

# Sexuality and Family Life Education Helps Prepare Young People

**In-school programs can result in positive behavior changes, but programs vary widely and questions about best models need more attention.**

Sexuality education in schools can result in delaying first intercourse or, if young people are already sexually active, in using contraception. Even so, such programs are often controversial because many believe that sexuality is a private matter for families and that talking about it in schools can lead to young people being more sexually active.

Policymakers and program planners generally agree that young people need accurate information about sexuality so they can make better and informed decisions. Programs addressing that need vary widely and are called health education, family life education, family life skills, or sexuality education. Some provide only biological information. Others put sexuality in a larger developmental context including such issues as self-esteem, setting goals, and having respect for others. Regardless of type of program, researchers have found that changing knowledge and attitudes about sexual behavior is far easier than changing behaviors.

Despite wide variations, several critical and common questions arise repeatedly:

- Do school-based sexuality programs lead teenagers to have sex?
- What makes a school-based sexuality education program successful?
- At what age should school-based programs about sexuality begin?
- Can curricula developed in one culture be adapted to another setting?

Evaluations of family life and sexuality education programs published in peer-reviewed journals suggest some answers to these questions.

## **Do school-based sexuality education programs lead teenagers to have sex?**

The World Health Organization (WHO) and the U.S. National Campaign to Prevent Teen Pregnancy have conducted the two most exhaustive reviews of studies in this field.

Both concluded that sex education programs do not promote or lead to an increase in sexual activity among young people. Almost all of the programs evaluated and reviewed did not lead to initiation of sexual relations and did not lead to an increase in frequency of sexual activity.





The WHO study reviewed 47 interventions that took place between 1974 and 1995, from developed and developing countries.<sup>1</sup> The U.S. study examined more than 250 evaluations of programs from the United States or Canada completed since 1980.<sup>2</sup> Both analyzed evaluations of school-based programs that measured behavior change regarding sex.

### **What makes a school-based sexuality education program successful?**

The U.S. analysis of 250 evaluations, conducted by Dr. Douglas Kirby, found that both general sex education programs and those concentrating on HIV prevention were successful.<sup>3</sup> HIV programs were more likely to show a decrease in the number of sexual partners and an increase in the use of condoms, while sex education programs had more impact on the use of contraception by sexually active youth. Of the few abstinence-only programs that had been evaluated rigorously, none reported any evidence of delayed sexual activity. School programs called “service learning” were among the most effective in preventing pregnancy while students were participating in the program even though they had no focus on reproductive health. These programs include voluntary community service with time for preparation and reflection on that service, suggesting the importance of a broader context for impact on reproductive health behaviors.

Dr. Kirby's analysis found that the most successful programs:

- give a clear, consistent message based on accurate information;
- focus on reducing one or more sexual behaviors that lead to unintended pregnancy, sexually transmitted infections (STIs), and HIV;
- have a theoretical framework proven to change health behaviors;
- use teaching methods that involve students, are skill-based, and use real-life situations;
- are age- and culture-specific and last sufficient time; and
- motivate and train teachers to participate.

He is currently working with WHO to review programs in developing countries to see what elements emerge as most important for changing behavior.

Few programs in developing countries include all of the common characteristics of successful programs, concluded the FOCUS on Young Adults program in a review of school-based programs that had undergone relatively strong evaluations.<sup>4</sup> But a few have incorporated many of the important elements. For example, a program in Tanzania developed by local health educators based on social learning and other behavioral change theories found in a 12-month follow-up survey that fewer boys and girls in the intervention group had initiated sexual relations compared to a control group. Although the differences between the intervention and control groups were large, particularly for boys, they were not statistically significant (3 percent vs. 6 percent for girls; 14 percent vs. 35 percent for boys).<sup>5</sup>

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## At what age should school-based programs about sexuality begin?

Research has not generally addressed this specific question, but studies do suggest that programs should begin at an early age. Many students will have dropped out of school before reaching the secondary level, and many will also be sexually active before reaching secondary school. The WHO review of 47 programs found that sexuality education programs had a greater impact on behavior if students took the course before they became sexually active rather than after. The study concluded that such courses might help establish patterns of sexual behavior more easily than they can change behavioral patterns that have already been formed.<sup>6</sup>

In Namibia, for example, female virgins participating in a curriculum called “My Future Is My Choice” were more likely to remain a virgin 12 months after the program, compared to virgins from the control group, who did not participate in the curriculum.<sup>7</sup> A U.S. study found that students who had not had sex before a sexual education program were significantly less likely to have begun sexual activity 18 months later (sexual activity increased from 12 percent to 29 percent), compared to a control group (from 14 percent sexually active to 38 percent).<sup>8</sup> In both the Namibian and U.S. studies, the rate of contraceptive use among those already sexually active before the programs began did not increase during the intervention, which underscores the importance of starting sexual education at an early age.

Surveys have found that many young people are sexually active before reaching secondary school. In a survey of 13- and 14-year-olds in a Tanzania project, half of boys and 10 percent of girls said they were sexually active. In a Jamaica project, 64 percent of boys ages 11 to 14 reported being sexually active but only 6 percent of girls did so. In

a U.S. survey of 13-year-olds, 65 percent of boys and 27 percent of girls reported being sexually active.<sup>9</sup>

The U.S.-based Sexuality Information and Education Council (SIECUS), which promotes comprehensive education about sexuality, has developed guidelines that emphasize beginning sexuality education young, when children are in primary school.<sup>10</sup> However, more evaluation of programs that begin at young ages are needed to determine if they do in fact lead to better behavioral outcomes. One study worked to instill a sense of belonging at school with elementary-age students, using teacher training, parenting classes, and social-competence training for children. When these students were 21 years old, they reported significantly fewer sexual partners and, when controlling for poverty, lower pregnancy and STI rates compared to a control group. Ninety-three percent of the fifth-grade students who were enrolled in the intervention group (144) and control group (205) were successfully interviewed at age 21.<sup>11</sup>

## ELEMENTS OF SUCCESSFUL SEXUALITY EDUCATION PROGRAMS

### Content

- Give clear, consistent message based on accurate information.
- Focus on reducing sexual behaviors that lead to unintended pregnancy and STIs/HIV.
- Be specific to age and culture.
- Have a theoretical framework proven to change health behaviors.

### Program Design

- Use methods that involve students, are skill-based, and address social pressures.
- Conduct sessions of sufficient length.
- Motivate and train teachers to participate.

Adapted from Kirby D. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, 2001.

## Can curricula developed in one culture be adapted to another setting?

Programs in many developing countries use a lecture format and concentrate on biological facts, an approach much different from the successful characteristics identified by Kirby in U.S. and Canadian programs. But is it feasible to adapt curricula deemed successful in one culture to another setting? Only one study has looked at this question, though other evaluations are under way.

A study in Namibia revised a curriculum designed for a U.S. setting, using examples that would be appropriate and understood in the Namibian context and incorporating Namibian cultural beliefs and practices. The program was successful in delaying sexual debut, leading the authors to conclude, "transplantation of a western-designed curriculum can be successful."<sup>12</sup>

Other adaptations under way include using the methodological approach from the Jamaican curriculum called "Vibes" for schools in Senegal and Rwanda. In Senegal, talking about pregnancy is taboo, so certain exercises from Vibes had to be changed. Results from an evaluation of this project are expected late in 2002. In Rwanda, the Senegalese version was used as the baseline for adaptation. Because the program in Rwanda involves the Catholic Church, new exercises were created to talk about religion and sexuality. Developing the initial Vibes curriculum took 16 months and cost U.S. \$120,000. The process in Senegal and Rwanda took much less time and money.

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### REFERENCES

1. 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.
2. Kirby D. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy, 2001.
3. Kirby.
4. FOCUS on Young Adults. *Advancing Young Adult Reproductive Health: Actions for the Next Decade*. End of Program Report. Washington, DC: Pathfinder International, 2001.
5. Klepp KI, Ndeki SS, Leshabari MT, et al. AIDS education in Tanzania: promoting risk reduction among primary school children. *Am J Public Health* 1997;87(12):1931-36.
6. Grunseit.
7. Stanton BF, Li X, Kahihuata J, et al. Increased protected sex and abstinence among Namibian youth following a HIV risk-reduction intervention: a randomized, longitudinal study. *AIDS* 1998;12:2473-80.
8. Kirby D, Barth RP, Leland N, et al. Reducing the risk: impact of a new curriculum on sexual risk-taking. *Fam Plann Perspect* 1991;23(6):253-63.
9. Klepp; Eggleston E, Jackson J, Hardee K. Sexual attitudes and behavior among young adolescents in Jamaica. *Int Fam Plann Perspect* 1999;25(2):78-84, 91; Siegel DM, Aten MJ, Roghmann KJ, et al. Early effects of a school-based human immunodeficiency virus infection and sexual risk prevention intervention. *Arch Pediatr Adolesc Med* 1998;152:961-70.
10. *National Guidelines Task Force, Guidelines for Comprehensive Sexuality Education. Second Edition*. 1996. Online. Available: <http://www.siecus.org/pubs/guidelines/guidelines.pdf>. May 2002.
11. Lonczak HS, Abbott RD, Hawkins JD, et al. Effects of the Seattle social development project on sexual behavior, pregnancy, birth, and sexually transmitted disease outcomes by age 21 years. *Arch Pediatr Adolesc Med* 2002;156(5):438-47.
12. Fitzgerald AM, Stanton BF, Terreri N, et al. Use of Western-based risk reduction interventions targeting adolescents in an African setting. *J Adolesc Health* 1999;25:52-61.

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