, rather than relying on the political or “moral” agendas of a strident minority?

Unfortunately, there is no single, ‘silver bullet’ solution. The mass media campaigns, the public health systems, and public health policies have their part in the Dutch, German, and French successes. Yet success doesn’t really rest on programs and services alone. It is the societal thinking – the norms – that make the Dutch, German and French successes possible. It is the openness and the acceptance that young people will have intimate sexual relationships without being married and that these relationships are natural and contribute to maturing into a sexually healthy adult. It is the refusal to brand the expression of sexuality as deviant behavior or to cast it solely in a negative light. It is the determination to present sexual expression as a balance – a normal part of growing up *and* a responsibility to protect oneself and others. It is the respect these societies have for adolescence, valuing them as much for who they are as for the adults they will become.

But how relevant is all this to the United States? The United States is larger, more populous, and more diverse than these European nations, and its cultural values are different. However, size and diversity do not explain the dramatic differences in public health indicators between the United States and the Netherlands, Germany and France. They do not explain why the United States has a higher teen birth rate than the Netherlands, France, Germany *and* Morocco, Albania, Brazil, and more than 50 other developing countries. They do not explain the dramatic differences in HIV and STD rates between the United States and the three European nations.

We need to look deeper – not just at confused and contradictory public policies but also at the contradictory norms that underlie those policies. As a society, we are

uncomfortable discussing sexuality issues and, especially, teenage sexuality. Advertising and programming in the entertainment media too often send sexual messages that seem to say, “Just do it!” The recent, Congressionally-mandated message to students is, “Just say no, until you’re married.” As a result, methods of dealing with teenage sexuality include pretending teens do not have sex or attempting to control and limit information about sex and contraception.

The negative message to teens is clear – “You shouldn’t have sex, so protection is irrelevant!” No wonder many young people in the United States are not motivated to be sexually responsible; and when they are, they are too often thwarted as they seek the information and services they need.

Despite U.S. adults’ general discomfort with the subject of teen sexuality, the vast majority does not agree with “head in the sand” approaches. Instead, the majority of adults say they want young people to have the information and services they need. The challenge will be to build on these positive attitudes and to articulate the values of honesty, openness, respect, and responsibility that promise to underpin a new, successful approach to adolescent sexual health in the United States.

Although the European experience can be helpful in guiding this effort, the United States cannot simply adapt European approaches completely. We are different in many ways. We place a greater value on abstinence and – given the early age at which our teens commence sexual activity – that is a good thing. But valuing abstinence must *not* override young people’s rights to accurate information that can protect and even save their lives. At a time when 70% of 18-year-olds in the United States have had sexual intercourse, we cannot afford to ignore the needs of sexually active youth.

But we can use the experience of the Dutch, the Germans, and the French to help us find a more balanced approach to adolescent sexual health. Indeed, the three ‘Rs’ of sexual health – rights, responsibility and respect – may help us overcome obstacles and achieve social and cultural consensus on sexuality as a normal and natural part of being a teen, of being human, of being alive.

Endnotes:

1. Berne, Linda and Huberman, Barbara. Aimer Sans Puer: (To Love Without Fear) European Approaches to Adolescent Sexual Behavior and Responsibility. Advocates for Youth, 1999.

Introduction

Submitted by Mary Gossart

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:

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

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. To be eligible for this 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.

- 46% of students in grades 7–12 want to know how and where to get birth control.

Challenges are ongoing over sexuality education in public schools, minors' access to contraceptive services and confidential testing / treatment for sexually transmitted infections. The media continues to feature explicit sexuality devoid of responsible messages. 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. They offer great insight and promise as we struggle here in Oregon and around the country to formulate our own plan of action. Oregon is ripe for bringing this issue to the next level. Consider:

- Through the state's Family Planning Expansion Project, great strides are being made in reducing barriers to sexual health services, contraceptives and sexual protection.
- The Oregon Governor's Adolescent Pregnancy Prevention Plan calls for action that encourages the adoption of multiple strategies which are similar or complementary to some of the western European approaches.
- While Oregon does not mandate that sexuality education be taught in public schools, there are specific criteria to be followed if a program is implemented. Oregon legislation requires that sexuality education "...enhance students' understanding of sexuality as a normal and healthy aspect of human development." (ORS 336.455 – see Appendix 1) The statute mandates that course materials and instruction be abstinence-based,

however “...abstinence shall not be taught to the exclusion of other materials and instruction on contraception and disease reduction measures.”

We have a number of pieces already in place. A public understanding of the European experience can provide a significant boost to move Oregon 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. Developing an Oregon team of advocates through the European study tour experience is but one component of an integrated, long-term commitment. In February 2001, with generous funding from the E. C. Brown Foundation, Planned Parenthood Health Services of Southwestern Oregon spearheaded an initial series of forums in Portland, Eugene, Coos Bay, Medford and Grants Pass to educate participants about adolescent sexual health issues and strategies, both here and abroad. The response was overwhelming with nearly 1,100 in attendance... representing youth, parents, community leaders and policy-makers, health care professionals, education specialists, clergy, social service providers and others who work with and care about youth and families. A most compelling presentation revealed why adolescent sexual health indicators are so much more positive in Germany, France, and the Netherlands than in the United States. The primary question of the day was, “Can we do better?”

These forums marked the launching of Oregon’s Rights, Respect, Responsibility® initiative as participants examined the European model, discussed its potential implications for Oregon, and ultimately began the process of providing the leadership and direction to move RRR® forward.

In addition to the initial education forums, the sponsorship of an Oregon team on the European Study Tour, and the development/coordination of that team as a cadre of advocates, a number of ongoing activities contribute to this early-on, grass roots organizing phase of the initiative. These include:

- Development and statewide dissemination of We Can Do Better, the Oregon team report of lessons learned during the European Study Tour and recommendations for adaptation in Oregon. This report can also be accessed on the RRR® website, **www.wecandobetter.org**;
- Development of an Oregon RRR® website, **www.wecandobetter.org** as a tool to educate about and promote RRR®, organize and link supporters and volunteers, provide opportunities for involvement in RRR® activities, and provide connections to related sites;
- Ongoing educational programs about Oregon RRR® occurring throughout the state with Oregon team members taking the lead. As a result of the kickoff RRR® educational event in February 2001, 114 programs have been requested by and provided for a number of groups and organizations. Nearly 3,000 people have attended these programs;
- A telephone survey of Oregon youth and adults to assess attitudes and awareness around a number of adolescent sexual health issues. This survey is being conducted in April, 2002; results will be compiled and disseminated;
- Clergy and faith community events have been requested and are being conducted around the state. These events are designed to educate faith leadership about Oregon RRR®, to train them in educating their congregations, and to support them in developing their own commitment to RRR® and implementing specific action plans that reflect RRR® within their own faith communities.

These are but a few of the fledgling efforts that are stirring both enthusiasm among Oregonians and the determined response that yes, we CAN do better! Through the pages of this report, additional insights, philosophies and strategies will emerge as seen through the eyes of the Oregon team members during their European Study Tour experience.

This is an intriguing story of how some cultures have chosen to do things very differently.

Planned Parenthood wishes to acknowledge the E. C. Brown Foundation for its generous support in funding the initial phases of Oregon RRR®, including the educational forums, the sponsorship of the 16-member European Study Tour team, the telephone survey of Oregon youth and adults, and the development and dissemination of this report.

Endnotes:

1. Welfare Reform Act of 1996 (P.L. 104–193).
2. Henry J. Kaiser Family Foundation. Sex Education in America: a Series of National Surveys of Students, Parents, Teachers and Principals. Menlo Park, CA: September, 2000.
3. Advocates for Youth. “The Future of Sexuality Education: Science or Politics.” *Transitions*: Volume 12 #3. March, 2001.

Family Influence

Submitted by Toby Hill-Meyer

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)
- 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 Dutch and German parents we met 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. Throughout our visit, the importance of parental involvement and influence was apparent. Family is expected to be the primary source of values, morals and beliefs surrounding sexuality and sexual choices.

In the Netherlands, pragmatic Dutch parents offer support to their children based upon research that shows healthy sexuality and positive sexual decision-making are fostered by open, honest parent/child communication. Parents are accepting of the possibility that their children may well become sexually active during their later teen years. The bottom line is that they want their children's sexual experiences to be loving, healthy and protected. "*Restrictive permissiveness* describes the approach most Dutch parents take with their teens – trying to pace their youth in their sexual development and encouraging them to be informed about all the issues and to seek information from many sources. Most Dutch parents expect their teens to use birth control." (Berne et al, 1999)

A number of community supports are in place to help German parents communicate about sex. Parent education and skills-training sessions are available through ProFamilia, and public education campaigns reinforce the sexuality education that youth receive in their homes. Sexuality education is clearly viewed as a primary responsibility of parents.

In general, family and community values in Germany support young people in delaying sexual intercourse. What *is* stressed is sex within the context of a loving, committed relationship – with the use of contraception.

The French family approach to sexuality education is quite different from that of the Dutch and Germans. Most French parents are not comfortable talking with their children – or anyone else for that matter – about sex. It is considered a private issue. The responsibility of providing sexuality education is assumed by a number of public education centers, clinics and mass media.

Young people in France are trusted to make their own responsible sexual decisions. In fact, trust and respect are fundamental to the European approach to adolescent sexuality. While an important piece of western Europe's success in reducing teen pregnancy,

abortion and sexually transmitted infection rates is the commitment to address sexual topics candidly, just as important is the commitment to treat youth with respect.

Young people are valued as contributing members of society. They are partners with adults in determining solutions to the challenges that affect them. Parents are less likely to view their children as needing to be controlled... rather they are in need of guidance and support. Parents trust their children to make moral decisions based upon information and personal values. This in turn causes children to turn to their parents as sources of counsel and influence.

A more complicated picture is emerging for the increasing number of sons and daughters of recent immigrants to western Europe. There is apparent conflict between the open societal approach to sexuality and the personal or religious beliefs held by much of the immigrant population. This is one arena in which the three countries we visited are struggling. Frankly, much needs to be done to create a more sensitive and respectful approach to the needs of those who are other than native-born.

Societal messages around sexuality often conflict with family beliefs and mores, creating a difficult environment for the children of immigrant families. We saw that often these young people were torn by the influences of their European peers and culture, and the pull of family and religious values. We did *not* see, however, any judgment or damning on the part of these young people... most were clearly at peace observing their own traditions and accepted that their western European peers chose a different path.

Recommendations

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, and community organizations; lunchtime on-site programs for working parents;
- access to resource materials including books, pamphlets, fact sheets, videos (Planned Parenthood is one valuable source of such materials); 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.

Various research has shown that positive outcomes can result from open and honest family communication about sexuality: less involvement in sexually risky behaviors, delay in sexual intercourse, and increased use of sexual protection. Once again we must heed the call to pay attention to the research and do all we can to support parents in the role of sexuality educators of their children.

Endnotes:

1. Kaiser Family Foundation / Children Now. "Talking with Kids about Tough Issues: a National Survey of Parents and Kids." Princeton Survey Research Associates, 1998.
2. Berne, Linda and Huberman, Barbara. Aimer Sans Puer: European Approaches to Adolescent Sexual Behavior & Responsibility. Advocates for Youth, 1999.
3. Office of Surgeon General. The Surgeon General's Call to Action to Promote Responsible Sexual Behavior, 2001.

Religious Influence

Submitted by Paul Robinson

In participating on the European study tour, I was especially interested in looking at the religious community's role in assisting and/or resisting the vision that has come to be known as Rights, Respect, Responsibility®. There are several similarities among the religious communities in Germany, France, and the Netherlands that helped create the moral climate for effective change. There are also differences that have evolved through the years and have had both positive and negative effects on the population's view of religion. These commonalities and differences will be the focus of my remarks.

The religious community's overall endorsement of the values embedded in Rights, Respect, Responsibility® and its pragmatic regard toward adolescent sexuality stem from the 18th century's Age of Enlightenment which reinforced the period of Reformation in the 16th century. What ultimately emerged from this period was an understanding that 1) the church could not 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 to decide the most effective way of handling the changing sexual scene created by the introduction of the birth control pill in the 1960's.

The Dutch Reformed Church in the Netherlands, which is the nation's largest Protestant denomination, has consistently viewed sex as a normal part of life and not something to be ashamed of. This attitude helped the church endorse the idea of ready access to birth control information and contraceptives. The Dutch Catholic Church has also been quite liberal. Its bishops refused to take a stand against the use of contraception as early as 1968.

The level of participation of youth ages 15-19 has steadily declined in both churches in the last 30 years from 60% in 1965 to 9% in 1993. Thus the role of the church has been significantly diminished in terms of its impact on young people. The Dutch Reformed Church promotes safer sex practices, especially to prevent HIV/AIDS. While the Catholic Church in the Netherlands has seen its liberal bishops replaced with more

conservative ones, this has had little effect on public attitudes and behaviors related to sexuality, and virtually no impact on policy.

In Germany, the church is state supported, so people are encouraged to declare a religious preference. Eighty five percent of the population claimed a faith in 1985, about evenly divided between Protestants and Catholics. Most people do not, however, engage in any regular religious activity.

Both Protestants and Catholics tend to be conservative on the subject of abortion – in fact it was the strong desire to avoid abortions that drove most people of faith to support making contraceptives available to all sexually active youth. We see the effects of the Reformation and the Age of Enlightenment in Germany, where the majority of people believe it is a woman’s right to choose personal control over her sexuality and pregnancy. Even when the Pope demanded that Catholic family planning centers stop issuing certificates authorizing abortions, those centers operated by the Catholic lay community continued to issue them.

*Oregon Team members Kitty Piercy and Wendy Shelden visit a cybercafe in Cologne, Germany to log onto **www.wecandobetter.org** - Oregon’s Rights, Respect, Responsibility website. During the tour, an online journal allowed those back home to follow the progress.*

France is about 90% Catholic, but like Germany and the Netherlands, church participation has drastically declined from a high of 80% in the 1960's to between 4% and 7% post-1980. Although France is culturally a Catholic nation, there has been a definite

separation between church and state since 1905. This has made it possible for the government to address sexual health concerns free of church interference. The Catholic leadership, in recognizing the loss of members, has acknowledged that it cannot and should not dictate its members' decisions over sexuality-related matters. The leadership views individual conscience as more important than church doctrine, and it readily acknowledges that France is a pluralistic society in which one faith should not set public policy.

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 a strong religious agenda. The fruits of its labor can be seen in the creation of abstinence-only until marriage curricula and programs which Congress has funded with over \$500 million – 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. With this in mind, I would make the following recommendations for engaging faith communities in Oregon:

Recommendations

- Organize the mainstream clergy/faith-based groups throughout the state to challenge the extremist voice in the public policy arena;
- Give these mainstream clergy/faith-based groups full and adequate information, training and resources to be effective;
- Support mainstream people of faith in making their presence felt wherever these issues are discussed, and work to create a presence on a pro-active basis. This includes having a voice in the legislature, on school boards, in religious groups, civic clubs, and in continuing education programs for health care professionals, etc.;
- 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.

Endnotes:

1. Berne, Linda and Huberman, Barbara. Aimer Sans Puer: European Approaches to Adolescent Sexual Behavior & Responsibility. Advocates for Youth, 1999.
2. Unitarian Universalist Association and United Church of Christ. Our Whole Lives: Lifespan Sexuality Education Curricula. Cleveland, Ohio, 2001.

Sexuality Education

Submitted by Ginny Ehrlich, Jon Benson, and Teresa Westmoreland

The governments of the Netherlands, Germany, and France all require schools to teach sexuality education. Although the specifics of implementation vary in each country, all aspects of sexuality are addressed, providing students with age-appropriate and accurate information.

The Netherlands

The Dutch view sexuality as a normal, healthy part of human development and believe that people – teens included – should be respected for the decisions they make with regard to their sexuality. School-based sexuality education reflects these convictions. This education provides students with accurate information, is nonjudgmental, and teaches teens to be responsible for their choices. The instructional message that schools communicate is that sex is healthy within the context of an intimate, caring, respectful, and responsible relationship. The expectation is “safer sex or no sex.” Students learn to view sexual intercourse on a continuum of sexual expression and loving relationships.

The Dutch government funds education – primary through university, public and private. Statute requires that all schools provide instruction about sexuality, and parents are not permitted to excuse their children from that instruction. While many primary schools (students aged 4 – 11) do not have a formal sexuality education curriculum, young people are taught basic human values that underlie healthy sexual behaviors and attitudes – self-respect, responsibility and caring for others. These fundamental values continue to be stressed in secondary school. Primary instructors address students’ questions about sexuality and are free to discuss any topic students raise in an honest, accurate, age-appropriate manner.

Sexuality education is taught in all secondary schools (students aged 12 – 16). The Dutch do not require a specific class called “Sexuality Education,” but instead integrate sexuality education across subject areas and grade levels. For example, students learn about the reproductive system in biology. Thirteen and fourteen-year olds take a required class called “Caring,” in which teens learn to take care of themselves and their basic

needs such as personal hygiene and cooking. They learn how to care for and about others; they learn what caring looks like in a relationship. In the context of caring for self and others, students receive core information on how to access and use sexual protection that reduces the risk of unintended pregnancies and sexually transmitted infections (STI). Sexuality education may occur in less obvious ways in other subject area classes. In literature, the reading of a love sonnet may initiate a discussion about relationships. In history, reading about a European monarch who died of syphilis may lead to a discussion about the spread of sexually transmitted infections.

Secondary teachers in all subject areas are trained to discuss sexuality issues with their students. Unlike their U.S. counterparts, Dutch teachers and students openly discuss any topic about human sexuality – including masturbation, homosexuality, sexual touching – without fear of censorship. Teachers answer questions in a positive manner with accuracy, honesty and respect.

Dutch school biology teacher demonstrates strength and elasticity of latex condoms by filling one with water.

The Dutch government funds national organizations that specialize in reproductive health and HIV/STI prevention to develop sexuality education materials and to work with the schools. Research guides resource development, further ensuring instruction that is effective in imparting sexual health knowledge and in shaping healthy attitudes and

responsible behaviors. Health professionals train teachers to present their lessons on sexuality in an interactive and lively manner that engages students and motivates them to listen and learn. Materials and expertise are available at no or minimal cost to schools.

Germany

The goal of Germany's sexuality education program is to support healthy, responsible sexual behaviors and attitudes, to prevent the spread of HIV, to reduce unintended pregnancies, and to teach skills to access services.

As in the Netherlands, the government oversees and funds schools. Sexuality education is a compulsory component of the national curriculum, and parents are not allowed to excuse their children from instruction. In fact, parents are encouraged to be involved in the sexuality education of their children.

The German school system targets young teens – the U.S. equivalent of middle school students – for formal sexuality education. In the sixth grade, one week is devoted to sexuality education in all classes. At the conclusion of the week's lessons, students are separated into same-gender groups for questions and discussion.

Poster in German middle school classroom provides information about the birth control pill.

In the eighth grade, the curriculum focuses on relationships of all types: friendships, love, divorce, same-sex and different-sex relationships. It also provides instruction in anatomy, physiology, contraception, abortion, and sexually transmitted infections. Parents are sent a letter about the sexuality education program and are asked to participate by checking their child's work and helping them with take-home lessons.

The government provides training to teachers and free materials to all schools. To ensure effectiveness, the materials and training programs are research-based. Educational resources include films, written materials, interactive CDs, and wooden penis models for condom-use demonstration.

France

The French are in the process of implementing a new law, effective December 2001, which mandates 3 hours of sexuality education *at every grade level*. Parents may not excuse their children from the classes.

The goals of sexuality education in France include: 1) developing a positive self-image; 2) understanding that the dimensions of sexuality should be integrated – physical, psychological, legal, etc.; 3) ensuring that students adopt preventive strategies and responsible sexual behaviors; and 4) linking the importance of social responsibility throughout the lessons. Schools are viewed as a place where students should be able to have access to accurate information about sexuality, thus teachers are instructed to teach without promoting their own values and beliefs. The personal and private experiences of students are to be respected.

Sexuality education begins in primary school and is focused on appropriate topics for this age level. Teachers are trained to provide quality and accurate instruction. Late elementary school curriculum includes discussion about social and emotional changes associated with puberty. When students are between 12 and 14 years old, well before most French teens choose to have sex, they receive instruction about the potential risks associated with sexual behavior, as well as prevention and risk reduction strategies.

French teens learn about a continuum of sexual behaviors, not just about sexual intercourse.

As in the Netherlands and Germany, materials used for sexuality education are highly engaging for teens, explicit in nature, and research-based.

The Current Status of Sexuality Education in Oregon

Oregon's laws and administrative rules provide a supportive climate for comprehensive sexuality education. There are two policies that govern the content and approach to sexuality education in Oregon. The first is Oregon Administrative Rule (OAR) 581-22-1440 which 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. (See Appendix 2) Instruction on HIV and Hepatitis B is required annually at grades 9-12. 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 risk-reduction strategies for sexual transmission of HIV. This includes the use of latex condoms.

The second Oregon policy that supports sexuality education is Oregon Revised Statute (ORS) 336.455. (See Appendix 1) This law 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.

Despite generally supportive laws and administrative rules, there are several key differences between Oregon and the three European countries that we visited. One difference is that Oregon focuses on disease prevention and abstinence, rather than on how sexual intercourse fits into a larger continuum of sexual expression and a loving relationship. A second difference is that each European country has developed research-based education programs that are effective and deliver a consistent message.

A third difference is that Oregon state-level policies do not specify the ages or grade levels at which students should receive certain instruction. Per the tradition of “local control” in Oregon, school boards, administrators and teachers decide when students receive vital information and skills pertaining to negotiation and communication in romantic relationships, and contraceptive/disease risk-reduction strategies. In the Netherlands, Germany and France, all students are provided accurate and comprehensive instruction in these areas at the equivalent of the U.S. middle school level.

Another difference between the European countries and Oregon is that the implementation of comprehensive sexuality education varies greatly from community to community. Some communities in Oregon 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.

Two recent studies conducted by the Oregon Department of Education provide some insight into the current implementation patterns in Oregon schools. The 2000-01 Oregon Sexuality Education Assurance Survey designed to monitor local implementation of ORS 336.455 and OAR 581-22-1440 shows that 80% of all Oregon schools describe their program as “abstinence-based,” including information on both postponement of sexual intercourse and disease prevention/contraceptive messages. Approximately 90% of schools report providing opportunities for the development and practice of communication skills and stressing the importance of respect and honesty in a relationship. This study suggests there are still gaps in the implementation of comprehensive sexuality education in Oregon. The majority of comprehensive instruction occurs at the high school level, with one out of three middle schools addressing issues pertaining to disease and pregnancy prevention strategies and less than half of elementary schools specifically addressing sexual activity.

The 2000 School Health Policy and Programs Study (SHPPS) provides additional information on the current state of comprehensive sexuality education in Oregon. In this study, the vast majority of secondary health educators reported that they taught sexuality and HIV prevention education in their classrooms. However, only about 9% of teachers reported using a proven, effective curriculum as opposed to over half indicating 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.

The SHPPS 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.

There are many theories as to why there are gaps in implementation of sexuality education and a decline in the use of proven, effective programs. Some factors influencing this trend may include:

- Increased pressure to improve performance on statewide math and reading assessments has reduced the time available for health education and consequently, comprehensive sexuality education. Health educators are often required to attend staff development events focused on state standards and benchmarks for language arts and math, rather than health-related opportunities. This puts many health educators behind in the latest trends in instruction and technical information. Additionally, it deprives many health educators of the opportunity to receive training in proven, effective curricula, and this lessens the likelihood of quality implementation.
- Funds to support the implementation of abstinence-only until marriage programs are readily available to school districts. In tight budgetary times, school districts have replaced proven, effective programs for which there is no state funding with free or very low cost programs yet to be proven to change student behaviors.
- The misperception of school administrators and educators is that the community is not supportive of comprehensive sexuality education. However, repeated public opinion polls have established that the vast majority of parents and adults (85-90%) believe that young people should receive sexuality education that includes information on contraception and condoms as risk-reduction strategies and the importance of respect and responsibility in human relationships.

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 to implement comprehensive sexuality education in all public schools.*
 - Provide adequate funds for effective sexuality education at all grade levels, particularly at the middle school level;
 - Provide funds for professional development in sexuality education for teachers at all grade levels and across subject areas, as well as for health educators.

- *Allocate class time to implement sexuality education.*
 - Ensure that there is adequate time built into course schedules for age-appropriate sexuality education at all grade levels;
 - Require formal sexuality education in the middle school grades;
 - Provide skills development, practice, and complete information on prevention and risk-reduction strategies two years prior to the median age of initiation of sexual intercourse;
 - Ensure that students receive vital human growth and development information before the onset of puberty.

- *Require the use of sexuality education programs and materials that research has proven to be effective. Fund these programs equally.*

- *Develop a clear, consistent, nonjudgmental message about healthy human sexuality that all educators will deliver.*

- *Provide school workshops for parents to encourage their active participation in the healthy sexual development of their children.*

Endnotes:

- Oregon Administrative Rules. Salem, Oregon, 2000.
- Oregon Revised Statutes. Salem, Oregon, 2000.
- 2000-2001 Sexuality Education Assurance Survey. Oregon Department of Education, 2001.
- Oregon School Health Policy and Programs Study. Oregon Department of Education, 2001.
- Oregon Healthy Teens Survey. Department of Human Services – Health Services. Portland, Oregon, 2001.

Media Campaigns

Submitted by Colleen Belisle and John Sulzman

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

The media campaigns in all three countries have similarities. 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 the research results to craft the next generation of campaigns. All three countries use a variety of media and have a consistent, focused, and frank sexual health message. These public information campaigns are well received by the viewing public.

The Netherlands

The Netherlands began its ongoing Safer Sex Campaigns in the 1980's, primarily in response to concerns about HIV/AIDS. In the beginning years, the approach was far less direct and graphic than it is today. For example, in 1987, a condom campaign did not use the word, condom. Research proved these early media campaigns ineffective. In response to the feedback from research and evaluation, the Dutch developed more frank, explicit, and focused campaigns. These later campaigns have proven effective in changing public attitudes and behaviors.

The Dutch use a variety of mass media including television and cinema commercials, radio spots, videos shown on buses, posters, magazine ads, brochures, and leaflets. They all offer consistent, positive, and straightforward messages about the prevention of sexually transmitted infections (STI) and HIV, condom use, and methods of communicating with one's partner about safer sexual practices.

In addition to focusing mass media campaigns on the prevention of STI and HIV, the Dutch message also focuses on the prevention of unintended pregnancy. Abortion is considered a “social failure” in the Netherlands. (Berne et al, 1999) The Dutch realize that one important way of reducing the need for abortion is the use of oral contraception. So they have combined the promotion of oral contraceptive use with the safer sex/HIV/STI prevention message. The outcome is a creative and powerful “Double Dutch” approach, which encourages the use of two methods: condoms for protection against STI, and birth control pills to avoid unintended pregnancy. Today in the Netherlands, “... 85% of ... adolescents use protection at first intercourse – 46% use condoms, 13% use oral contraceptives, and 24% use ‘Double Dutch’ – the pill and condom together.” (Berne et al, 1999)

The art of public health education through mass media campaigns has been well honed in the Netherlands, and perhaps one of the most impressive elements is the way in which campaign developers have responded to lessons learned from each year’s research and evaluation. Through this process, they have developed the following guidelines: (Berne et al, 1999)

- stimulate openness, step by step
- use the results of research and evaluation
- 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 to improve acceptance of the message
- integrate messages about HIV/AIDS, STI, and pregnancy prevention
- promote condom use
- represent the diversity of relationships
- communicate practical skills
- integrate messages for native Dutch and immigrants

- use the campaign as an umbrella for activities targeting specific groups and interventions at local and regional levels

The Dutch realize that these campaigns alone do not change behavior. Rather, they provide an essential component of sexuality education that strengthens and complements healthy sexuality messages conveyed in the home, in the faith community, and in school.

Germany

Mass media campaigns are also a key element of Germany's efforts to promote sexual health. In response to the very real public health concern about HIV infection, the Ministry of Health set up the Federal Center for Health Education (FCHE) to educate the public about HIV prevention. FCHE implemented a nationwide mass media campaign to spread the message. From the beginning, the Germans created messages without moralistic judgments or scare tactics to promote safer sex, condom use, and HIV prevention. As in the Netherlands, the campaigns began slowly and cautiously. Over the last fifteen years, the messages have grown more and more straightforward and graphic as research affirmed their success. Today the national media campaigns are widely accepted by all sectors of the public.

Like the Dutch, the Germans responded to research and evaluation to fine-tune their public information messages. The fundamental principle that guides FCHE is to create a positive message without making judgments and or using scare tactics. Their sexual education messages focus on teaching their audience to: (Berne et al, 1999; Bundeszentrale, 1998)

- recognize the need for protection
- know protection options
- develop motivation to protect oneself and others
- build communication skills with one's partner
- learn safe and unsafe behaviors with people infected with HIV
- change beliefs about HIV infected people

The Germans, like the Dutch, utilize a wide variety of media: TV, radio, cinema spots, billboards, posters, fliers, bus ads, postcards, films, documentaries, traveling theaters, stickers, pamphlets, and even tee shirts. Schoolbook publishers print the campaign prevention message in book chapters dealing with HIV/AIDS and STI. The campaign logo is printed on tickets to major events. Travel guides and other publications offer cost-free advertising space. FCHE created Love Line, an interactive CD-ROM for teens. Love Line has a question/answer format and deals with sexuality education topics and relationships. Among the supporters and promoters of the CD are the Catholic and Evangelical media centers.

Our study group viewed snippets of the German national campaign. Each piece was clever, humorous and straightforward. All the ads fit under the umbrella theme, “Mach’s Mit”, which roughly translated means “Join with us.” Coupled with “mach’s mit” is the message, “Gib AIDS Keine Chance” (Don’t Give AIDS a Chance.”). A particular favorite of the group was an ad that was a takeoff on the Olympics theme of “go for the gold.” The TV spot starred a gold colored, fully extended condom, its face set with determination as it high jumped, breast stroked, pole vaulted and ultimately ended up the first place medal winner. The accompanying graphic featured a gold-colored condom proudly poised atop the first place platform.

As with the Dutch, the German national media campaigns are one component of sexual health education that supports and reinforces what is taught by family members, religious leaders, and teachers.

AIDS prevention campaign in Germany takes advantage of the Olympic theme to promote condom use.

France

Like the Netherlands and Germany, France began its media/educational campaigns cautiously. Because France is primarily a Catholic country, early marketing campaigns focused only on the prevention of HIV/AIDS. As research proved the campaigns effective and public support grew, the French added more topics to their campaigns including the prevention of sexually transmitted infections (Berne et al, 1999) and contraception. Today in France, as in the other two European countries, the educational campaigns focus on all aspects of sexuality and have tremendous support from the general population and the government.

The French sexual health media campaigns began in 1986 with the establishment of the Regional Center for the Prevention of AIDS (CRIPS) by the government. Today CRIPS employs about 45 professionals including psychologists, nurses, educators, and marriage counselors. They have created numerous public education/social-marketing materials that are creative, clever, powerful, and often quite explicit. Materials reflect the diversity of French society – couples of various ages, shapes and sizes; same and other sex couples; and biracial couples. In addition to developing and implementing mass-media campaigns, CRIPS provides educational programs in secondary schools and estimates that it sees 80,000 students a year.

This pamphlet produced by CRIPS includes information about accessing condoms and HIV/AIDS information throughout Europe.

As in the other two countries, French public health campaigns utilize a wide array of media: TV and radio spots, posters, billboards, and hotlines. One successful campaign that CRIPS produced consisted of a number of vignettes that aired on television, in theaters, and in schools. “The Joy of Life” is a series of twenty vignettes that was broadcast on national TV in between regular programming for children. The vignettes showed a grandmother talking to her multi-racial grandchildren about sexuality in age-appropriate language. Topics covered a myriad of sexuality-related issues: relationships, puberty, contraception, pleasure, respect, and responsibility.

A particularly powerful strategy CRIPS employs is to involve populations targeted for specific campaigns in the development of the message and materials. For example, in an effort to reach teens with the AIDS prevention message, CRIPS sponsored a national poster contest for youth. Young people submitted more than 5,000 posters. The winning posters were distributed as part of the campaign, and the innovative ideas of youth were used to launch subsequent advertisements and educational materials.

CRIPS is currently building Cyber CRIPS, a gathering place for young people to access a wealth of sexuality information on- and off-line. Information about drugs, depression and suicide, nutrition, and other general health topics is also available. The initial goal is to have ten touch-screen computers with bookmarks to access useful sites that focus on sexuality. Cyber CRIPS offers materials designed for parents and professionals to use to help youth develop healthy sexual practices and avoid drug use. Also planned is a condom museum featuring 80 different kinds of condoms.

Our visit to France reaffirmed what we heard in the Netherlands and Germany: public information campaigns are an effective method of educating about healthy sexual behaviors and shaping the social norms that reinforce those behaviors. The campaign messages must be developed over time, using research and evaluation to test their effectiveness as well as acceptance by the general viewing public. Messages must be positive, accurate and straightforward; they must avoid being judgmental; and they should avoid fear-based tactics. Also of importance is that the media campaigns must be

reinforced and supported with sexual health education at home, at school, and within the religious community.

Watching the evolution of this and other mass media campaigns in the western European countries left our study tour group 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 can be as sensitive, clever, persistent and persuasive as the Europeans to create effective public information campaigns to promote healthy sexual attitudes and behaviors.

Endnotes:

1. Berne, Linda and Huberman, Barbara. Aimer Sans Puer: European Approaches to Adolescent Sexual Behavior & Responsibility. Advocates for Youth, 1999.
2. Bundeszentrale für gesundheitliche Aufklärung (BzgA). Sex Education and Family Planning: Research and Model Projects Sponsored by and in Collaboration with the FCHE. Cologne: BzgA, 1998.

Clinical Services

Submitted by Diane Duke, Ingrid Tyson and Wendy Shelden

The Netherlands

Spurred on by the advent of the birth control pill in the 1960's, the Dutch have taken a practical approach toward sex. Healthy sexual outcomes and the reduction of sexually transmitted infections and unintended pregnancies (particularly among teens) are a national priority. Recognizing these as public health issues, the country committed to implementing pragmatic, research-based strategies that had a proven history of effectiveness. Key steps in the process included: (Berne et al, 1999)

- 1969 - The Netherlands legalized the sale of contraceptives; condoms became available in vending machines;
- 1971 - National health insurance coverage included oral contraceptives (the pill);
- 1980's - The government funded the Rutgers Foundation to provide reproductive health care and sexuality education, with a special focus on adolescents;
- 1981 – Abortion was legalized.

Rutgers Foundation operates seven clinics throughout the Netherlands, utilizing a multidisciplinary approach in providing reproductive health care to “clients who are hard to reach, especially single women, young women, and newly arriving immigrants.” (Braeken, 1998) A team of physicians, nurses and psychologists are specially trained to deliver a myriad of services including medical exams, birth control methods, emergency contraception, pregnancy testing, diagnosis and treatment of sexually transmitted infections, counseling related to sexual abuse, and infertility services.

In addition to operating clinics, Rutgers Foundation is a major source of sexuality education materials and programs. While the primary emphasis is on education for youth, the Foundation provides educational services for adults, including programs to support parents in communicating with their children about sexual issues.

Rutgers Foundation makes reproductive health services more available to youth through strategies that are sensitive to the particular needs of young people. Clinics 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.

In the Netherlands, the birth control pill is the most popular choice of contraception for teenage women. Additionally, the concept of “Double Dutch” is widely promoted and embraced – she uses the pill and he wears a condom – reducing the risk of both pregnancy and sexually transmitted infections.

Over 99% of the Dutch population are covered by health insurance under the Comprehensive National Health Policy (Kirkman-Liff, 1996). Rutgers Foundation defines the standard for contraceptive services for youth. Together, this creates a system of no cost reproductive health services including contraceptive methods, emergency contraception, abortion, diagnosis and treatment for HIV and sexually transmitted infections, pregnancy testing, prenatal services and delivery. Interestingly, condoms are not funded but are readily available.

Most Dutch citizens receive health care services from their family physician. These practitioners are well versed in the area of reproductive health and have specialized training in counseling and referral services. The concept of family practice in the Netherlands is different than in the US with the emphasis placed on providing health care to the entire family. One physician is assigned to each family and provides care to every member of that family. Physicians in the Netherlands pride themselves in knowing their

families well and are often considered a valued member of the extended family. While there is the option to change physicians, it means reassignment for the entire family.

Due to the sensitive nature of sexually transmitted infections (STI) and the need to protect the public health, the Dutch Ministry of Health finances easy-access clinics designed to provide rapid and efficient diagnosis and treatment. These walk-in clinics also offer free HIV testing, pre- and post-test counseling, contact tracing and treatment of infected partners. (Berne et al, 1999) The clinics provide safer sex education and free condoms. Providers speak several languages, and translators are available. Everyone is eligible for services at no cost. In the Netherlands, prevention of STI and HIV is serious business... whatever it takes, the Dutch are committed.

Legalized in 1981, abortion is funded by the national health insurance plan. Restrictions include a five-day waiting period and parental consent or social worker bypass for young women under 16 years of age. However it is important to say, the emphasis is on support not deterrence. Success in preventing unintended pregnancies through the implementation of proven public health strategies allows the Netherlands to boast the lowest abortion rate in the industrialized world.

Germany

Similar to their Dutch neighbors, Germans enjoy health insurance that is subsidized by the government. Only 10% of the population – those in the highest income levels – pay for private coverage. As is also true in the Netherlands, “government provides generous support for sexuality education, family planning, and contraceptive services.” (Berne et al, 1999)

Contraception is viewed as a means to avoid abortion. For women 20 years of age and younger, contraceptive methods are free of charge, and the barrier of a required physician visit has been removed. This is a reflection of the German belief that sexual protection is absolutely essential – a philosophy held by German teens and demonstrated in their effective use of birth control. In fact, parents, schools, and the culture as a whole favor birth control use among teens who are having sex. This ethic so permeates German

society that, according to a 1995 study conducted by The Federal Center for Health Education, 84% of male teens and 92% of female teens use contraception the first time they have intercourse. (Federal Center for Health Education, 1995) Condoms, which are used by more than half of German teens, are openly available in a number of outlets including pharmacies, markets, restaurants, clubs and public restrooms.

Pro-Familia is one of the local family planning clinics that provide reproductive health care. A fundamental goal is ease of access, so the clinics are designed to provide a variety of services on site, including medical visits, contraception, diagnosis and treatment of sexually transmitted infections, education and counseling. The hours and locations of clinics are planned with the convenience of the clients in mind.

2001 Study Tour participants pause for a photo with Pro-Familia staff.

Students frequently have school sponsored field trips to Pro-Familia to familiarize the young people with the clinic locations and services that are available to them. Safer sex instruction, condom use and emergency contraception messages are offered in many venues and in clinic phone messages heard by clients on hold. Educational and public health messages are available in many languages and presented in appealing and “teen friendly” ways.

In 1996, Germany legalized first trimester abortion. Counseling is required, and while the decision is left up to the pregnant woman, the life of the fetus is stressed. Parental consent is required under the age of 18, but some doctors may perform abortions without this consent if they believe the teen is mature enough to understand the implications of the procedure.

Second trimester abortion is permitted only in the case where the mother's life is endangered. Strict regulations around second trimester abortions have forced German women to travel outside the country for the procedure.

France

All reproductive health services are covered by the national health insurance plan in France. In 1974, the government permitted family planning clinics to dispense condoms and contraceptives and required that services be confidential and free to those 18 years of age and younger. (Bellanger, 1998)

As in Germany and the Netherlands, France approaches adolescent sexual behavior and responsibility from a research-based perspective. The provision of services is built upon strategies that are proven effective. Reproductive health care is easily available to young people, and many innovative programs have been developed to engage teens. For example, French schools do not hold classes on Wednesday afternoons. So, it made sense for family planning clinics to take advantage of the opportunity to reserve this time for teen clients. Clinics encourage walk-in appointments, and teens are welcomed to visit alone, with a partner, or in groups.

The government has kept the price of condoms very low to encourage use. Access has been greatly increased with the installation of condom vending machines and maps that identify their location. These dispensers are strategically placed at sites that are frequently visited by teens. Specially marked condom packets are imprinted with everything from advertisements to political party messages on them and are distributed at concerts and other public events.

France has a number of clinics that specialize in the prevention, testing and treatment of sexually transmitted infections and HIV, along with the provision of contraceptive services. Many are located on school campuses and provide medical services, education around safer sex, and sexual protection.

France provides for free and legal abortion through the 10th week of gestation, with the restriction of a 10-day waiting period. Beyond this point, women must obtain services outside of the country. Minors must have consent from at least one parent, but doctors can overlook this requirement if they think it is in the best interest of their patient. (Bellanger, 1998) Given that France is a predominantly Catholic country, emphasis is placed on preventing unplanned pregnancies through responsible sexual behavior. Consequently, the government is firmly committed to removing barriers to education and services, for teens as well as adults.

Oregon

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 - see appendix 3). 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 services from 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.

A number of factors can affect convenient access to clinical services for family planning (FP) and sexually transmitted infections (STI) in Oregon: insurance status, citizenship,

age, need, and place of residence can be potential barriers. In urban areas, people with private health insurance essentially have ready access to FP and STI services comparable to that in the Netherlands, Germany or France. In rural communities, residents may need to travel long distances to obtain any FP, STI or abortion services. Uninsured non-citizens often have difficulty accessing health care.

Family Planning and STI providers receive state and federal dollars and support for services in all 36 Oregon counties. These clinics may or may not be administered by local County Health Departments. In Oregon there are public health clinics in each county, but location and/or limitations of providers may be insurmountable barriers to teens receiving adequate care. In small communities there may be only one site that offers services, clinic hours may be prohibitive and a young person's family or friends may be working at the site, thus compromising confidentiality. Oregonians should also be alarmed at the current effort to allow county health departments to opt out of providing family planning services altogether. Yamhill County has done just that, and Columbia County's Board of Commissioners is considering this move.

Private providers, county health departments and non-profit organizations such as Planned Parenthood are vital players in the provision of clinical services to teens. Nurse practitioners and physician assistants are an integral part of the provider network in Oregon. The quality of services as well as the availability of a wide range of services may vary from site to site depending on the provider, the client's insurance or health plan status and the philosophy of the clinic.

School-Based Health Centers (SBHCs) are another source of health care for some teens. There are only 44 SBHCs providing primary care in 14 Oregon counties. Pregnancy prevention including abstinence, and STI/HIV prevention are routine components of health services at SBHCs. Certified centers must offer a limited set of basic reproductive health services on site, including reproductive health exams, pregnancy testing and counseling, STI treatment, and HIV testing and counseling. Other services may be offered on site or may be referred to other providers. Only one school district allows birth control and emergency contraceptives (ECP) to be distributed on site. Two school

districts allow condoms to be distributed. One school district allows the distribution of condoms only if a student has already been diagnosed with a sexually transmitted infection. SBHCs are not permitted to provide options counseling around crisis pregnancy or abortion referrals.

In Oregon there are no restrictions on abortion although access is somewhat limited to more urban communities. Abortions can be performed in Oregon up to 23 weeks with a cost ranging from \$350 to \$1800, depending on gestation and the facility. The Oregon Health Plan will pay for abortions for individuals at or below poverty level. Parent notification/ consent is not required for a minor aged 15 and older. There has been a history of picketing, harassment and violence, including clinic arson, bombings and attempted murder of abortion providers in Oregon.

Recommendations:

- 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 SBHCs;
- 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 women who need them;
- Promote a zero-tolerance policy of harassment and violence towards abortion providers and their clients;
- Focus on preventing the need for abortion in the first place. This must rise to the top of everyone's agenda, including family planning clinics that provide abortions and organizations that advocate for reproductive rights.

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Public Policy

Submitted by Frank Gibson, Kitty Piercy, JoAnn Miller

Overview

“Freedom to engage in an activity gives society the means to control the activity, to make it safe.” These words, spoken by a Dutch sexuality educator, sum up the public policy of Germany, France and the Netherlands as it relates to sexuality: allow and regulate.

When it comes to developing public policy around sexual health services, education programs, 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 its 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. “We have no need to do much research here,” he explained. “”The best studies have been done in your own country.” 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 sexuality 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.

As to the relative utility of the prohibitive and regulatory approaches, consider this: The legal age of consent to sexual intercourse in most of the United States is 18 years. It is 14 in Germany, 15 in France, and 16 in the Netherlands. Yet, on average, American teenagers start having sexual intercourse at age 16.4 years, compared to 16.9 years in Germany, 17.5 years in France, and 17.7 years in the Netherlands.

Oregon Team Member, Toby Hill-Meyer, reports back in a group summary session.

Before the birth control pill was introduced in the 1960's, Dutch public policy toward sexuality was much like ours was then and is now. But the Dutch are practical: If there is a straight line between a problem and its solution, the Dutch will find it. The Dutch like to stick to the rules, and do not easily accept fundamental contradictions between the rules and life as it is actually lived. So, in response to the change in sexual behavior occasioned by the arrival of the Pill, the practically-minded but rule-based Dutch: (1) gradually changed their social norms to be accepting of responsible and respectful sex before marriage, and (2) developed effective programs to prevent unwanted pregnancy and sexually transmitted infections.

It is true that the U. S. has been quite successful in responding to some public-health challenges where the Europeans have not: campaigns against cigarette smoking and drunk driving are two good examples. The U.S. – and our own state of Oregon – could be much more successful in the prevention of sexually transmitted infections and unintended teen pregnancy if we were willing to approach those problems in a more pragmatic, focused and research-based manner.

Public Policy and Sexuality Education

Although sexuality education is required by law in the Netherlands, the country has no national curriculum. Instead, the Dutch Ministry of Health has simply funded professionals to do the job, and it trusts their expertise in choosing the best use of that funding. Teachers and counselors are supported in providing the most effective sexuality education for their students. Parents are expected to impart their values and to teach about responsible and caring relationships.

Municipal governments in the Netherlands play a much larger role in the provision of reproductive health services than do their counterparts in the United States. In making programmatic decisions for the teenage population, Dutch municipalities rely on input from young people to a much larger degree than do U.S. decision-makers. For instance, teen councils in the Netherlands are consulted regularly regarding all aspects of service delivery.

In Germany, the federal German government takes primary responsibility for research and AIDS-related public media campaigns, as well as the development of sexuality education materials. In both France and Germany, comprehensive sexuality education has long been required by law for all students, including those attending parochial schools. Lawmakers there reject the idea of parents opting their children out of these courses because they believe that the greater good is not served if some children are allowed to remain dangerously ignorant of the means to protect themselves and others. However, it must be said that, despite their national laws requiring sexuality education, French and German experts acknowledge that whether and how this information reaches students in a particular school is determined by the school director.

In Oregon, the Department of Education must report to the legislature at each regular session on the implementation of courses on family life, HIV/AIDS, and human sexuality, based on data from school districts' annual assurance reports. (See ORS 336.475, Appendix 4). Oregon law requires that HIV/AIDS education be taught in all school districts (See OAR 581-022-1440, Appendix 2). While sexuality education is *not* mandated, there are specific guidelines that must be followed *should a school district decide to implement human sexuality education courses*. These guidelines contain a number of criteria, including the mandate that course instruction be comprehensive, and that it provide information about practices which eliminate or reduce the risks of pregnancy as well as infection with HIV and other sexually transmitted diseases. Abstinence is to be promoted for school age youth, *however it is not to be taught to the exclusion of instruction about contraceptive and disease prevention practices* (See ORS 336.455, Appendix 1). Unlike parents in France and Germany, Oregon parents are permitted to opt their children out of HIV/AIDS and sexuality education in the public schools.

One can logically assume that it is virtually impossible to meet the Oregon mandate of educating students about HIV/AIDS without addressing the issues of sex and sexuality. The question to ponder then is, how is it that Oregon's teen pregnancy prevention program, run by The Department of Human Services – Children and Family Services, elects to fund abstinence-only until marriage programs* which apparently are not in

line with related laws and regulations? Moreover, these programs show no scientific evidence of changing the sexual risk behaviors of youth.

Some Oregon schools provide abstinence-only programs and leave it at that. Monetary and time constraints prevent them from supplementing these programs with a comprehensive curriculum. It seem to us that they are out of compliance with the law... and that students are being short-changed.

Some Oregon school districts do provide a more comprehensive approach to sexuality education that addresses their students' needs and interests. Classes conducted by school staff may be supplemented with effective peer education programs and community educators provided by Planned Parenthood, county health departments or other health agencies.

Public Policy and Reproductive Health Care

The great majority of Dutch reproductive health care is provided by general medical practitioners who receive ample training in this field from Dutch medical schools, and whose services are covered by national health insurance. Practitioners may not deny service because of religious or moral beliefs, and they must keep the confidentiality of patients. As a result of this dependence on general practitioners, the number of private, nonprofit reproductive health clinics has decreased in recent years from 37 to seven.

The predominance of the general practitioner and national health insurance coverage exists in Germany and France as well. All types of birth control services and supplies are covered (except condoms, which are cheap and ubiquitous), as are screening, abortions and sterilization.

In Oregon, we have had some success in extending coverage to the uninsured through the Oregon Health Plan, which does cover contraceptives. However, the 2001 Oregon

*Programs include: FACTS (Family Accountability Communicating Teen Sexuality), Northwest Family Services: Portland, OR; Stop & Think, Lane Pregnancy Support Services: Eugene, OR; STARS which utilizes the Postponing Sexual Involvement curriculum by Marian Howard, Grady Memorial Hospital: Atlanta, Georgia.

Legislative Assembly failed (for the third time) to pass legislation to require private insurers to include coverage of contraceptives to the same extent that other prescription drugs are covered.

Oregon youth rely heavily on private nonprofit and governmental clinics for free or low-cost reproductive health care. This has been especially true since 1999, when our state obtained a Medicaid waiver that increased state and federal funding for free reproductive health care through a program known as the Family Planning Expansion Project (FPEP). The public response to FPEP has been remarkable as previously unserved Oregonians at risk of unintended pregnancies, births and abortions now have access to services. The renewal of this five-year program may well be at risk, given the anti family planning policies of the current administration in Washington.

School-based health clinics are successful but far from available throughout Oregon. Moreover, within these clinics, providers often find their efforts to provide needed services for youth stymied. For example, one school board policy allows the distribution of condoms only if a student has already tested positive for a sexually transmitted infection.

Fiscal Policy

As an example of relative tax burdens, the Dutch income tax rate (including social security tax) for incomes in the range of \$70,000 to \$200,000 is 50%, while property tax is less than 1% of value. For this, the Dutch receive health care and all prescription drugs; free education, primary through Ph.D. levels; a minimum monthly allowance if unemployed (even if childless and single); retirement benefits of at least \$1,500 or 70% of most recent salary if greater; full coverage for long-term nursing home care; and all infrastructure construction and maintenance, including a highly accessible and reliable public transportation system. Universal access to health care and education, as well as the greater social safety net for food, housing and unemployment stipends, combine to drive down rates of unintended pregnancies far below U.S. levels.

In comparison to the United States, the western European countries we visited are able to achieve much more for their money in the areas of sexuality education and HIV/AIDS prevention. For example, SOA, the Dutch agency in charge of public information campaigns in these topic areas, obtains an 85% discount for air time from media outlets overall. In Germany, a country of 82 million people, combined federal and state spending on sexuality education and HIV/AIDS prevention totals approximately \$7.5 million per year. In the United States, a country of 250 million people, federal and state governments have focused spending – more than \$500 million during the last five years – on abstinence-only until marriage education programs. Yet the incidences of unintended teen pregnancies, births, abortions, and sexually transmitted infections are far lower in Germany than in the U.S.

Frank Gibson presents Barbara Huberman of Advocates for Youth with a thank you gift from the study tour participants. Barbara is the driving force behind the annual study tours.

Social Conservatives and Public Policy Relating to Human Sexuality

There are socially conservative lawmakers in western Europe who are anti-abortion. However, they do not believe it is good public policy to deprive women of the right to choose. Conservative legislators instead support easy access to birth control and

comprehensive sexuality education in order to reduce the number of abortions. As a direct result of the successful European policy consensus to reduce the need for abortion, the debate about the procedure's legality and morality occupies a far less important place on the European political scene than it does in our country.

The Netherlands, Germany, and France are not, however, without anti-choice religious forces. In France last year, some conservative ministers succeeded for a time in overturning the Health Ministry's authorization for schools to dispense emergency contraception without parental consent or prescription. Religious conservative members of the Dutch Parliament succeeded in pressuring the Minister of Justice to threaten prosecution against the crew of the "abortion ship" because the crew had not obtained a Dutch abortion clinic license before sailing to Ireland to provide the services to Irish women in international waters. Nevertheless, these conservative, anti-choice religious forces are effective only at the margins, and are not allowed to impede the provision of effective reproductive health care and sexuality education.

In the United States, socially conservative policy makers continue to fight an ongoing battle against reproductive rights, adding more restrictions to access. These restrictions include parental notification laws, waiting periods, excessive clinic requirements, barriers to mifepristone (RU486), and outlawing specific abortion procedures. In recent years they have begun a new attack on access to contraception and have imposed funding restrictions on aid to other countries that would be considered unconstitutional in the U.S. At the national level, efforts are underway to siphon funds from family planning and reallocate them to abstinence-only until marriage programs. Additionally the Global Gag Rule has been reenacted, denying family planning dollars to poor countries throughout the world.

During the 2001 session of the Oregon legislature, 16 anti choice bills were proposed but none made it through due to pro-choice legislators, advocates and the governor's veto pen. There was also a multi bill effort to create religious and conscience exemptions to the provision of birth control and emergency contraception, thereby allowing for the denial of insurance coverage for contraceptive methods.

Public Policy Relating to Abortion

In all three countries we visited, counseling is required by law before an abortion can be performed. We were informed that mandatory counseling was the political trade-off to win the legalization of first-trimester abortions. No particular counseling content is mandated, however, and certainly not anti-abortion propaganda. Instead, the counseling requirement appears to have matured into a process that can be helpful to the patient by (1) giving the patient a confidential ear so she can tell her story, and (2) empowering counselors to authorize second-trimester abortions (the Netherlands), or abortions for young girls when it would be dangerous to ask for parental consent (as is otherwise required in Germany and France). Post-first-trimester abortions are so strictly controlled in Germany and France that women usually travel to other countries to obtain them. In Germany, counseling is required to occur in a location separate from the facility where abortions are performed, with different personnel involved. Post-abortion counseling is available as a regular part of the procedure.

In the United States, abortion is essentially legal, but subject to a myriad of restrictions and threats at the state level. States have enacted 264 anti-choice measures during the last six years, making women's reproductive rights more restricted than they were in 1973 when the Supreme Court handed down the *Roe v. Wade* decision which legalized abortion across the country. (NARAL, 2001)

Outside the public-policy arena, abortion providers are under constant attack from protestors and terrorists in many places. This has caused a decline in numbers of providers who must consider the danger to their lives and families. At last count, 86% percent of U. S. counties have no known abortion provider. (Henshaw, 1995-1996)

Public Policy Challenges in Western Europe Relating to Human Sexuality

Policy makers in the countries we visited face a number of significant challenges:

Effective Programs for Immigrant Populations

All three countries have fast-growing populations of immigrants and refugees. Dutch, German and French efforts to provide appropriate sexuality education to immigrant

teenagers have been difficult and challenging. These western European nations have attempted an assimilation strategy which does not include appreciation for the contributions of other cultures.

In western Europe, many immigrant teenagers report living two lives: one at school, based on modern western values; and another at home, based on traditional parental values from their native countries. An example of how this dual life plays out is marked by an increase in a plastic surgery known as "hymen reconstruction."

Inconsistent Public Funding

Because the Dutch have been so successful in achieving low teen pregnancy rates, the Ministry of Health has significantly reduced public funding for school-based sexuality education. Both Dutch and German experts reported frustration with this paradox: If progress is made, the government sees little need to fund programs; if progress does not occur, governmental skepticism sets in. The experts said that they are willing to be responsible for developing effective programs and proving it through rigorous evaluation, but they want their governments to show consistency and commitment over the long haul.

Backsliding Safer Sex Practices

Europeans, like Americans, are experiencing a reduction in safer sex practices because HIV/AIDS is not considered as much of a crisis as it once was. Serial monogamy is the norm for young people there, as here. Young people on both continents appear to feel that they are not in danger because they are having sex with only one partner at a time.

Recommendations for Action in Oregon

Based on the foregoing observations, we recommend that the following actions comprise the first steps to be taken to improve Oregon's public policy relating to human 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. Trainings

are offered at no charge to participants, however school districts must provide release time and substitutes. This requirement has 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 human sexuality.
- 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 children are safe from sexually transmitted infections.

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