



## **Comprehensive sexuality education and life skills training**

### ***What is comprehensive sexuality education?***

Comprehensive sexuality education seeks to assist young people in understanding a positive view of sexuality, provide them with information and skills about taking care of their sexual health, and to help them acquire skills to make decisions now and in the future.

A comprehensive sexuality education program includes information as well as an opportunity to explore attitudes and develop skills in such areas as human development, relationships, personal skills, sexual behaviour, sexual health, and society and culture<sup>i</sup>. Comprehensive sexuality education enables choice and promotes safe, consensual sexual behavior.

### ***Sexuality education as a strategy to empower young people***

Immediate investment in adolescent sexual and reproductive health and rights (SRHR) is a valuable step in achieving basic human rights and sustainable development<sup>ii</sup>. It is one of the best investments a nation can make; a quick win that can go a long way in strengthening the capacity of countries to fight poverty<sup>iii</sup>. Evidence-based comprehensive sexuality education can play a crucial role in supporting young people in their (sexual) development, becoming responsible adults and active citizens; it can help decrease vulnerability to SRH problems, including HIV/AIDS; it is crucial for correcting ignorance and misconceptions about sexuality and reproduction. Sexuality education is effective in helping young people to choose for healthy lifestyles: delaying their sexual debut, safer sex and fewer partners<sup>iv</sup>.

In recognition of the needs of young people and of evaluations that demonstrate the effectiveness of such programs, the world's governments have since 1995 agreed five times that comprehensive sexuality education and health services must be provided to young people: in the ICPD Programme of Action (PoA) of 1994, the Fourth World Conference on Women in Beijing (1995), ICPD+5, the UN General Assembly Special Session on Children and ICPD+10. School-based sexuality and reproductive health education is even declared to be a mandatory part of primary and secondary school curricula worldwide to achieve the MDGs<sup>v</sup>. However, a study of 107 countries in 2001 found that 44 still did not include AIDS

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<sup>i</sup> National Guidelines Task Force, *Guidelines for Comprehensive Sexuality Education, 2nd Edition, Kindergarten-12th Grade*, New York: Sexuality Information and Education Council of the United States, 1996, pp. 3,5.

<sup>ii</sup> State of the World Population Report: 1997. UNFPA, 1998, New York

<sup>iii</sup> Statement by Thoraya Ahmed Obaid, Executive Director, UNFPA. In: *Population and Reproductive Health: Culture and Religion Matter. 8th General Assembly Asian Forum of Parliamentarians on Population and Development*, 12 November 2005, Jakarta

<sup>iv</sup> Family Health International. *Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries*. FHI Working Paper Series No. WP05-03. 2005, Research Triangle Park, NC 27709 USA.

<sup>v</sup> *Youth and the Millennium Development Goals: Challenges and Opportunities for Implementation*. Interim Report of the Ad Hoc Working Group for Youth and the MDGs. United Nations Programme on Youth in the Department of Economic and Social Affairs (DESA), November 2004, New York

education in their school curricula<sup>vi</sup>. These unfulfilled promises and gaps in ICPD's PoA clearly demonstrate the need for promoting sexuality education to empower young people and fighting poverty.

### **What are the result of comprehensive sexuality education?**

Comprehensive education about sexuality is effective in delaying the onset of sexual intercourse, reducing the number of sexual partners, and increasing contraception and condom use among teens<sup>vii</sup>. Unlike what is often thought, comprehensive sexuality education does not increase the number of sexual partners among young people<sup>viii</sup> or increase any measure of sexual activity<sup>ix</sup>.

Youth receiving comprehensive sexuality education—including information, skills and assertiveness to make safe decisions and have them respected, including to say no and delay sexual intercourse and to systematically protect themselves during intercourse—are more likely to delay initiating sex and to use protection when they do have sex compared to youth who receive abstinence-only programs<sup>x, xi</sup>.

Openness about sexuality is a precondition to create a safe, non-judgmental and respectful environment in which people can enjoy their sexuality. Attention to the positive sides of sexuality, providing insight in one's own sexual development and achieving skills in communicating, are the factors enabling people to negotiate safe and consensual sexual behaviour. It also helps people to make their own choices, either to abstain or enjoy sexuality free of guilt, shame and regret. It contributes to gender equality, decreases stigma and discrimination and decreases sexual violence<sup>xii</sup>.

A recent review study (2005) on the impact of sex and HIV education programs on sexual behaviours of youth in developing and developed countries showed that all reviewed programs were far more likely to have a positive impact on behaviour than a negative impact on one or more of six aspects of sexual behaviour: 1. initiation of sex; 2. frequency of sex; 3. number of sexual partners; 4. condom use; 5. contraceptive use in general, and 6. sexual risk-taking. Effective education programs commonly created a safe environment for youth, focused on clear goals of preventing HIV/STI and/or pregnancy, focused on specific behaviours leading to these health goals and gave a clear message about those behaviours, addressed psycho-social risk and protective factors affecting those sexual behaviours, included multiple activities to change the targeted risk and protective factors, employed instructionally sound teaching methods that actively involved the participants and helped them personalize the information, employed appropriate activities and messages (for participants' culture, age, sexual experience) and covered topics in a logical sequence<sup>xiii</sup>.

Young people need access to comprehensive and confidential services that respond to the realities of their lives. And if they do have sex - and eventually most of them will - they need

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<sup>vi</sup> State of World Population 2003. UNFPA, New York, 2003

<sup>vii</sup> Douglas Kirby, *No Easy Answers*, The National Campaign to Prevent Teen Pregnancy, 1997

<sup>viii</sup> *Young people, HIV and the churches*. Christian Aid, 2003

<sup>ix</sup> Douglas Kirby, *No Easy Answers*, The National Campaign to Prevent Teen Pregnancy, 1997

<sup>x</sup> Grunseit A. *Impact of HIV and Sexual Health Education on the Sexual Behavior of Young People: A Review Update*; Grunseit A, Kippax S, Aggleton P, et al. Sexuality education and young people's sexual behavior: a review of studies. *J Adolesc Res* 1997;12(4):421-53.

<sup>xi</sup> Baldo M et al. *Does sex education lead to earlier or increased sexual activity in youth?* WHO, 1993

<sup>xii</sup> *Call for Action* International conference 'What about sex?', 6-7 March 2006, The Netherlands, website [www.wpf.org](http://www.wpf.org)

<sup>xiii</sup> Family Health International, Youth Research Working Paper No. 2, *Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in developing and Developed Countries*, By Douglas Kirby et al. 2005

access to the information and means to protect themselves and to enjoy a satisfying sexual life, whenever that will start.

### ***ABC strategy not effective to reach at healthy behavior and ABC outcomes***

Abstinence, a delay of sexual debut, fidelity and a reduction of sexual partners as well as condom use are *behaviours* that play a key role in fighting the HIV/AIDS pandemic. However, there are different *strategies* aiming to promote healthy behaviour and these different strategies greatly differ in their effectiveness as research shows.

Over the past years, abstinence-only education programs are increasing in numbers all over the world, driven by enormous US financial support. The 'evidence' that supports the effectiveness of these programs is also increasing, usually based on common sense knowledge that abstinence is 100% safe or distorted evidence<sup>xiv</sup>.

Abstinence is 100% effective, if used with perfect consistency (that is 100% of the time). Unfortunately, in the real world, abstinence has a high failure rate: for example, a study presented at the 2003 annual meeting of the American Psychological Society found that over 60% of college students who pledged virginity had broken their vow to remain abstinent until marriage. Another factor contributing to the failure rate, is that it is often unclear what 'abstinence' means exactly. For instance: many young people believe they abstain if they refrain from having sexual intercourse, but oral (or even anal) sex is ok, even though these behaviours still put them at risk for contracting an STD or HIV<sup>xv</sup>. In addition, for a lot of girls and women abstinence is a far away dream: they are forced to have sex as a result of gender inequality, violence or, because of economic hardship, have sex for money. To decrease their risk of contracting HIV, broad, inclusive, rights-based, non-judgemental outreach using different approaches and methods, including engaging boys and men, is necessary.

In addition, abstinence-only programs often do not give sufficient information about safe sex, condoms or contraceptive use. The evidence whether these programs delay the onset sexual activity effectively is mixed. However, there is evidence that shows that when young people do have sex, they are less likely to take preventive measures against STIs, HIV or unplanned pregnancies, thereby not providing a solution for these problems but at best postponing them a little<sup>xvi</sup>.

Even though fidelity during marriage is a behaviour playing a role in preventing HIV, marriage and women's own fidelity are not enough to protect them against HIV infection<sup>xvii</sup>. Men have often contracted the disease during earlier unsafe sexual encounters or have sex with others while being in a stable relationship. Within marriage, woman are not in a position to negotiate condom use or say no to sex and the simple message of 'fidelity' does not offer them any protection. Educating people about condoms and risky sexual behaviour, without judgement of sexual relationships out side of marriage, is therefore indispensable in fighting the pandemic.

In ABC strategies, Abstinence and Being faithful are the preferred options. Condom use is promoted for special groups only, such as truck drivers and sex workers. This strategy

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<sup>xiv</sup> Human Rights Watch, *The less they know, the better: Abstinence-only HIV/AIDS programs in Uganda*, March 2005 Vol. 17, No. 4 (A)

<sup>xv</sup> The Guttmacher Report on Public Policy, Understanding 'Abstinence': Implications for Individuals, Programs and Policies. December 2003

<sup>xvi</sup> *Ibid.*

<sup>xvii</sup> UNAIDS/WHO, AIDS epidemic update: December 2005

discourages people to use condoms as they don't want to be seen as such a specific group. As Abstinence-only and AB programmes don't provide a solution for unwanted pregnancies, STIs, and HIV, discouraging condom use is particularly harmful. Therefore, unlike comprehensive sexuality education, such ABC strategies do not promote healthy behavior.

### ***Abstinence-only education in Uganda and the USA***

'Uganda' is often used as a success-story for abstinence-only education. Uganda's HIV prevalence steadily increased until about 1991, when it peaked at 15%. It then turned sharply downwards through the mid 1990s and reached 5% by 2001.

A study by The Alan Guttmacher Institute<sup>xviii</sup> shows that during the time period when the HIV prevalence was declining, three key changes in behaviour occurred: fewer Ugandans were having sex at young ages, levels of monogamy increased and condom use rose steeply among unmarried sexually active men and women. These behavioural changes were the result of a range of complementary messages and services delivered by the government and a wide diversity of NGOs. Contrary to the assertions of social conservatives that the case of Uganda proves that an undiluted 'abstinence-only' message is what makes the difference, there is no evidence that abstinence-only educational programs were even a significant factor in Uganda between 1988 and 1995.

The same results are now coming forward for abstinence-only education programmes in the USA. Advocates for Youth contracted with an independent statistician to analyze data, recently released by the Centers for Disease Control and Prevention, about sexual behavior among high school students from 1991 to 2003. Advocates' report on the analysis of the Youth Risk Behavior Surveys (YRBS), found that the much-touted improvements in adolescent sexual risk-taking behavior actually took place from 1991 to 1997. These improvements did not continue into the time period between 1999 and 2003—which corresponds to the first years of the abstinence-only initiative<sup>xix</sup>.

Neither Uganda nor the USA prove the success of abstinence-only education.

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<sup>xviii</sup> Beyond slogans: lessons learned from Uganda's experience with ABC and HIV/AIDS, 2003

<sup>xix</sup> <http://www.advocatesforyouth.org/abonlyreports.htm>, *Trends in Sexual risk Behaviors among High School Students-United States, 1991 to 1997 and 1999 to 2003*, 2004