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The Politics of "Comprehensive Sexuality Education"

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Content

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Main points

- The "Sex Education Establishment" (SEE), is an array of influential organizations that create and fund policy guidelines worldwide. They are reluctant to debate interpretations of guidelines that are different from their agenda.

- Sex education is necessary especially because today's youth experience difficulties in understanding and managing their own affectivity and sexuality.

- Public resources should not be spent assuming that the SEE represents all parents, educators and researchers. Parents should be empowered to educate their children following their own values and have the right to protect them from the possible harm of messages such as the non-evidence-based "safe-sex" message.

- In the documents of the SEE, evidence-based facts and more ideological issues have to be distinguished and analyzed separately because each aspect warrants a different strategy/approach in the debate.

- The concepts of "comprehensive sex education", "gender", "human rights", "discrimination", "sexual rights", "sexual and reproductive health", "life skills", "evolving capacity", "intimate citizenship" may have different and reasonable interpretations that are not evidence-based but debatable and thus democratic discussions, dialogue and dissent should be the rule.

- From an evidence-based and Public Health perspective, sexual activity is considered a risk factor for the sexual and reproductive health of adolescents. This fact is seldom acknowledged in the documents of the SEE.

- *The Lancet* consensus prioritizes messages calling for a delay of sexual debut in youth or for the return to abstinence in those having casual sex. When having sex is chosen, the consensus prioritizes the message of mutual monogamy. The SEE focuses more on technology based preventive interventions.

- The majority of youth under 18 are not sexually active. They are at zero risk of unplanned pregnancies, STIs and other physical, social, and psychological problems related to premature sex. They should be protected from messages that invite them to be sexually active as if this is risk free with condom-use.

- Since condoms are not 100% effective, their promotion using the "safe sex message" typical of the SEE "risk reduction" strategy may actually foster a false sense of security in youth and lead, paradoxically, to increased risk taking behaviors and vulnerability such as beginning sex at earlier ages and having more sexual partners (Phenomenon known as "risk compensation").

- As opposed to the so called "comprehensive" sex education programs, the "abstinence centered" programs are evidence-based, effective, less patronizing to youth and rely on their ability of making free and optimal decisions regarding their sexuality if they are thoroughly and holistically informed without *a priori* assuming that "risk avoidance" is not possible in practice.

- Abstinence centered sex education programs are the preferred choice of millions of parents, educators, researchers and youth around the world and are the real "holistic sexual education programs".

Executive summary

The Sex Education Establishment has a hidden strategy

We describe the characteristics of the "Sex Education Establishment": an array of influential and international organizations, global authorities such as UNICEF, UNFPA, WHO, as well as powerful and diffuse associations and/or donor agencies such as IPPF, USAID, CARE, Population Council, etc.

These institutions create policy guidelines and fund initiatives worldwide to carry out their strategic priorities. Sometimes called "best practices", these priority interventions are presented as neutral, factual information but their track record is often questionable.

Even if some aspects of their documents are clearly debatable, they are reluctant to accept interpretations of guidelines that are different from their agenda. This seems inappropriate in a democratic setting.

1. Sexual education is necessary but different approaches are reasonably acceptable

Sex education is necessary and urgent especially under the circumstances of today's youth, where they are experiencing difficulties in understanding and managing their own affectivity (which can be considered a form of "affective analphabetism"). However, sexual education cannot be entirely "evidence-based" as the sex education establishment contends. This is the main point of disagreement that parents, educators and researches are having when they intend to stop some international programs from being implemented worldwide.

A greater effort has to be made to achieve a greater consensus with respect to different issues that are often raised in official documents of the sex education establishment such as:

- The empowerment of parents and educators to better educate children following the values they want for their children
- The existence and possibility of choice from different alternatives of sexual education programs that take into account values that parents consider important for the well-being of their children; the optimal age to address some topics.
- The necessary input of the critical and constructive perspective of the adults that love their children and that are the primary persons responsible for their education and well-being. These children are the targets of some sex education programs from the sex education establishment and parents are sometimes not welcome to give their inputs or insights.

Public resources should not be spent assuming that the Sex Education Establishment necessarily represents all parents, educators and researchers and their differing views and approaches concerning the sexual education of children.

Parents have the right to seek democratic and legal assistance to protect their children from the possible harm of some messages. For example, "safe-sex" messages in some countries result in conveying the wrong idea among youth that sex is totally risk free provided they use condoms.

2.a. The documents of the Sex Education Establishment often mix evidence-based information with ideological information but their content is presented as wholly factual and scientific.

Any country, association, or person that does not agree with the contents of such documents is rapidly considered "moralistic" "prejudiced", "biased" or "unscientific" and thereby dismissed.

These documents can be difficult to debate because they constantly mix:

- Affirmations with which many can and do agree with

- Information that is correctly presented as being evidenced based
- Definitions that seem clear cut when they can in fact have different interpretations in practice
- Information that is incorrectly presented as evidence-based
- Aspects concerning sexuality that can be opened to different criteria or opinions

These circumstances have to be taken into account before approaching the documents of the Sex Education Establishment for debate and during any debate. Each aspect warrants a different strategy/approach.

2.b. The Sex Education Establishment uses definitions that seem clear but that have in fact different interpretations in practice

The concepts of “comprehensive sex education”, “gender”, “human rights”, “discrimination”, “sexual rights”, “sexual and reproductive health”, “life skills”, “evolving capacity” and “intimate citizenship” may have different and reasonable interpretations that are not evidence-based but debatable and thus democratic discussions, dialogue and dissent should be the rule. However, the Sex Education Establishment uses these terms to pursue a hidden agenda and is therefore reluctant to accept any debate about their meanings.

3. Adolescents and sexual and reproductive health

From an evidence-based and Public Health perspective, sexual activity is considered a risk factor for the sexual and reproductive health of adolescents. This fact is seldom openly acknowledged in the documents of the Sex Education Establishment.

Epidemiological data around the world show that the vast majority of youth under 18 (usually the prime targets of the sex education programs tailored by the Sex Education Establishment) are not sexually active. They are therefore at zero risk of unplanned pregnancies, sexually transmitted diseases STIs and other physical, social, and psychological problems related to premature sex.

More should be done to protect them from messages that invite them to be sexually active as if this is risk free when condoms are used.

4. Prevention: Risk Avoidance and Risk Reduction

In 2004, a consensus statement to prevent AIDS and other STIs was published by *The Lancet*. It is also known as the “ABC strategy”: Abstinence (A), Be faithful (B), use Condoms (C). Abstinence and being mutually faithful are the best ways for avoiding risk whereas condoms reduce risk in individuals who choose not to avoid risks with "A" nor "B".

The Lancet consensus states that messages should be tailored to specific target groups. It points out the importance of prioritizing messages by calling for a delay of sexual debut in youth or for the return to abstinence in those who are having casual sex. When having sex is chosen, the consensus prioritizes the message of mutual monogamy.

Those who choose not to accept "A" nor "B", and chose “C”, should be advised that they can reduce, albeit never totally eliminate, the risk of infection.

The documents of the Sex Education Establishment tend not to take seriously that the implementation of A or B is possible.

5. Different approaches to sex education and the “holistic” approach to sex education

As opposed to the so called “comprehensive” sex education programs, the “abstinence centered” programs are evidence-based, effective, less patronizing to youth and rely on their ability of making free and optimal decisions regarding their sexuality if they are thoroughly and holistically informed without a priori assuming they will not be able to make certain choices such as to abstain from sex precisely because they value their sexuality in another way. For these reasons, abstinence centered sex education programs are the preferred choice of millions of parents, educators, researchers and youth around the world and can be appropriately defined as truly “holistic sexual education programs”.

Introduction: the Sex Education Establishment

For the purpose of this briefing paper, we will use the term "Sex Education Establishment" to refer to an array of influential and international organizations, global authorities such as UNICEF, UNFPA, WHO, as well as powerful and diffuse associations, donor agencies and non-governmental organizations (NGOs), such as IPPF (using different names in different countries such as "SENSOA" in Belgium and "NISSO group" in Holland), USAID, CARE, Population Council, etc. These institutions create policy guidelines and fund initiatives worldwide to carry out their strategic priorities. Nongovernmental organizations which are often dependent on governmental funding for their survival and frequently share the donor´s world view collaborate by carrying out donor agency priorities, sometimes called "best practices" even if their track record is often questionable.

Some characteristics are shared by the documents and policies promoted by the Sex Education Establishment worldwide:

- They often base their recommendations on "official" documents in which ideology or subjective thinking is mixed throughout with scientific facts.

- The documents are nevertheless presented as if they were entirely factual and not debatable.

- The documents are based on definitions of key concepts such as "comprehensive sex education", "gender", "human rights", "discrimination", "sexual rights", "sexual and reproductive health", "life skills", "evolving capacity", "intimate citizenship", etc. that can have different meanings for different people. Alternative interpretations are usually not acknowledged and their documents always assume that their own partisan interpretations are the right ones.

- Whenever a disagreement occurs with any issue on any document, terms such as "religious/moral judgment", "prejudice or bias" are often used to dismiss any dialogue.

- Members of the "Sex Education Establishment" and indeed some entire associations have serious competing interests with respect to their connections to large and powerful pharmaceutical companies that are involved in the promotion and sale of contraceptives and/or of abortion.[1] There is often "big business" behind some of their recommendations. Strong, consumer-directed commercial forces seem to be increasingly driving many priorities set by the SEE and this is severely compromising the main pursuits of public health. A main example of this phenomenon can be observed when one sees how studies associating the contraceptive pill with cardiovascular diseases (hypertension, cerebrovascular disease, thromboembolism, myocardial infarction) or cancers of the breast, cervix or the liver are systematically downplayed compared to those showing the protective effect of the contraceptive pill with ovarian and endometrial cancer. [2] Other examples are the recommendations in favor of extensive vaccination programs to prevent HPV infection or many other expensive technological preventive measures. [3]

- Their documents are often signed and/or endorsed by large numbers of researchers, universities, associations, NGOs and this often puts pressure on the readers towards having

1 Check acknowledgment sections and affiliations of authors in documents of the sex education establishment.
2 Lopez del Burgo C, Vaquero-Cruzado JA, de Irala J. Salud de la Mujer. En: Martínez González MA. Conceptos de Salud Pública y estrategias preventivas. Un manual para ciencias de la salud. Barcelona; Elsevier, 2013.
3 Carlos S, de Irala J, Hanley M, Martinez-Gonzalez MA. The use of expensive technologies instead of simple, sound and effective lifestyle interventions: a perpetual delusion. *Journal of Epidemiology Community Health* 2014;68:897-904.

> to accept their contents without dialogue or being critical. But the quality of science should not be measured by “eminence, consensus, vehemence or eloquence based medicine”, or by the weight of documents. They should, rather, be carefully reviewed and judged according to their quality and the scientific evidence presented to support their contents.

It is important to acknowledge these characteristics when referring to such documents and/or policies because under any democratic perspective, alternative choices, options and interpretations should at least be accepted for discussion.

1. Why is sexual education necessary?

We are sexual beings, i.e., we are males or females, from the very beginning of our lives. Sex education is indeed necessary because sexuality is a basic element of any human person. It has to do with his/her identity, with one's way of "being", with how he/she communicates with others, with his/her development and growth and with the capacity of giving life. In addition, many affirm that these characteristics can be harmonized by love. Any decisions we make in this regard have important consequences in our lives. Our affectivity is one of the components that are present within our sexuality. Therefore, character education should precede education concerning the more biological aspects of sexuality.

There is a strong bond between personality and sexuality and this is why both (sexuality and personality) can be subject to development; they belong in the sphere of personal formation and are properly considered matters that can be taught. The decisions taken concerning sexuality are important because they can affect aspects of anybody's life and future: making the right decisions helps us to achieve happiness and a fulfilled life. Mistakes do not necessarily imply failures but they can indeed make things more difficult for anyone.

Character education enables the development of necessary life skills that empower one to better manage his/her affections, sentiments and emotions. This empowerment is essential for anybody to make free decisions and commitments in life. This character education can then be combined, at the right moment, with the evidence-based biological information concerning human sexuality. For many, at the end, human sexual education should have the goal of forming persons that are capable of integrating sexuality and affectivity.

Neither the reductive and biologically-centered viewpoint of human sexuality of some organizations of the Sex Education Establishment, nor the silence and omission of some parents concerning sexual education, are appropriate approaches to sexual education. As males or females, young people worldwide need a specific education that can be opened to affection, love, and commitment.

The societies where parents grew up are different from the societies where their children are now living. Not everything that was useful to educate children then is necessarily useful to educate children today. The following socio-cultural issues and their implications on sexual education have to be considered by educators (parents and other educators):

(a) Concerning sexual education some topics can be considered "evidence-based" (for example the description of anatomy and biology related to human sexuality), whereas other topics can be, and should be, opened to a variety of options and therefore should be debatable. Whether the concept of "love" should be included in this education, what values should be included in sexuality education, whether certain topics should or not be included at certain ages, etc. are topics where different reasonable views can exist. The definitions of some aspects related to the concept of "love" are themselves open to discussion. For example, love can be defined as the capability of serving others with all the value individuals have as female or male persons, instead of being focused on satisfying one's own personal desires in individualistic fashion.

(b) Social media are invading family intimacy and are usually responsible for making some topics concerning affectivity and sexuality reach children too early. Furthermore, social media often separate affectivity from sexuality and thus portray sexuality as mere "genital activity". From the parent's perspective, the optimal age to address some topics is being involuntarily advanced.

(c) This precocious introduction of information can make the proper comprehension of all the underlying dimensions of sexuality difficult for children. It will therefore be necessary for parents and educators to be sufficiently aware and close to their children, in order to help them

harmonize this information. The critical and constructive perspective of the adults that love them and who are responsible for their education and well-being is essential.

(d) Some role models present in society do not coincide with the formation that parents consider ideal for the well-being of their children.

(e) Some terms are used in a non-evidence-based way in our society and can be, and should be, opened to interpretation: “normal”, “frequent”, “affectivity”, “sentiment”, “self-determination”, etc. The sex education establishment tends to perceive their own definitions as the only ones “free of prejudice” but this in itself can be considered a sign being prejudiced.

(f) In recent years, we have been moving from the negation of sentiments to the exaltation of emotions; in the process, any rational thinking based on data and experience is being displaced. For example, the existence of “will power”, directly related to freedom and love, is seldom considered in the debate. Personal decisions end up depending on personal desires, emotive and sentimental states. Important aspects of human sexuality are left aside: for example, the importance of commitment, the value of waiting until this commitment can be made before having sexual relations and also the relevance of being personally responsible and respectful towards society when having sexual relationships.

In summary, sex education is necessary and urgent especially under the circumstances of “affective analphabetism” that many youth are experiencing today. However, sexual education cannot be entirely “evidence-based” as the Sex Education Establishment contends. This is the main point of disagreement that parents, other educators and researchers have when they intend to stop some international programs from being implemented worldwide. A greater effort has to be made to achieve a greater consensus on these matters:

(a) More resources have to be implemented to empower parents to better educate their children in accordance with their personal values because parents consider these values to be important for the well-being of their children and because they are indeed responsible for the education of their children.

(b) The same empowerment should be achieved for the educators (often chosen by parents) that want to work together with these parents in this sexual education.

(c) Public-funded sex education programs should be tailored to the values of parents that should be able to freely choose or reject them for their children. This is the way resources paid by everyone should be allocated in a democratic society. Different programs with different values should preferably be “in the market”. A program without values is not “value free”. Conversely, such programs value, i.e. give priority to, “not including values”. If parents have to adapt to what the Sex Education Establishment considers “the right content and the right way to convey sex education” this is undemocratic, not necessarily evidence-based, and can be harmful to many youth.[4,5] Parents would then have the right to seek democratic and legal assistance to protect their children from this possible harm. For example, “safe sex” messages in some countries result in conveying the wrong idea among youth that sex is totally risk free provided they use

4 J de Irala. The risk left after risk reduction can remain high. http://www.bmj.com/rapid-response/2011/11/01/risk-left-after-risk-reduction-can-remain-high

5 J de Irala. Sexual abstinence only programs to prevent HIV infection in high income countries: systematic review. http://www.bmj.com/rapid-response/2011/11/01/sexual-abstinence-education-what-evidence-we-need

condoms.[6] Some youth end up frankly surprised when they are suddenly informed that they do have an infection in spite of having used condoms correctly and consistently.

6 J de Irala. The risk left after risk reduction can remain high. http://www.bmj.com/rapid-response/2011/11/01/risk-left-after-risk-reduction-can-remain-high

2. The approach of the Sex Education Establishment: mixing evidence-based information with debatable ideological claims.

Documents of the Sex Education Establishment

The Sex Education Establishment has a firm hold on, and is well represented in international forums. This gives the Establishment strength when pronouncing their ideas, and when they come up with "official" documents and/or guidelines that are often presented as the only evidence-based "state of the art" guide on the topic of sexual education. Any country, association, or person that does not agree with the contents of such documents is swiftly depicted as "moralistic" "prejudiced", "biased" or "unscientific". These documents can be difficult to debate because they constantly mix:

a) Affirmations with which many can and do agree with, such as "sex education is necessary" or "children have the right to be informed on sexual health according to their age".

b) Information that is correctly presented as being evidence-based such as "condoms are useful in reducing individual risks of pregnancies and some sexually transmitted infections (STIs)"; "Adolescents are biologically prepared to have sex".

c) Definitions that seem clear cut when they can in fact have different interpretations in practice such as "comprehensive sex education", "gender", "human rights", "discrimination", "sexual rights", "sexual and reproductive health", "life skills", "evolving capacity", "intimate citizenship", etc.

d) Information that is incorrectly presented as evidence-based (they are therefore scientifically inaccurate) such as "condoms are the only way of effectively avoiding STIs" (in reality, condoms only "reduce" risks but abstinence "avoids" risk); "Adolescents are prepared to have sex" (they might be from a biological perspective but are certainly not ready from a psychological perspective).

e) Aspects concerning sexuality that can be open to different criteria or opinions or where one can have different opinions on how they should be implemented in real life situations. For example the issues of "love", "commitment and marriage", the meaning of "sexuality", what is "age appropriate", who should have priority in "speaking to children about sexuality", "character education", the issue of giving way to "desires" as opposed to being empowered to recognize and manage one's impulsive desires, etc.

f) It becomes extremely complex to constructively debate these documents unless the above characteristics are previously taken into account and clearly separated because each topic requires a particular approach. For example, scientific disagreement will need more evidence-based papers to clarify what is the state of the art of a given issue. Conversely, non-factual information that can be contradicted on the grounds of normal democratic pluralism would simply need reasonable alternative explanations and opinions to be brought up in the debate so they could be included on an official document or evaluated by the general public.

For the reasons described above we consider careful and critical reviews of such documents to be necessary before they are accepted. Even if accepted by the Sex Education Establishment, countries and families remain free (taking into account the aforementioned mix of information) to implement them or not (whether partially or not) following their own understanding of the issue of sexual education. These documents should never be considered as "the solution" to the issue of sexual education and no one should feel pressured to approach them without a critical opinion and understanding of their content.

Given that brevity is essential in a document such as this briefing paper we will concentrate on sections (c) through (d) above to present short examples of the main points raised (and the respective references when appropriate) to better make our points and facilitate constructive discussions.

Definitions that seem clear but have different interpretations in practice

Comprehensive sex education

The International Planned Parenthood Federation (IPPF) defines comprehensive sex education as: "Education about all matters relating to sexuality and its expression. Comprehensive sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about sexual and reproductive health services. It may also include training in communication and decision-making skills".[7]

Upon reading this definition a lot of people would probably agree with it. However several issues remain uncertain in the definition: what is "all matters"?; how is "gender" defined?; how is "reproductive health" defined and what does it mean in practice?; What emphasis and skills are given to minors about sexual abstinence as an alternative to just using condoms? What exactly do we say about condom use?[8] The word "comprehensive" entails more than simply "giving a lot" or "giving all the information available". It could mean giving certain priorities at certain ages and experts could disagree on the appropriateness of this particular timing. We will discuss this further in section 5 of this paper.

Gender

Gender can be defined as what pertains to "social roles" that women and men have in different societies. The World Health Organization defines "gender" as the economic, social and cultural attributes and opportunities associated with being male or female in a particular point in time.[9] Indeed some roles such as working on a given type of job or taking care of children, or house-keeping are gender roles that are and should be independent of one being "male" or "female". However, a hidden agenda under this terminology often used by the Sex Education Establishment is the use of gender as meaning that any person can choose his/her sexual identity and that being "male" or female" is considered a social construct in itself; by this understanding, one could choose "differing versions of masculinity and femininity". This is one reason for being cautious about accepting such a term in any document.

Human rights and Discrimination

Human rights are widely regarded as essential and thus most people would also be against discrimination defined as "the practice of unfairly treating a person or group of people differently from other people or groups of people".[10] However, the Sex Education Establishment often uses these terms in order to oblige readers to accept their ideas and/or criteria on sexual education as the only valid, acceptable and applicable ideas. One can be sensitive to both human rights and non-discrimination but this does not mean one has to implement any idea on sexuality as equally valid (the opinion that sex with a consenting minor is acceptable or that women should not seek pleasure in sexuality are some examples of opinions that should not be implemented in programs). The acceptance of a person does not necessarily mean we have to accept his/her views as equally valid to any other view. For example, even if we accept and respect a person we need not accept his/her dictatorial understanding of politics as equally valid to our democratic views. We may agree with the idea of children having the right of

7 http://www.ippf.org/resources/media-press/glossary/c (last visited March 24, 2014)
8 MA. Martinez-Gonzalez. Are condoms the answer to rising rates of non-HIV sexually transmitted infections? No. http://www.bmj.com/rapid-response/2011/11/01/no-magic-bullett
9 http://www.ippf.org/resources/media-press/glossary/g (last visited March 24, 2014)
10 http://www.merriam-webster.com/dictionary/discrimination (last visited March 12, 2014)

getting true information concerning sexuality but parents do have the responsibility and the right to decide what information is sensible and can be given at the right moment. Parents can make mistakes of judgment but there is no reason to believe teachers and/or other educators are necessarily better off in avoiding these mistakes. Parents can be educated and/or advised in this educational task instead of just being "replaced" as educators of their children.

Sexual Rights

Several definitions of sexual rights include:

> "The right of information and education as well as access to sexual health services, the respect of physical integrity, the free choice of a couple, to have or not an active sexual life, the freedom to have consentual sexual relationships or a freely consented marriage, and the decision to have children and to have a satisfactory and pleasurable sexual life".

The problem with this theoretical definition is that some underlying issues are not specified and there can be a rightful disagreement between what the Sex Education Establishment understands and what the general population may consider acceptable. For example, the appropriate age to have sexual relationships, the age at which consent can really be considered "a free choice", the age at which it could be beneficial for minors to access health services or sexual health services without parent's consent/information, the difference between choosing to "become pregnant" or not and the decision of "terminating" a pregnancy that is already present. Many agree that we should be able to choose "when" to become pregnant but many also believe this choice does not include the choice to eliminate an existing pregnancy. In addition to the sole fact that another human being is now living and growing, we could also argue that the "reproductive health" of a new unborn human being, the right to have his/her own sexual relationships and pregnancies in the future, is now at sake as well. The issue of "a pleasurable sex life" cannot be separated either from the discussion about what specific and more appropriate ages we are considering when accepting the statement. The Sex Education Establishment tries not to place any age limit on issues concerning sex whereas many in the general population believe children have to be protected by helping them to avoid harmful choices and postpone some decisions until they are mature enough to make better choices and assume the consequences of such decisions.

Sexual and reproductive health

Sexual and reproductive health is defined by the IPPF as "the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health".[11] When the Sex Education Establishment uses this definition they usually do not include the healthiest and safest messages for minors, or make any attempt to prioritize them in sex education programs. In fact, following objective, evidence-based medical criteria, the best way to achieve sexual and reproductive health among minors is to help them avoid having sexual relationships and avoid abortion altogether. This is what is healthiest for them both in terms of biological and psychological health (see section 3 for a more thorough discussion of this issue). This is the reason why reasonable, corresponding recommendations have earned widespread scientific consensus, albeit not including from members of the Sex Education Establishment.[12]

Life skills

The term "life skills" is often used in the official documents of the Sex Education Establishment but is seldom described in detail. The term could refer to decision making skills, the skill of being proactive and assertive, self-esteem, etc. or, alternatively, simply the capacity to use a condom or

11 http://www.ippf.org/resources/media-press/glossary/s (last visited March 24, 2014)
12 Halperin DT, Steiner MJ, Cassell MM, Green EC, Hearst N, Kirby D et al. The time has come for common ground on preventing sexual transmission of HIV. Lancet 2004;364:1913–5.

another contraceptive device with complete disregard for the age of those exposed to such "life skills" indoctrination. Condoms are now being produced and sold for 10 year old children in Switzerland.[13]

Evolving capacity

The concept of "evolving capacities" of the child first emerged in international law through the Convention on the Rights of the Child. Article Five of the Convention states that:

> "States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, *in a manner consistent with the evolving capacities of the child*, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention." (The emphasis is ours)

Article Twelve also addresses evolving capacities, stating that:

> "States Parties shall assure to *the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.* For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law." (The emphasis is ours)

The Sex Education Establishment, in essence, uses the statements underlined above, to redefine the matters over which children are capable (or not) of forming their own views and exercising their own judgment. In fact, they use such statements to justify why parents should be disregarded on issues concerning sexuality and why children should basically make their own choices on these matters, whatever their age. This "hidden agenda" becomes clearer when one observes how parent participation is presented more as a problem rather than as part of the solution to sexual education.[14] In the 2013 World Health Organization document, "Standards for Sexuality Education in Europe. Guidance for Implementation", the section on the role of parents and educators is quite short and states the following:

> A second possible objection to sexuality education in schools may be the conviction that it is the exclusive responsibility of parents. At this point, it should be emphasized that the school can complement parents in this respect. This makes sense for several reasons. *Firstly, most parents do not possess all the relevant knowledge* children and young people need to acquire. *Secondly, children and young people should learn to communicate with each other on sensitive issues, a skill which they can learn only among their peer group, particularly their own class, facilitated by a trained teacher. Thirdly, parents are not always the most suitable people to discuss sexuality with their adolescent children*, since the latter are involved in a process of distancing themselves from their parents and gradually gaining independence. *Fourthly, many parents feel themselves unable to address difficult issues related to sexuality*, and they are grateful if professionals do so in their stead. However, because of the need for close collaboration with parents, parent representatives should be involved in the development of the curriculum framework. (The emphasis is ours)

It seems rather evident that parents can be educated and/or advised on how to better educate their children; furthermore, studies worldwide show that children would prefer talk to their parents about

13http://www.telegraph.co.uk/health/healthnews/7361181/Extra-small-condoms-for-12-year-old-boys-go-on-sale-in-Switzerland.html (last visited September 19, 2014)
14 WHO Regional Office for Europe and BZgA. Standards for Sexuality Education in Europe. Guidance for Implementation; 2013.

these issues rather than friends or other sources.[15,16] This can be more efficient in the long run, particularly in comparison to expending vast resources to literally replace them in this educative role. It is not clear from the definition above how parents will finally be "involved in the curriculum framework" after all the difficulties raised concerning parents in the same paragraph.

Intimate citizenship

Intimate citizenship is defined as follows in the "Standards for Sexuality Education in Europe" document:[17]

> The concept of "intimate citizenship", relates to sexual rights from a social science perspective. Researchers in social science and sexual studies are currently calling for the establishment of moral negotiation as a valid sexual morality for today. The essence of this morality is that issues should be negotiated in a spirit of mutual consent by mature participants who are equal in status, rights and power. One important precondition for this is that the participants should develop a common understanding of the concept of "consent" and become aware of the consequences of their actions particularly in the context of relationship behavior and sexual behavior.

Again, this concept, that in theory seems oriented towards consenting adults, is in a document that provides guidance on sexual education for minors. They furthermore elaborate on the definition of "intimate citizenship" by saying the following:

> Assuming that this precondition is fulfilled, we may make use of the concept of "intimate citizenship". This is a sociological concept describing the realization of civil rights in civil society. It is based on the principle of moral negotiation. *Apart from sexuality, it covers sexual preferences, sexual orientations, differing versions of masculinity and femininity, various forms of relationship and various ways in which parents and children live together.* Thus the term intimacy overlaps greatly with the broad understanding of sexuality proposed in this paper. Intimate citizenship focuses on equality of social and economic status for individuals, who maintain autonomy in their lives while respecting the boundaries of others. (The emphasis is ours)

Finally, the very concept of "moral negotiation" and "autonomy in one's lives while respecting the boundaries of others" is debatable because many personal decisions can indirectly harm others even if made by "autonomous individuals" who are, supposedly, deemed to be "respecting the boundaries of others". Even if one achieves a "common understanding of consent", this does not guarantee that what is being consented to, is harmless to these individuals and/or to others. The "Standards for Sexuality Education in Europe" document also suggests that "This entitlement strengthens the individual against intrusions by the family or society." Obviously one can understand the implication of this sentence: if "intimate citizenship" exists between consenting minors, parents might also be considered as "intrusions".

15 De Irala J. (coord.). Adolescentes con cultura. Estilo de vida de los estudiantes adolescentes de El Salvador. Consejo Nacional para la Cultura y el Arte. El Salvador, 2008.
16 Corcuera, P., de Irala, J.,Osorio, A. y Rivera, R. Estilos de vida de los adolescentes peruanos. Piura (Perú): Aleph 2010.
17 WHO Regional Office for Europe and BZgA Standards for Sexuality Education in Europe. A framework for policy makers, educational and health authorities and specialists; 2010 (page 19)

3. Adolescents and sexual and reproductive health

From a Public Health perspective, sexual activity is plainly regarded as a risk factor for the sexual and reproductive health of adolescents.[18,19] Early sexual activity increases the risk of sexually transmitted infections (STIs) or unplanned pregnancies, mainly because it is associated with other unhealthy behaviors, such as having multiple partners (concurrent or lifetime) or condom misuse.[20,21,22] Adolescent sexual activity is also associated with adverse psychological consequences such as feelings of disappointment and regret[23,24] and a higher incidence of depression and suicide attempts.[25,26,27] In addition, the early onset of sexual activity has been linked with substance use and lower academic achievement. All these evidence-based facts are routinely ignored, or at least do not seem to find their way into the documents of the Sex Education Establishment.

Epidemiological data around the world show that the vast majority of youth under 18 (usually the prime targets of sex education programs tailored by the Sex Education Establishment) are not sexually active.[28,29] They are therefore at zero risk of unplanned pregnancies, STIs and other physical, social, and psychological problems related to premature sex. More should be done to protect them from messages that invite them to be sexually active as if this is harmless "as long as condoms are used". This includes litigation, when appropriate, to protect them from messages that are not evidenced based such as any "safe sex" message used to promote condoms. The Sex Education Establishment tends to assume that most minors are sexually active and their programs do very little to protect the majority of non-sexually-initiated youth.

4. Prevention: risk avoidance and risk reduction

In 2004, a consensus statement to prevent AIDS and other STIs was published by *The Lancet*.[30] It is also known as the "ABC strategy": Abstinence (A), Be faithful (B), use Condoms (C). Abstinence and being mutually faithful are the best ways for avoiding risk whereas condoms reduce risk in individuals who choose not to avoid risks with "A" nor "B". *The Lancet* consensus states that messages should be tailored to specific target groups. It points out the importance of prioritizing messages by calling for a delay of sexual debut in youth or for the return to abstinence in those who are having casual sex. When having sex is chosen, the consensus prioritizes the message of mutual

18 Currie C et al., eds. Social determinants of health and well-being among young people. Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey. Copenhagen, WHO Regional Office for Europe, 2012 (Health Policy for Children and Adolescents, No. 6).
Available in: http://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf
19 Madkour AS et al. Early adolescent sexual initiation as a problem behavior: a comparative study of five nations. Journal of Adolescent Health 2010;47(4):389–398.
20 Louie KS, de Sanjose S, Diaz M et al. Early age at first sexual intercourse and early pregnancy are risk factors for cervical cancer in developing countries. Br J Cancer 2009;100:1191–7.
21 Ma Q1, Ono-Kihara M, Cong L, Xu G, Pan X, Zamani S el tal. Early initiation of sexual activity: a risk factor for sexually transmitted diseases, HIV infection, and unwanted pregnancy among university students in China. BMC Public Health 2009;22,9:111.
22 Kaestle CE, Halpern, CT, Miller WC & Ford CA. Young age at first sexual intercourse and sexually transmitted infections in adolescents and young adults. A J Epidemiology 2005; 161,774–780.
23 Eshbaugh EM, Gute G. Hookups and sexual regret among college women. Journal of Social Psychology 2008;148:77–89.
24 Osorio A, Lopez-del Burgo C, Carlos S, Ruiz-Canela M, Delgado M & de Irala J. First sexual intercourse and subsequent regret in three developing countries. Journal of Adolescent Health 2012;50:271-278.
25 Hallfors DD, WallerMW,Ford CA, et al. Adolescent depression and suicide risk: Association with sex and drug behavior. Am J Prev Med 2004;27:224–31.
26 Kaltiala-Heino R, Kosunen E, Rimpel ÅM. Pubertal timing, sexual behavior and self-reported depression in middle adolescence. J Adolesc 2003;26:531–45.
27 Heidmets L, Samm A, Sisask M, et al. Sexual behavior, depressive feelings, and suicidality among Estonian school children aged 13 to 15 years. Crisis 2010;31:128–136.
28 De Irala J, Osorio A, Carlos S, Ruiz-Canela M, López del Burgo C. Mean age of first sex: Do they know what we mean? Archives of Sexual Behavior 2011;40:853-855
29 Madkour AS, Farhat T, Halpern CT, et al. Early Adolescent Sexual Initiation as a Problem Behavior: A Comparative Study of Five Nations. Journal of Adolescent Health. 2010;47(4):389-98.
30 Halperin DT, Steiner MJ, Cassell MM, Green EC, Hearst N, Kirby D et al. The time has come for common ground on preventing sexual transmission of HIV. Lancet 2004;364:1913–5.

monogamy. Those who choose not to accept "A" nor "B", and chose "C", should be advised they can reduce, albeit never totally eliminate, the risk of infection by using condoms.

The documents of the Sex Education Establishment tend to assume that applying A or B is not really possible or realistic. They focus instead on the debatable, unqualified claim that "sexual activity among young people is a reality" and that "there is an urgent need to empower them to make responsible decisions regarding their sexual lives…" (basically meaning that they should use condoms). These assertions are not evidence-based and are pessimistic, unrealistic and patronizing with respect to the decisions that well informed and empowered youth are able of making all over the world. It is clear that the majority of adolescents are not sexually active all around the world[31] and messages should therefore concentrate in helping them remain sexually abstinent as this removes risk of unplanned pregnancies, STIs and other social, physical and psychological problems. For those that continue to make the risky decision to have sexual relationships, they should be informed that condom use can help them reduce their risks but that they should never think that they are completely safe and "protected". In other words they can still end up becoming infected in spite of a correct and consistent condom use.

In addition, condom promotion using the "safe sex message" typical of the Sex Education Establishment documents may actually foster a false sense of security in youth and lead, paradoxically, to increased risk taking behaviors and vulnerability such as beginning sex at earlier ages and having more sexual partners[32]. This behavioral phenomenon is known as "risk compensation".[33,34,35,36]

The countries that have integrated a specific message for different target populations in national programs have reduced HIV incidence, while those relying exclusively on condom promotion have not.[37,383940] As explained in a document from UNAIDS, "young people are leading the prevention revolution (…), especially in parts of sub-Saharan Africa. Waiting longer to become sexually active, young people have fewer multiple partners and there's an increased use of condoms among those with multiple partners."[41]

5. Different approaches on sex education

As we have previously described, risk avoidance is better than risk reduction, and therefore the main goal for adolescents is to delay the age of initiation of sexual activity. How can this perspective be conveyed to adolescents? How can sex education programs target the different aspects of the ABC approach?

Sex education programs can be considered to be composed of 4 main classifications:

[31] De Irala J, Osorio A, Carlos S, Ruiz-Canela M, López del Burgo C. Mean age of first sex: Do they know what we mean? Archives of Sexual Behavior 2011;40:853-855

[32] De Sanjose S, Cortes X, Mendez C, Puig-Tintore L, Torne A, Roura E, et al. Age at sexual initiation and number of sexual partners in the female Spanish population. Results from the AFRODITA survey. Eur J Obstet Gynecol Reprod Biol. 2008;140:234–40.

[33] Pinkerton SD. Sexual risk compensation and HIV/STD transmission: Empirical evidence and theoretical considerations. Risk Analysis 2001; 21:727-736.

[34] De Irala J, Alonso A. Changes in sexual behaviours to prevent HIV. Lancet. 2006;368:1749-50.

[35] Cassell MM, Halperin DT, Shelton JD, Stanton D. Risk compensation: the Achilles' heel of innovations in HIV prevention? BMJ 2006; 332: 605-7.

[36] Richens J, Imrie J, Copas A. Condoms and seat belts: the parallels and the lessons. Lancet 2000; 355:400-403.

[37] Stoneburner RL, Green T, Hearst N, McIlhaney J. Evidence that Demands Action; Comparing risk avoidance and risk reduction strategies for HIV prevention. In: Edited by Patricia Thickstun KH, editor: The Medical Institute, 2004.

[38] Halperin, DT, Mugurungi O, Hallett TB, Muchini, B, Campbell B, Magure T et al. A surprising prevention success: Why did the HIV epidemic decline in Zimbabwe? PLoS Medicine, 8(2),e1000414.

[39] Norman Hearst, Allison Ruark, Esther Sid Hudes, Jennifer Goldsmith & Edward C Green. Demographic and health surveys indicate limited impact of condoms and HIV testing in four African countries, African Journal of AIDS Research, DOI: 10.2989/16085906.2013.815406

[40] Edward C. Green, Phoebe Kajubi, Allison Ruark, Sarah Kamya, Nicole D'Errico, and Norman Hearst. The Need to Reemphasize Behavior Change for HIV Prevention in Uganda: A Qualitative Study. Studies in Family Planning 2013; 44[1]: 25–43

[41] OUTLOOK breaking news: Young people are leading the HIV prevention revolution. UNAIDS, 2010. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20100713_outlook_youngpeople_en.pdf

"Safe-sex" or "risk-reduction" programs

For the sake of accuracy, these programs should preferably be called "safer sex" programs because condoms are not 100% effective to protect individuals from unplanned pregnancies or STIs.[42,43,44,45] "Safe sex" programs explicitly emphasize the promotion of condom use, including sessions on how to actually place a condom on a penis. This is sometimes shown to children who have not even reached puberty and this can promote experimentation and, consequently, high risk behaviors. Some studies have shown that these programs do indeed increase condom use among youth. However, they also increase important risk behaviors such as multiple sexual partners.[46] In the long run, risk compensation can end up placing these individuals at greater risk of an infection.[47]

"Abstinence-only" programs

These programs teach adolescents to abstain from sex until they are engaged in a steady and mutually monogamous relationship where a lifelong commitment is possible. Some of these programs not only promote abstinence; they also teach social skills that help youth maintain their goal of abstaining from sex.

"Comprehensive" or "abstinence-plus" programs

These programs usually include both messages (abstinence and condoms). However messages are typically conveyed with either an equal emphasis on both approaches, or by placing more emphasis on condom use. These two approaches are not really evidence-based because they do not reflect or affirm what is really best for adolescents and youth.[48.] Generally, these programs begin by mentioning abstinence but immediately assert that sooner or later adolescents will have sex; therefore, these programs end up concentrating on condom use as the main preventive measure. These programs usually rely heavily upon the concept of "risk reduction" since they assume "risk avoidance" is not possible. They end up maintaining that many adolescents do have sex, that they have the right to do so, and to enjoy it however they wish. These programs believe they should not try to put pressure on youth by promoting the opposite message of abstinence if they are in fact already having sex. They consider, from an ideological basis, that the best educational messages to target to adolescents are the "safer-sex" messages (that they usually, and incorrectly, call "safe sex") in "comprehensive" programs. The problem with this approach is twofold:

Firstly they assume that the majority of youth are sexually active when this is usually not true, especially in some target populations.[49,50] We can confidently estimate that these programs would leave

42 Kost K, Singh S, Vaughan B, et al. Estimates of contraceptive failure from the 2002 National Survey of Family Growth. Contraception 2008; 77:10-21.
Martin E, Krantz E, Gottlieb S, et al. A Pooled Analysis of the Effect of Condoms in Preventing HSV-2 Acquisition. Arch.Intern.Med. 2009; 169:1233-1240.
43 Weller S, Davis K. Condom effectiveness in reducing heterosexual HIV transmission. Cochrane Database Syst Rev 2002; D003255.
44 Winer RL, Hughes JP, Feng QH, et al. Condom use and the risk of genital human papillomavirus infection in young women. N.Engl.J.Med. 2006; 354:2645-2654.
45 Martin E, Krantz E, Gottlieb S, et al. A Pooled Analysis of the Effect of Condoms in Preventing HSV-2 Acquisition. Arch.Intern.Med. 2009; 169:1233-1240.
46 Kajubi, Phoebe; Kamya, Moses R; Kamya, Sarah; Chen, Sanny; McFarland, Willi M; Hearst, Norman. Increasing Condom Use Without Reducing HIV Risk: Results of a Controlled Community Trial in Uganda. J Acquir Immune Defic Syndr 2005;40:77–82
47 Matthew Hanley y Jokin de Irala.Affirming Love, Avoiding AIDS: What Africa Can Teach the West. NCB 2010.
48 Halperin, DT, Mugurungi O, Hallett TB, Muchini, B, Campbell B, Magure T et al. A surprising prevention success: Why did the HIV epidemic decline in Zimbabwe? PLoS Medicine, 8(2),e1000414.
49 De Irala J, Osorio A, Carlos S, Ruiz-Canela M, López del Burgo C. Mean age of first sex: Do they know what we mean? Archives of Sexual Behavior 2011;40:853-855
50 Madkour AS, Farhat T, Halpern CT, et al. Early Adolescent Sexual Initiation as a Problem Behavior: A Comparative Study of Five Nations. Journal of Adolescent Health. 2010;47(4):389-98.

around 70% of young people without the message that is certainly more appropriate and beneficial to them. These individuals would clearly benefit from messages affirming that their decision to remain abstinent is the right one and which help them to do so. Furthermore, the risk reduction approach sends a message that abstaining from sex is equivalent to being on the wrong side of "sexual health" objectives and in the minority according to the health statistics, when the contrary is in fact true. The abstaining youth are indeed the best suited to meet this broad objective of health and they should know it and be encouraged to continue this way.

Secondly, the risk reduction approach often implies that it is equally safe to just let oneself be driven by any sexual desire of the moment, by any type of sexual activity, as long as condoms and other contraceptives are used.[51,52,53]

From a health education perspective, giving the same weight to two contradicting messages at the same time ("abstain" and "use condoms"), is simply not realistic and will foreseeably drive youth towards the path of risk compensation and finally to worse sexual health outcomes. This is why countries such as Spain have the highest condom use among 15 year-olds in Europe and, at the same time, have problems with rising levels of STIs such as clamidia or herpes.

"Abstinence-centered" programs

These programs give complete information on the different preventive measures, but without the "neutrality" of the so called "comprehensive" programs. Abstinence centered programs concentrate on teaching youth that the only risk avoidance strategy and thus their best, healthiest choice is to abstain from sex. Some of these programs not only promote abstinence; they also teach social skills that help youth to maintain their goal of abstaining. Experimental studies have shown that this approach is effective and also guards against risk compensation.[54,55]

It is clear that some adolescents might not listen to the abstinence message and will have sex. But, should we give up before this fact? Or should we try to lower the number of adolescents who do so? We do not give up in trying to help adolescents refrain from smoking, drinking or using other drugs. We do not advise adolescents to smoke low-nicotine cigarettes or to drink alcohol in "safe" places. If we have established that adolescent sex represents a risky behavior, it is educators' responsibility to increase efforts to promote sexual abstinence among them.

Of course, other preventive measures must be explained. And, when targeting sexually active youth who intend to continue having sex, in spite of having received the "return to abstinence" message, the "safer-sex" message (including partner reduction and condom use) is common in health settings. But, when addressing the general adolescent population, the emphasis should be placed on risk avoidance. Hence, "abstinence-centered" programs are the best choice for this target population.

From the point of view of Public Health policy, one can chose different strategies: (a) The use of population-centered messages (for example "use seatbelts") when it is clear that the message equally applies to anyone and when there is a clear benefit and no prospect of "risk compensation"; (b) The use of individually-centered messages (for example, the personal recommendation of a health professional to his/her adult patient to increase the consumption of some red wine during meals because the patient needs to reduce his/her cardiovascular risk). This strategy is especially useful when risk compensation

[51] Centers for Disease Control and Prevention. HIV transmission risk. Atlanta (GA): CDC; 2012. Available at: http://www.cdc.gov/hiv/law/pdf/HIVtranmsmision.pdf.
[52] Committee Opinion No. 582: addressing health risks of noncoital sexual activity. Committee on Adolescent Health Care; Committee on Gynecologic Practice.Obstet Gynecol. 2013;122(6):1378-82.
[53] Centers for Disease Control and Prevention. http://www.cdc.gov/hiv/basics/transmission.html
[54] Cabezón C, Vigil P, Rojas I, Leiva ME, Riquelme R, Aranda W, García C.Adolescent pregnancy prevention: An abstinence-centered randomized controlled intervention in a Chilean public high school. J Adolesc Health 2005;36(1):64-9
[55] J de Irala. Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review. http://www.bmj.com/rapid-response/2011/11/01/sexual-abstinence-education-what-evidence-we-need

could easily result: for example, there could be an increase of alcohol consumption among youth if the “some alcohol can be good for you” message is indiscriminately conveyed to the whole population.[56] It is quite interesting to observe that what is being communicated with respect to alcohol consumption worldwide is not being applied to messages concerning condom use; in the latter case, population strategies tend to make no distinctions, for example, between a commercial sex worker and an adolescent who is not sexually initiated: both are systematically told to “use condoms”. This is certainly not an “evidence-based” strategy because these two populations would benefit from messages that are more tailored to their personal circumstances. Indeed adolescents would benefit more from “keep abstinent” or “return to abstinence” messages.

With respect to the question of effectiveness of sex education programs in general we propose the following thought for consideration: whether those programs work is important but that is not necessarily the issue to be debated. The real issue is whether we are asking ourselves the right questions about them. Does anybody truly believe it is possible to change any human behavior with a dozen sessions at school, if parents at home, television programs, movies, youth magazines, health and educational authorities and society at large convey the opposite message?

Think of gender violence, sexism, discrimination, academic failure, lack of exercise, unhealthy eating, the problem of drinking and driving, smoking and other drug taking. Would a dozen classes in eighth or ninth grade change these behaviors if everywhere else the message was different?

The central question is "how" we can convey the right messages and not "whether" we should convey them. If a program aiming to prevent gender violence does not succeed, it would be a terrible mistake to conclude that "education against violence is not effective". We would rather have to think of a way to do it better given that this particular program had failed, or we would have to think of how we could help this program to succeed. Let us not forget many anti-smoking programs, for example, have little success and no one doubts we should prevent smoking among youth.

Do we really expect that "abstinence promotion" during a few school sessions will work in a society in which the media conveys the exact opposite message? The question is: do we really believe abstinence is a good choice for our youth and do we really want to promote abstinence? Empowering youth to make the best choices is crucial and, when behaviors are involved, this includes character education. We cannot just give them information and slogans; we have to help young people internalize good, sensible and healthy values and develop the skills, or habits, that go with them. This is not the work of one single program. It pertains to the concept of “holistic sexual education” that we will discuss in the last section of this paper.

The most central and underlying issue we face, is to decide what we want to convey to our youth. It is unlikely any program will help change risky behaviors, unless youth are given truthful information, and unless they are empowered with life skills through character education. This can hardly be achieved unless society at large and especially educational and health authorities are willing to make the right efforts to convey consistent messages to specific target groups, thus helping parents do their job at home as well.

Are we ready to convey what is best for our children and to place confidence in their ability to make right decisions? Or, should we pessimistically and patronisingly decide for them that they cannot achieve risk avoidance and that they therefore have no other choice other than to try to reduce the risks? These are crucial issues in our opinion and parents, educators and sex education researchers worldwide are undoubtedly in disagreement with the Sex Education Establishment when their documents and policies overtly dismiss sexual abstinence and character education as reasonable and beneficial goals pertaining to youth sexual and reproductive health worldwide.

[56] Anderson P, Møller L and Galea G, eds. Alcohol in the European Union. Consumption, harm and policy approaches. The Regional Office for Europe of the World Health Organization, 2012.

6. Final comments "holistic sexuality education"

In their 2013 "Guidance for Implementation document", the WHO refers to what they call "Holistic sexuality education" as a more adequate definition rather than "comprehensive sex education".[57] Holistic sexuality education is defined as follows:

> "Holistic sexuality education has to do with learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education starts early in childhood and progresses through adolescence and adulthood. It aims at supporting and protecting sexual development. It gradually equips and empowers children and young people with information, skills and positive values to understand and enjoy their sexuality, have safe and fulfilling relationships and take responsibility for their own and other people's sexual health and well-being."

They also state that in the "Standards for sexual education document", the term "holistic" sexuality education has been suggested as the preferred term.

As we have described in this report, the concept "comprehensive" is mainly used to contrast itself with "abstinence-only" education. It advocates the inclusion of contraception and so called "safe-sex" practices in educational efforts, because abstinence education is felt to be too narrow and not effective in practice. As such, the focus of comprehensive sexual education is on prevention of sexual ill-health.

The World Health Organization uses the concept of "holistic" sexuality education as opposed to "comprehensive" sex education and has defined it this way:

> "Sexuality is a positive (and not primarily a dangerous) element of human potential; and a source of satisfaction and enrichment in intimate relationships. Furthermore, the starting point of "holistic" sexuality education is a human rights viewpoint: people have the right to know about sexuality and the right to self-determination, in matters related to their sexuality as elsewhere. It is self-evident that prevention of sexual ill-health (including the prevention of high-risk behavior) is also part of holistic sexuality education. The primary focus is on sexuality as a positive element of human potential and a source of satisfaction and pleasure. The need for the knowledge and skills required to prevent sexual ill-health, although clearly recognized, comes second to this overall positive approach".[58]

We obviously acknowledge that sexuality should be recognized as "a positive element of human potential" and agree that "satisfaction and pleasure" are important components of sexual relationships. Furthermore we also agree that "knowledge and skills required to prevent sexual ill-health comes second to this overall positive approach". The problem with these propositions is clear: the way different concepts end up being defined and especially applied in practice can be very different from what they might reasonably be assumed to mean when some actors initially agree to be included in these "official" documents. Concepts such as "right to know", "right to self-determination" and "positive element of human potential and a source of satisfaction and pleasure" can have several reasonable interpretations. In a democratic setting, these differing interpretations should be allowed equal exposure in official and international settings even if they are not in line with what the Sex Education Establishments considers optimum.

Based on the considerations and arguments described above, we contend that programs such as the "abstinence-centered sexual education programs" are evidence-based and effective; furthermore, they are the preferred choice of millions of parents, educators, researchers and youth around the world and can be appropriately defined as truly "holistic sexual education programs".

[57] WHO Regional Office for Europe and BZgA. Standards for Sexuality Education in Europe. Guidance for Implementation; 2013.
[58] WHO Regional Office for Europe and BZgA. Standards for Sexuality Education in Europe. Guidance for Implementation; 2013.