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Sexuality Education
in New Zealand

A Critical Review

By Miriam Grossman, MD
with Christopher White



Report to Family First
New Zealand June 2013



Author

Miriam Grossman MD is a physician, author, public speaker, and media commentator. She is known internationally for her courage in breaking ranks and calling foul on the Sexuality Education industry. Dr Grossman has been on over 200 radio, news, and television shows, and has lectured at the British House of Lords and the United Nations.



Dr Grossman speaks to parents, students, educators, policy makers and health professionals on the importance of childhood innocence, and the dangers of a powerful sex education lobby that promotes sexual licence instead of sexual health.

Dr Grossman graduated with honours from Bryn Mawr College and from New York University Medical School. She completed an internship in paediatrics at Beth Israel Hospital in New York City, and a residency in psychiatry at North Shore University Hospital – Cornell University Medical College, followed by a fellowship in child and adolescent psychiatry at the same institution. Dr Grossman is board certified in psychiatry and in the sub-specialty of child and adolescent psychiatry.

Dr Grossman visited New Zealand in 2012.

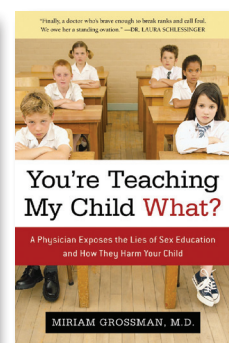
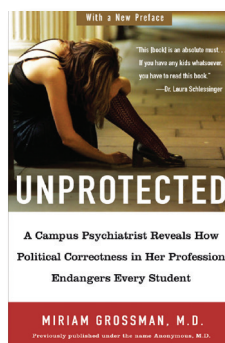
For more information, see www.MiriamGrossmanMD.com

Portions of this report were previously published in:

Miriam Grossman, **You're Teaching My Child WHAT? A Physician Exposes the Lies of Sex Education and How They Harm Your Child.** Washington, D.C.: Regnery Publishing, 2009.

Miriam Grossman, **Unprotected: A Campus Physician Reveals How Political Correctness in Her Profession Endangers Every Student.** New York: Sentinel, 2006.

Grossman, Miriam. **New York City Sexuality Education Report.** New York, World Youth Alliance, 2011



For additional copies, please contact Family First NZ:

tel: 09 261 2426

fax: 09 261 2520

email: admin@familyfirst.org.nz

web: www.familyfirst.org.nz

post: PO Box 276-133, Manukau City 2241, New Zealand

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Executive Summary

Consider some of the common medical problems found in developed countries: heart disease, hypertension, and diabetes. These life-threatening conditions are associated with behavioural choices, such as smoking, an unhealthy diet and a sedentary lifestyle. Their prevention, therefore, is based on educating consumers about the dangers of those behaviours, and promoting healthier choices.

With sexual health, the approach is different. A premise of modern sex education is that young people have the right to make their own decisions about sexual activity, and no judging is allowed. Risky behaviours are normalised and even celebrated. Children and adolescents are introduced to sexual activities their parents would prefer they not even know about, let alone practice. It's reasonable to ask: is the 'comprehensive sexuality education' foisted on young people all over the world about sexual health, or sexual licence?

The following report provides an analysis of the sex education resources recommended to adolescents in New Zealand: curious.org.nz, iwannaknow.org, Family Planning resources, theword.org.nz, getiton.org.nz, and sexnrespect.co.nz.

While these resources claim to promote sexual health, we find, overall, little encouragement of restraint or self-discipline. Instead, students are informed that at any age, sexual freedom is a 'right'.

Other material, such as **Sex with Attitude**, do a better job of promoting sexual health.

Morality aside, with record numbers of STIs in New Zealand – higher than the United Kingdom and many parts of Europe – delaying sexual activity until adulthood is sound medical advice. Early sexual debut, especially in girls, is associated with a wide range of negative consequences in multiple spheres: medical, social, educational and economic.

A guide published by the Ministry of Education states: "A key message within our sexuality education programme is the need to delay the start of sexual activity."

Sounds good, but the resources reviewed in this analysis provide a different message.

Most resources have one-liners such as "abstaining from sexual contact is the surest way to avoid infection," or "for all STDs, abstinence is the best protection." But these messages are like postscripts or disclaimers, and delaying sexual activity until adulthood is not presented as a viable alternative with considerable rewards.

Resources from **Family Planning**, theword.org.nz, and iwannaknow.org assume adolescents are miniature adults – capable of rational, thought out decisions. *Provide teens with information, they posit, and make sure they have access to contraception. They are able to make responsible, mature decisions.* The argument could have been legitimate a few decades ago, but now we know better.

We cannot rely on an adolescent's consistent ability to 'use their heads', because this skill is still under construction. Neuropsychology says teens are not ready for sexual relationships. Sex education must say the same thing.

Also of concern is that *all* the publications and resources reviewed in this analysis fail to adequately alert the student to the well-established dangers of anal intercourse, with or without a condom. At least two sites, getiton.org.nz and the old curious.org.nz, actually celebrate this high risk behaviour.

As well, sexuality educators do not describe the complex psychological issues that often follow the diagnosis of a sexually transmitted infection. Research indicates,

Students are informed that at any age, sexual freedom is a 'right'.

Early sexual debut, especially in girls, is associated with a wide range of negative consequences in multiple spheres: medical, social, educational and economic.

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however, that they can be substantial, especially when the infection is with an incurable virus such as HPV or herpes.

It is our conclusion that the sexuality education programmes that have been reviewed are seriously flawed, with both sins of commission, and sins of omission.

The information is not accurate, comprehensive, or up-to-date. Sex is seen as risky only when it's 'unprotected'. The efficacy of condoms is overstated, in some cases vastly so. The quantitative data about their use is absent. The vulnerability of the immature cervix and the hazards of anal intercourse are omitted. Chlamydia is incorrectly described as 'easily cured'. Young people are led to believe that sex is easily divorced from emotional attachment. Worst of all, critical life and death information is distorted or ignored.

Students are left misinformed, and with a false sense of security. Surely this is the last thing we want.

We cannot expect teens to delay sexual activity while instructing them, "*only you know when you're ready*". It is the nature of adolescence to feel 'ready' for just about anything.

Is every young person going to postpone sex? Of course not. But we are still obligated to inform them of the grave risks they face, to teach them biological truths about their physical and emotional vulnerabilities, to warn them in a no-nonsense manner about avoiding high risk behaviours, and to encourage the highest standard.

The approach to teen sex upon which these programmes are based can harm children. We need, instead, a different model for sex education in the 21st century. This model should have one goal: to keep young people out of the offices of doctors and counselors and to keep students free from unnecessary physical and emotional distress.

It will require straight talk with all the sobering facts. *We are fighting a war against a horde of bugs, we should explain to students, and the bugs are winning. Sure, sex is great, but it's an appetite, and just like all appetites, it must be restrained. You have urges, and they are healthy urges – but it is not healthy for you to act on them, not at this time in your lives.*

We must make teens understand that sex is a very serious matter and that a single encounter can change their lives forever. Our message must be consistent and firm: the only responsible choice is to delay sexual behaviour until adulthood. We must provide students with an ideal to strive for, one that offers them the healthiest option physically and emotionally. The healthiest ideal is to postpone sexual activity until adulthood and, ideally, until marriage.

Of course, students must be told it's not easily achieved. Reaching that ideal isn't easy, of course, and this fact should be acknowledged. But just as in other areas of education, where the ideal is presented as the point of excellence towards which we encourage young people to strive, the same holds true with our sexual activity and choices.

Keeping the ideal in front of young people and supporting them in achieving it should be the first priority of sexual education programmes.

On behalf of concerned parents and educators, we're calling these groups out. We demand they be held accountable, and that students be provided with the information and guidance they need.

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I. Sex Education: Health or Licence?



Consider some of the common medical problems found in developed countries: heart disease, hypertension, and diabetes. These life-threatening conditions are associated with behavioural choices, such as smoking, an unhealthy diet and a sedentary lifestyle. Their prevention, therefore, is based on educating consumers about the dangers of those behaviours, and promoting healthier choices.

The medical establishment describes an ideal towards which it hopes people will strive, and as a matter of course, health providers instruct patients to practice self-discipline and adopt a healthy lifestyle: stop smoking, lose weight and get enough exercise. This is standard public health policy, and no one questions it.

With sexual health, the approach is different. A premise of modern sex education is that young people have the right to make their own decisions about sexual activity, and no judging is allowed. Risky behaviours are normalised and even celebrated. Children and adolescents are introduced to sexual activities their parents would prefer they not even know about, let alone practice. It's reasonable to ask: is the 'comprehensive sexuality education' foisted on young people all over the world about sexual health, or sexual licence?

The following pages provide an analysis of the sex education resources recommended to adolescents in New Zealand: curious.org.nz, iwannaknow.org, **Family Planning** resources, theword.org.nz, getiton.org.nz, and sexnrespect.co.nz. While these resources claim to promote sexual health, we find, overall, little encouragement of restraint or self-discipline. Instead, students are informed that at any age, sexual freedom is a 'right'. Other material, such as **Sex with Attitude** (attitude.org.nz), do a better job of promoting sexual health.

Our concern is that the health and well-being of adolescents in New Zealand – and around the world – is jeopardised by the current state of affairs. The negative consequences of teen sex – pregnancy, sexually transmitted infections, emotional turmoil - can be serious medical issues. In some cases, they are a matter of life and death. Sex education fails to provide students with basic scientific facts about reproductive health; instead, it gives them a false sense of security.

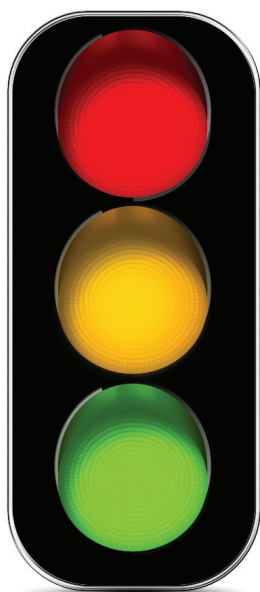
This is a dangerous situation. On behalf of concerned parents and educators, we're calling these groups out. We demand they be held accountable, and that students be provided with the information and guidance they need.

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II. Red Light, Green Light



In a 2010 poll of New Zealand adults,¹ 69% said schools should encourage pupils to abstain from sex until they are old enough to handle the possible consequences of pregnancy. Somewhat surprisingly, those aged under 40 were most in favour of this.

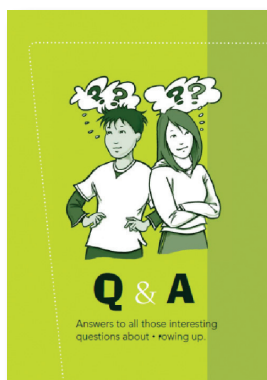
And for good reason. Morality aside, with record numbers of STIs in New Zealand – higher than the United Kingdom and many parts of Europe – delaying sexual activity until adulthood is sound medical advice.² Early sexual debut, especially in girls, is associated with a wide range of negative consequences in multiple spheres: medical, social, educational and economic.

A guide published by the Ministry of Education states: "A key message within our sexuality education programme is the need to delay the start of sexual activity."³

Delaying sexual activity until adulthood is sound medical advice.

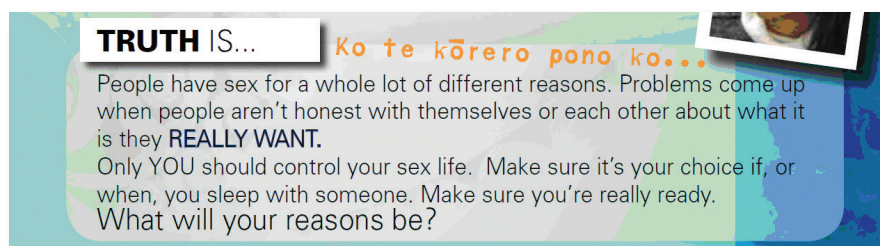
Sounds good, but the resources reviewed in this analysis provide a different message. They inform students the decision is theirs: delaying sex is a good option, but 'safer sex' – sex with a condom – is also acceptable. The Education Ministry gives a red light to teen sex, as it should. But the websites and pamphlets created for teens by sexuality educators give a green light.

Most resources have one-liners such as "abstaining from sexual contact is the surest way to avoid infection," or "for all STDs, abstinence is the best protection." But these messages are like postscripts or disclaimers, and delaying sexual activity until adulthood is not presented as a viable alternative with considerable rewards.



The Education Ministry gives a red light to teen sex, as it should. But the websites and pamphlets created for teens by sexuality educators give a green light.

Take for example, a Family Planning pamphlet for youth called "Your Choice".⁴ It instructs students: "Only YOU should control your sex life. Make sure it's your choice if, or when, you sleep with someone. Make sure you're really ready....Only YOU know when it is right for YOU."



1 <http://www.familyfirst.org.nz/wp-content/uploads/2011/02/Abstinence-Final-Results-March-2010.pdf>

2 "Sexually Transmitted Diseases in New Zealand in 2011." Institute of Environmental Science and Research. http://surv.esr.cri.nz/PDF_surveillance/STISurvRpt/2011/2011AnnualSTIRpt.pdf

3 New Zealand Ministry of Education. Sexuality Education: Revised Guide for Principals, Boards of Trustees, and Teachers, 2002, Page 30

4 Your Choice http://www.familyplanning.org.nz/Portals/5/Resource%20Shop/PDFs/Booklets/FP_YourChoice-2009-lowres.pdf

And how do students know they're ready? **"Your Choice"** provides this quote from a teen: *"I think you're ready to have sex if you feel it's right. If you like hear little voices...you know 'don't do it, - don't do it -... you should hold off. But you know if it's like 'yeah I'm ready', then OK."*



"I think you're ready to have sex if you feel it's right. I think if you like hear little voices like I used to hear - you know 'don't do it, - don't do it - you don't know what you are doing anyway' then I think then you are unsure, and you should hold off. But you know if it's like 'yeah I'm ready,' then OK."

The recommendation to practice abstinence is merely a wink and a nod, before a much longer and detailed instruction on how to go about having sex with your partner(s).

From another **Family Planning** pamphlet called **"Q&A – answers to all those questions about growing up"**⁵:

"There is no 'right' age to have sex. The age someone chooses to have sex is different for everyone. It needs to be when it feels right for that individual person."

People might also choose to have sex for a combination of different reasons.

WHAT'S THE RIGHT AGE TO HAVE SEX?

There is no 'right' age to have sex. The age someone chooses to have sex is different for everyone. It needs to be when it feels right for that individual person. This can depend on their values, religion, if they're in a relationship or not, or lots of other different factors. As we get older we develop our own attitudes and values that help us to make decisions. What's important is that people choose to have sex when they feel ready. Often it can feel like everyone is having sex but that's not true. It is not legal in NZ to have sex with someone under 16. The average age in NZ is 17, but many wait until they are older. If someone isn't sure, the best advice is to wait.

Sexual behaviour in adolescence is a high risk behaviour, especially for girls.

From **"The Word: Sex information for under 25"**⁶, also by **Family Planning**:

"Before you have sex for the first time, there are definitely a few things that need to be discussed."

"Are we ready? How comfortable do we both feel about becoming intimate with each other?"

"Contraception – what option works best for both of you? Remember, it's best to

⁵ Q&A... <http://www.familyplanning.org.nz/Portals/5/Resource%20Shop/PDFs/Book-lets/Q-and-A-puberty-2009-FamilyPlanning.pdf>

⁶ The Word <http://www.theword.org.nz/site/topic/mechanics/allaboutsex/vaginalanaloral>

use condoms AND lube AND contraception until you are in a long-term committed relationship." [underscore added – the phrase gives tacit endorsement of relationships that are short-term and not committed]

Consider also iwannaknow.org,⁷ a website young people are referred to by **Sex With Attitude**. iwannaknow.org correctly defines abstinence as:

"Choosing not to have any kind of sex. Someone who practices sexual abstinence does not run any risk of contracting an STI or having an unwanted pregnancy."⁸

This message, however, can only be found under the "Definitions" page – not under any section providing real advice or medical facts about sexual health. Under the section "Sexual Health and You", the endorsement of abstinence is weak: "Abstinence is good and can happen at different times in life." Just a few lines later, the recommendation is made to "Talk to your partner (before you have sex)" and "Make sure you and your partner know how to use a condom correctly."⁹

The message is ambivalent, and the expectations are low. Delaying sex is 'good' – but at the same time, know how to use a condom. As such, the recommendation to practice abstinence is merely a wink and a nod, before a much longer and detailed instruction on how to go about having sex with your partner(s) – all under the banner of 'sexual health'.

Here's how the 'expert' at iwannaknow.org suggests parents answer teens who ask, "When is it OK to have sex?"

"I'm very glad you asked me. I would ask myself several questions if I were thinking about having sex, like: Do I really care about this person and does this person really care about me? Am I ready to have sex, and do I really want to? Does my partner really want to? Have we agreed on a reliable way to prevent sexually transmitted infections and pregnancy? I feel that two people should be able to talk about these things before they have sex. I'd ask myself if I could handle the possible consequences by myself. I know that it's normal for people your age to be interested in sex. I think sexuality is an important part of life, so let's talk about it some more. Let's talk about what you think you might want in a relationship."¹⁰

Sexual behaviour in adolescence is a high risk behaviour, especially for girls. Most parents know that instinctively. They want their children, daughters as well as sons, to know: sex is a serious matter. One encounter can change your

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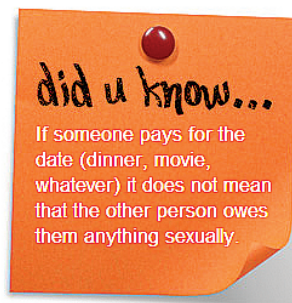
Parents want their children, daughters as well as sons, to know: sex is a serious matter.

So you have thought about it and you know what you want to do sexually. Now what? It's time for some communication. Communication and showing respect helps make sexual experiences better.

Here are some things you can ask to see if someone is keen to be sexual with you.

ASK

- "May I...?"
- "Can we...?"
- "What do you want to do?"
- "What turns you on? I like..."
- "I'd like to... would you like to? If not, what would you like to do?"
- "How do you feel about doing...?"
- "Are there things you know you don't want to do: what are they? Mine are..."
- "Is there anything you need to feel comfortable or safe when we do...?"
- "I'm really interested in doing... with you and it feels like the right time for me, do you want to do that and does the timing feel right to you?"
- "I'd like to have sex tonight, would you? What do you want to do or try?"



sexnrespect.co.nz

⁷ <http://www.iwannaknow.org/about.html>. Retrieved on 12/30/2012

⁸ http://www.iwannaknow.org/teens/glossary_a_d.html#abstinence. Retrieved on 12/30/2012

⁹ Ibid.

¹⁰ <http://www.iwannaknow.org/parents/teen.html>. Retrieved on 12/30/2012.

life forever. That's why, although your interest in it is normal and healthy, sex is for adults. The advice from iwannaknow.org fails to convey those truths. If anything, it endorses teen sex! And the sexnrespect.co.nz site has no mention whatsoever of the need for teens to delay sex.¹¹

Finally, consider the vision of **Advocates for Youth** – a website recommended by iwannaknow.org:

"Advocates for Youth believes that all young people have the right to the reproductive and sexual health information, confidential, safe services and a secure stake in the future. Advocates envisions a world in which societies view adolescent sexual development as normal and healthy, treat youth as partners in promoting sexual health and value young people's relationships with each other and with adults. The core values of Rights. Respect. Responsibility. (3Rs) animate this vision."¹²

Note the emphasis on rights, confidentiality, and valuing "young people's relationships with each other." **Advocates for Youth** believes that regarding sexual matters – treatment of sexually transmitted infections, access to contraception and abortions – teens should be treated as adults. Is there any place for parental rules and values? Do these rights extend to early adolescence? These are fair questions to ask.

Adolescent Brain Development¹³

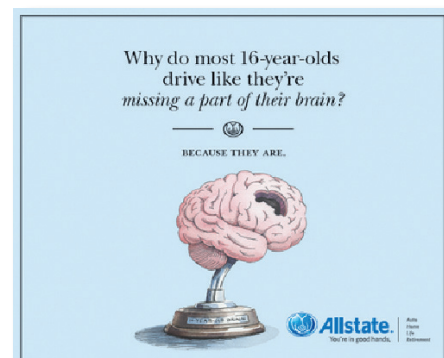
Why do so many young men and women engage in high risk, impulsive behaviours, including sex? It's likely related, at least in part, to their immature brains. The research in this area has been ground-breaking, but the findings are ignored by the sex education industry.

Until the mid-1990's, the study of brain development focused on the fetus, infant, and toddler. By age two, the brain reaches close to 80 percent of its adult weight, so those early years were considered the critical periods of development. Later maturation was considered almost insignificant. Research was limited, because it was unethical to expose healthy children to the radiation of x-rays or CT scans. As a result, investigators had to rely on animal studies and cadavers.

All of this changed, however, with the introduction of magnetic resonance imaging (MRIs), which provide accurate images of the brain without radiation. Even more exciting, real-time images of the brain at work – doing a math problem, recalling an event, feeling pleasure or fear – were readily available with the advent of functional MRI (fMRI). With the elimination of health risks, MRI and fMRI permitted observation of healthy children and teens, revolutionising the study of brain development.

For researchers, the biggest surprise came when they looked inside the heads of adolescents. They discovered that brain maturation does not end in early childhood; it simply pauses for some years, only to restart with vigour at the onset of puberty. During the second decade of life and into the third, a period of "explosive growth and restructuring" takes place. There is a "dramatic metamorphosis of the brain," writes a leading developmental psychologist in this young field. Dr. Jay Giedd, chief of brain imaging in child psychiatry at the National Institute of Mental Health, found that the last area to mature is an area behind the forehead, known as the prefrontal cortex (PFC). The PFC is responsible for the executive functions of the brain: judging, reasoning, decision-making, self-evaluation, suppression of impulses, and weighing the consequences of one's decision. It does not complete development until the mid-twenties.

Is there any place for parental rules and values?



Insurance advertisement in the U.S.A.

Judging, reasoning, decision-making, self-evaluation, suppression of impulses, and weighing the consequences of one's decisions. It does not complete development until the mid-twenties.

11 <http://www.sexnrespect.co.nz/Sex-n-Respect/4-easy-steps-to-Sex-n-Respect/How-do-I-ask-some-one-to-have-sex/>

12 Advocates for Youth. "The Vision" <http://www.advocatesforyouth.org/the-3rs>. Retrieved on 2/12/13.

13 Miriam Grossman, *You're Teaching My Child WHAT?* Washington, D.C.: Regnery Publishing, 2009. Pgs. 70-76.

This is critical information, yet most people fail to connect it to sex education. Resources from **Family Planning, theword.org.nz**, and **iwannaknow.org** assume adolescents are miniature adults – capable of rational, thought out decisions. *Provide teens with information, they posit, and make sure they have access to contraception. They are able to make responsible, mature decisions.* The argument could have been legitimate a few decades ago, but now we know better. We cannot rely on an adolescent's consistent ability to 'use their heads', because this skill is still under construction. Neuropsychology says teens are not ready for sexual relationships. Sex education must say the same thing.

We cannot rely on an adolescent's consistent ability to 'use their heads', because this skill is still under construction.

III. Girls and Boys are different

From the opening pages of **Sex with Attitude**:

"Sex requires maturity. Yes, your body might be mature enough to have sex, but it takes mental and emotional maturity to handle the impact of sex on yourself, your partner, the physical risks of pregnancy and sexually transmitted infections."¹⁴

So far so good. Sex does require maturity and there are mental, emotional, and physical risks, as the following sections of this report will highlight. But there's a glaring omission here: The risks are greater for girls. In general, girls pay a higher price than boys for early sexual debut and multiple partners.

Why? Because of her anatomy, and her hormones.

Any sex education resource, including those created by **Family Planning, curious.org.nz** and **iwannaknow.org** that omits these biological facts cannot be considered comprehensive, medically accurate, science-based, or up-to-date.

Adolescents must be taught about the hormone oxytocin, and the emotional attachment that often accompanies intimate relationships, especially in women.

Oxytocin

Oxytocin was identified in 1906 by the English researcher Sir Henry Dale, who discovered its role in giving birth.¹⁵ Since that time, and especially in the past two decades, our understanding of this primarily female molecule has been transformed. We now know that oxytocin plays a leading role in the biochemistry of sexuality and human relationships.

In addition to its role in labour, delivery, and nursing, oxytocin promotes social bonds. It acts on the brain to fuel feelings of attachment, trust, and generosity. The brain's reward center lights up; the circuits for critical assessment and fear dampen. Oxytocin tells the brain: it's time to relax, feel good, trust, and connect. This same hormone is released during intimate behavior. Oxytocin is released in response to stimulation of the nipples and orgasm; intercourse is not necessary.¹⁶ Even a prolonged hug can raise oxytocin levels, leading a prominent neuropsychiatrist to warn women, *"Don't hug a guy, unless you plan to trust him."¹⁷*

This is powerful information. Neuroscience is affirming what parents want adolescents to grasp: Sex is serious. Sex is complicated. You'll get attached

There are critical biological facts about reproductive health that are omitted from popular resources.

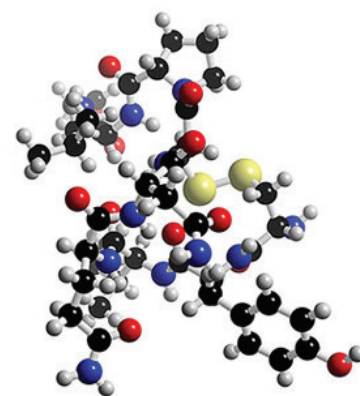
14 Sex with Attitude. 2012 Revised Edition. Pg. 4.

15 Moberg, Kerstin Uvnas. The Oxytocin Factor: Tapping the Hormone of Calm, Love, and Healing. Da Capo Press: 2003.3.

16 Baumgartner, Thomas et al. "Oxytocin Shapes the Neural Circuitry of Trust and Trust Adaption in Humans." Neuron 58 (2008): 639-650.

17 Brizendine, Louann. The Female Brain. Random House: New York, NY 2006. Pg. 68.

and you'll get hurt. There are consequences, whether or not 'protection' is used. At a time when casual, no-strings-attached sexuality is widespread among adolescents and they are bombarded with messages encouraging risky lifestyles, it's critical to include the current science of oxytocin in all sex education resources.



Perhaps related to the actions of oxytocin and other hormones, girls appear to be more emotionally vulnerable to sexual behaviour than boys. One study on a US campus indicated that after a hook-up, 91% of girls admitted to having feelings of regret, at least occasionally, and 80% wished the hook-up hadn't happened.¹⁸ In other research, 84% of women said that after having sex a few times, even with someone they didn't want to be emotionally involved with, they begin to feel vulnerable and would at least like to know if the other person cares about them; only 23% of males felt the same way.¹⁹ Teen girls must be made aware of studies such as these.

*A Girl's Biology Says: Wait!*²⁰

The cervix, the entrance to the uterus, plays a central role in female sexual health. But few people are aware of how it increases a young woman's vulnerability to sexually transmitted infections.

The cervix is the site of two of the most common sexually transmitted infections, HPV and chlamydia. HPV is responsible for nearly all cases of cervical cancer and chlamydia may cause chronic pelvic inflammatory disease, ectopic pregnancies, miscarriages, and infertility. Girls under the age of twenty-four are being hit hardest²¹ by these epidemics.²² One reason is their immature cervix.²³

All things being equal, the cervix of an adult is more difficult to infect than the cervix of a teen. The more mature cervix is protected by twenty to thirty layers of cells. In contrast, the cervix of a teen²⁴ has a central area called the transformation zone ("T-zone"). Here the cells are only one layer thick. The transformation zone is largest at puberty, and it slowly shrinks as the cervix matures.²⁵ The thin folds of fragile, single cells are transformed progressively into a thick, flat shield with many layers. The T-zone can be seen during a routine pelvic exam. It makes the cervix look like a bull's eye, which is fitting, because it's exactly where the infections want to be.

Any virus or bacteria's purpose or intent is to find a place, a home, where it can multiply and increase – that's the purpose of its existence. To reach that home, the layers of cells must be penetrated. It's difficult, if not impossible,

Adolescents must be taught about the hormone oxytocin, and the emotional attachment that often accompanies intimate relationships, especially in women.

18 Baumann, ME (2007) The "Hookup Culture": Pluralistic Ignorance and Its Consequences. Unpublished undergraduate thesis, Princeton University, New Jersey

19 Campbell, Anne (2008). The Morning After the Night Before: Affective Reactions to One-Night Stands among Mated and Unmated Women and Men. *Hum Nat* (2008), 19, 157-173

20 Taken in part from Miriam Grossman, *You're Teaching My Child What?* Washington, D.C.: Regnery Publishing, 2009. Pgs. 77-82.

21 Stats for 2011: Chlamydia: 3,722.5 cases per 100,000 females between ages 20-24, higher than any other age group and almost 3 times the reported cases in males (<http://www.cdc.gov/std/stats11/figures/5.htm>).

22 "Sexually Transmitted Disease Surveillance 2007 Supplement," Department of Health and Human Services, Centers for Disease Control and Prevention, <http://www.cdc.gov/stf/Chlaymdia2007/CYSurvSupp2007Short.pdf>; and Quick Stats: Prevalence of HPV Infection Among Sexually Active Females, Aged 14-59 Years, by Age Group," National Health and Nutrition Examination Survey, United States, 2003-2004, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5633a5.htm?s_cid=mm5633a5_e

23 Amanda Dempsey, Sharon Humiston, and Anna-Barbara Mosckicki, "Panel Discussion: Practical Pediatrics: Effective Communication Strategies for Cervical Cancer Prevention" (part of symposium held October 8, 2006, called Pediatrics at the Forefront of Preventing Cervical Cancer: What You Need to Know About HPV), <http://medscap.com/viewprogram/6281>.

24 There is a wide individual variation in the size of the transformation zones.

25 To be more accurate, it moves up through the uterine os, or opening, toward the uterus. But for the purposes of this discussion, it's fair to describe this as "shrinking" because the area available for infection gets smaller.

Neuroscience is affirming what parents want adolescents to grasp: Sex is serious. Sex is complicated. You'll get attached and you'll get hurt.

to get through the many layers of the mature cervix. But penetration of the transformation zone's single layer is a cinch, making this area of the cervix prime real estate for genital infections. This is one of the primary reasons for our current pandemic of genital infections in teen girls.

Take note, however, that infection (the mere presence of an organism, an STI) is not enough to cause disease (an STD), which in the case of HPV, would be pre-cancerous changes.²⁶ The body has mechanisms for eliminating the virus before it causes damage, and for fixing the damage should it occur; it has methods of preventing an infection from developing into a disease. But these strategies are impaired in an HPV-infected T-zone.

Like police forces in a city, the body has specialised units²⁷ whose job is surveillance and safety. These are cells and organs that take care of 'problems'. In the cervix, these security guards are called Langerhans cells.²⁸ They watch out for unfamiliar 'visitors'. When one is identified, it's taken into headquarters for 'questioning',²⁹ and taken care of – eradicated. In the T-zone, compared to the more mature cervix, the number of Langerhans cells is lower,³⁰ the security is weaker, and dangerous 'visitors' like viruses and bacteria may go unnoticed. Once HPV has settled in, the virus itself can incapacitate³¹ Langerhans cell functioning.³² So aside from having a large area that's vulnerable to invasion, the young cervix also has a weaker 'police force' to recognise and deal with danger.

Also, cells in the T-zone are highly sensitive to estrogen and progesterone.³³ Studies suggest these hormones can enlarge the T-zone, empower HPV, and stimulate cervical cells to rapidly reproduce.³⁴ That's a hazardous combination. First, it provides bugs with more available 'real estate'. Because viruses can't replicate by themselves – they must hijack the machinery of the cell 'hosting' them, their job is facilitated: hijacking is easier when the cell is working at high gear. So female hormones may boost the power of HPV to cause damage. They may also interfere with the actions of the 'police force' – those Langerhan's cells. It's been demonstrated that taking birth control pills containing both estrogen and progesterone for eight to ten years places women at higher risk of cervical cancer.³⁵ This is thought to be related to the hormones' different effect on T-zone vulnerability: defence is lowered and HPV power is boosted.³⁶

Infection with HPV can result in other negative consequences. When new cells are made, and DNA copied, errors occur. You don't want DNA mistakes; these

Girls are, in general, more emotionally vulnerable than boys.

Girls under the age of twenty-four are being hit hardest by these epidemics.

The details are complex, but the message is clear. Regarding sexual activity in teens, biology says "wait!" – especially for girls.

26 Frank Remoue et al, "High intraepithelial expression of estrogen and progesterone receptors in the transformation zone of the uterine cervix," American Journal of Obstetrics and Gynecology 189 (2003): 1660-5.

27 I.e. the immune system.

28 Sun Huie Tay and Albert Singer, "The effects of oral contraceptive steroids, menopause and hormone replacement therapy on the cervical epithelium," in Jordan, Singer, Jones, and Shafi, eds., The Cervix, 2nd edition (Blackwell Publishing, 2006), 132.

29 i.e. a lymph node.

30 Margaret A. Stanley, "Immunocytochemistry and Immunology of the Cervix," in Jordan, Singer, Jones, and Shafi eds., The Cervix, 57

31 Smoking can also inhibit these cells functioning.

32 Sandra L. Giannini et al, "Influence of the Mucosal Epithelium Microenvironment on Langerhans Cells: Implications for the Development of Squamous Intraepithelial Lesions of the Cervix," International Journal of Cancer, 97 (2002): 654-59 and Szarewski (2001); also see Cervix, 57.

33 Frank Remoue et al, "High intraepithelial expression of estrogen and progesterone receptors in the transformation zone of the uterine cervix," American Journal of Obstetrics and Gynecology 189 (2003): 1660-5.

34 Sun Huie Tay and Albert Singer, "The effects of oral contraceptive steroids, menopause and hormone replacement therapy on the cervical epithelium," in Jordan, Singer, Jones, and Shafi, eds., The Cervix, 2nd edition (Blackwell Publishing, 2006), 135

35 Ibid.

36 From a discussion with Anna-Barbara Moscicki, MD, October 2007; and Jordan, Singer, Jones, and Shafi, eds. The Cervix, 135. With the average age of sexual debut at age fifteen, and the postponement of childbearing for ten years or more, this is something to keep in mind.

are abnormal cells with cancer potential. A healthy cell has molecules that find these mistakes and repair them. HPV interferes with these molecules, allowing the damaged DNA to replicate. The abnormal cells proliferate, and a tumour begins to grow.

The details are complex, but the message is clear. Regarding sexual activity in teens, biology says “wait” – especially to girls. Yet most sex education resources instruct students to simply get vaccinated, use a condom, and have regular Pap tests. Consider the “**Know Your Body**” portion of [iwannaknow.org](http://www.iwannaknow.org). The cervix is mentioned only as part of female anatomy; there is no mention of that organ’s vulnerability to STIs. In fact the immature cervix is why so many young women get an STI from one of their first partners. As time passes the cervix matures and is more difficult to infect. This is one of many health reasons it’s wise for young women, in particular, to delay sex. Boys don’t have an area that’s highly vulnerable to infection in their reproductive systems. [iwannaknow.org](http://www.iwannaknow.org) fails to fully inform young people about their bodies, and to warn them of the dangers of sexual activity prior to adulthood.³⁷

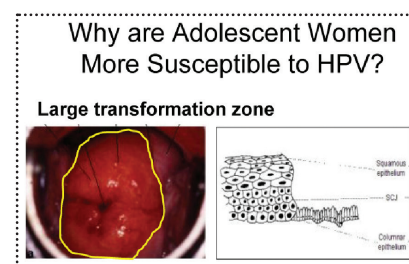
There is an important caveat: sexual intercourse speeds up the process of maturation. A study of teens who had multiple ‘partners’ and were HIV-positive revealed that their cervixes were like those of adults – covered by many layers of cells. Something associated with intercourse – the mechanical insult, a substance found in semen, or the presence of an STI – speeds up the process by which the T-zone matures.³⁸

So if a girl is having vaginal intercourse, her body ‘knows’ it, and responds by accelerating its defense: a thicker barrier of cells. But here’s the problem. When the cells in the T-zone are proliferating machinery is working overtime. As previously explained, the cell in high gear is the cell that HPV easily takes over. Since girls are likely to be infected with the virus from one of their first partners,³⁹ this is bad news. The virus is present, and now the machinery through which it does its damage is working overtime. It is now likelier than ever that abnormal cells will get the chance to proliferate. So even though intercourse accelerates cervical maturation, a girl who has just begun having sex is more vulnerable than she was as a virgin, at least to the cancer-causing potential of HPV. This is something she should know, when she comes in for birth control or testing. The awareness of this risk, along with communication skills, may help her to begin saying “no”.

IV. Safe Sex? The Efficacy of Condoms⁴⁰

Central to most sex education curricula is a reliance on condoms to prevent pregnancy and infection. Prior to reviewing how ‘safe sex’ is promoted to New Zealand youth, the limitations of this public health strategy must be understood.

In the 1980’s, groups at high risk for HIV were strongly advised to use condoms. Because the virus is larger than the diameter of latex pores, condoms were, and still are, considered a barrier to HIV transmission, at least under laboratory conditions. Sexual intercourse with a condom came to be known as ‘safe sex’. Since the device also acts as



The awareness of this risk, along with communication skills, may help her begin saying “no”.

A girl who has just begun having sex is more vulnerable than she was as a virgin, at least to the cancer-causing potential of HPV.

37 “Know Your Body.” <http://www.iwannaknow.org/teens/sexualhealth/know.html>

38 Jordan, Singer, Jones, and Shafi, eds. *The Cervix*, 91.

39 R.L. Winer, “Risk of female human papillomavirus acquisition associated with first male sex partner,” *Journal of Infectious Disease* 197, no. 2 (January 15, 2008): 279-82.

40 This and the following section taken in part from Grossman, Miriam. *New York City Sexuality Education Report*. August 2011. http://www.miriamgrossmanmd.com/wp-content/uploads/2012/11/sex_ed_report.pdf.

a contraceptive, people could, in theory, avoid both HIV and pregnancy with its use. The notion of 'safe sex' was expanded and institutionalised in the years that followed. The original idea – promoting condoms to prevent HIV among homosexuals, intravenous drug users, and their sexual partners – grew to include prevention of all sexually transmitted infections, as well as pregnancy, among all sexually active people, including adolescents.

The following decade brought epidemics of both herpes and HPV, and it became clear that practicing 'safe sex' was sometimes not so safe. Health practitioners began using the term 'safer sex' instead. But, whether 'safe' or just 'safer', the '80s paradigm – reliance on condoms to avoid pregnancy, STIs, and HIV – was entrenched in medical practice, public health, and sex education.

Now, almost thirty years after the introduction of the 'safe sex' strategy, we know much more about the efficacy of condoms in preventing pregnancy and sexually transmitted infections. We know that the efficacy is less, in some cases dramatically so, than was assumed.

That's why every health provider has seen patients facing a pregnancy or STI who insist, "but we used a condom, every time".

Are young people made aware of the limited efficacy of condoms?

From the **Family Planning** pamphlet "**Sexually Transmitted Infections**":
"These [condoms] are great at helping to protect you from STIs."⁴¹

From the **Family Planning** pamphlet "**Condoms**":
"Used correctly, condoms are up to 98% effective."⁴²

From the **Family Planning** pamphlet "**Your Choice**":
"If used correctly every time, condoms are 90-98% effective. They are easy to use, easy to carry, your best protection against STIs and come in many different sizes, colours, flavours, and textures for extra stimulation! Cheapest from the doctor, Family Planning or Sexual Health Clinic where you can get heaps for \$3!"⁴³

From **iwannaknow.org**:
"Latex condoms work really well in stopping most sexually transmitted infections (STIs) from being passed from an infected partner to another..."⁴⁴

While it's accurate to say condoms help prevent pregnancy and STIs, it's prudent to ask, how much do they help? These are serious health issues, and a false sense of security may lead to high risk behaviours.

Hard Data, Hard Truths

Any discussion of condom efficacy must underscore that prevention of pregnancy and prevention of infections are two separate issues. The materials reviewed fail to do so.

The 98% effectiveness cited in the **Family Planning** pamphlet refers to pregnancy prevention only. While it could be argued that the 2% failure rate (or 98%

Condoms were, and still are, considered a barrier to HIV transmission, at least under laboratory conditions.

It became clear that practicing 'safe sex' was sometimes not so safe. Health practitioners began using the term 'safer sex' instead.

We know that the efficacy is less, in some cases dramatically so, than was assumed.

Safe vs. safer sex?

No contraceptive is 100% safe, and most do not protect from STIs. For that reason we use the term 'safer sex' to reinforce that there are things you can do to minimise the risk of pregnancy, and infection.

DOUBLE WHAMMY!

Condoms (plus lube) - CONTRACEPTION AND STI PROTECTION. If used correctly every time, condoms are 90-98% effective. They are easy to use, easy to carry, your best protection against STIs and come in many different sizes, colours, flavours and textures for extra stimulation! Cheapest from the doctor, Family Planning or Sexual Health Clinic where you can get heaps for \$3!

"Your Choice" pamphlet

41 http://www.familyplanning.org.nz/Portals/5/Resource%20Shop/PDFs/Pamphlets/FP_Youth_STI-June2011.pdf

42 http://www.familyplanning.org.nz/Portals/5/Resource%20Shop/PDFs/Pamphlets/FP_Youth_Con-dom-June2011.pdf

43 Your choice http://www.familyplanning.org.nz/Portals/5/Resource%20Shop/PDFs/Booklets/FP_YourChoice-2009-lowres.pdf

44 <http://www.iwannaknow.org/teens/sti/condoms.html>

effectiveness) is very close to 100% effectiveness, the number is based on studies of adult couples with 'perfect use' – meaning correct use of condoms, every time. Much more common is 'typical use' – the device is not worn for every act, and occasionally it's used incorrectly. With 'typical use' by adults, studies show pregnancy prevention falls to 85%.⁴⁵

These rates are quoted by the manufacturers of Durex condoms, as found in the instruction pamphlet in the condom package.⁴⁶ Taking into account their immaturity, use of alcohol before sex, and other factors, teens' typical use of condoms could be expected to prevent pregnancy at a much lower rate.

Of interest is a study of over 10,000 women who had abortions; 54% reported having used contraception.⁴⁷ The male condom was the most commonly reported method. 42% of condom users cited condom breakage or slippage as the reason for pregnancy. Other research on contraceptives demonstrated a probability of condom failure that was only one percentage point lower than probability of failure for withdrawal.⁴⁸ This is information teens desperately need. Yet like so much critical data, it is omitted from sexuality education.

Condoms and HIV

As noted, the latex from which condoms are made is impermeable to HIV. Transmission of the virus through the intact membrane is impossible – condoms confer 100% protection in the laboratory.

In real life, however, conditions are different.

Putting aside the question of how feasible it is to rely on an adolescent's perfect condom use, even when used perfectly, condoms can be defective. They can slip and break; semen can escape around the edges. Frequently used terms like 'very effective', 'good protection', and 'helpful' mean different things to different people, causing further confusion.

Quantitative estimates of condom efficacy in preventing HIV transmission have been available for over a decade. Studies were done of couples in which one person was HIV positive and the other was HIV negative. Compared to the couples who never used a condom, there was an 80% reduction in HIV transmission between the couples who always used a condom.⁴⁹ Therefore, the current state of scientific research indicates that when used correctly for each act of vaginal intercourse, condoms reduce the transmission of HIV by 80%.

It is alarming indeed, that not one of the resources reviewed for this analysis included this data. Instead, they lead adolescents to believe that HIV is transmitted only during 'unprotected' intercourse. With this reassurance, trusted authorities give students a green light to have sex, even with an HIV-positive partner, so long as a condom is used. This is an egregious display of irresponsibility, and further evidence that the priority of sexuality education is sexual licence, not sexual health.

Condoms - As Effective as Abstinence?

What's missing is a quantitative assessment of how well condoms prevent the transmission of herpes, HPV, syphilis, chlamydia, or gonorrhea. This is a notable

A false sense of security can lead students to take risks.

The number is based on studies of adult couples with 'perfect use'. Much more common is 'typical use'.



This is information teens desperately need. Yet like so much critical data, it is omitted from sexuality education.

45 Trussel, James. "Contraceptive Failure in the US." *Contraception* 70.2 (2004): 89-96. Print.

46 Durex Pleasure Pack [package insert]. Norcross, GA. Durex Consumer Products, Inc.

47 Jones, RK et al. "Contraceptive Use Among US Women Having Abortions in 2000-2001." *Perspective on Sexual and Reproductive Health* 34.6 (2002): 294-303. Print.

48 Kost, K. et al. "Estimates of Contraceptive Failure from the 2002 National Survey of Family Growth." *Contraception* 77 (2008): 10-21. Print.

49 Weller, D.C. and K. Davis-Beatty. "Condom effectiveness in reducing heterosexual HIV transmission." *Family Planning Perspectives* 36.1 (1999): 272-79. Print.

disservice, as these organisms – particularly herpes and HPV – are highly prevalent and can cause serious physical and emotional harm.

While there is no doubt that proper use of condoms prevents some infections to some degree, research demonstrates levels of protection that many people would consider unacceptable. It is not a simple matter to quantify the amount of protection that condoms confer from transmission of infection; nonetheless, the following data have been reported in authoritative, peer-reviewed journals:

- Herpes: 30% lower risk.⁵⁰
- HPV: 50-70%⁵¹ lower risk; but some studies have shown no protective effect associated with condom use for women.⁵²
- Chlamydia and gonorrhea: 50% lower risk.⁵³
- Syphilis: 50% reduction.⁵⁴

Adolescents should be given these numbers – and be told that these are conservative estimates. Instead of providing a false sense of security, with reassurances such as *"using condoms consistently and correctly can really reduce the risk of getting HPV"*,⁵⁵ educators and health providers should encourage teens to strive toward the ideal: when two people postpone sexual activity until adulthood, and stay in committed, faithful relationship. After all, that's what we do in every other field of health - promote an ideal, regardless of how difficult it may be to achieve. Eat lots of fresh fruit and vegetables. Keep fats and sugars to a minimum. Make sure you exercise, and for heaven's sake, don't ever smoke!

Why is sexual health any different? There is an ideal behavioural choice in this area too, and the closer adolescents can get to it, the better.

*Condoms and Anal Sex*⁵⁶

Adolescents are introduced to three types of intercourse (vaginal, anal, and oral), but without adequate explanation of the associated medical risks.

Returning to the research indicating that condoms reduce the transmission of HIV by 80%, note that that data refers to when condoms are used correctly for every act of *vaginal intercourse*.

Aside from a small number of studies, there is no body of data that suggests a statistically significant reduction of HIV transmission with condom use during anal intercourse. Nearly all the data about condom protection refers to vaginal intercourse alone.

Terms like 'very effective', 'good protection', and 'helpful' mean different things to different people.

Trusted authorities give students a green light to have sex, even with an HIV-positive partner, so long as a condom is used. This is an egregious display of irresponsibility.

50 Emily T. Martin, et al. "A Pooled Analysis of the Effect of Condoms in Preventing HSV-2 Acquisition." *Archives of Internal Medicine* 169.13 (2009): 1233-1240. Print.

51 Vaccarella, Salvatore et al. "Sexual behavior, condom use, and human papillomavirus: pooled analysis of the IARC human papillomavirus prevalence surveys." *Cancer Epidemiology, Biomarkers & Prevention* 15.2 (2006): 326-33. Print.; "Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention." National Institute of Allergy and Infectious Diseases, National Institutes of Health. 20 July 2001. Web. 21 November 2006. <<http://www.niaid.nih.gov/did/stds/condomreport.pdf>>; Manhart, LE and LA Koutsky. "Do condoms prevent genital HPV infection, external genital warts, or cervical neoplasia? A meta-analysis." *Sex Transmitted Disease* 29.11(2002): 725-735. Print.; Winer, RL, JP Hughes, Q Feng, ET al. "Condom use and the risk of genital human papillomavirus infection in young women." *New England Journal of Medicine* 354.25 (2006): 2645-2654. Print.

52 Winer, Rachel L. et al., op. cit.

53 Baeten, J.M., P.M. Nyange, B.A. Richardson, et al. "Hormonal contraception and risk of sexually transmitted diseases acquisition: Results from a prospective study." *American Journal of Obstetrics and Gynecology* 185.2 (2001): 380-385.

54 Ahmed, S., T. Lital, M.Wawe, et al. "HIV incidence and sexually transmitted diseases prevalence associated with condom use: a population study in Rukai, Uganda." *AIDS* 15.16 (2001): 2171-2179. print. National Institute of Allergy and Infectious Diseases. "Workshop summary: Evidence on Condom Effectiveness for Sexually Transmitted Prevention." Bethesda, MD: National Institute of Allergy and Infectious Disease. 2001. Print.

55 <http://www.iwannaknow.org/teens/sti/hpv.html>

56 Grossman, Miriam. *New York City Sexuality Education Report*. August 2011. Pgs. 24-25.

Adolescents are introduced to three types of intercourse (vaginal, anal, and oral), but without adequate explanation of the associated medical risks.

The importance of this point cannot be overstated. While intuitively one would expect condom use to decrease transmission of HIV during anal intercourse, the studies to support this have not been done.

In 2005, over 270 physicians concerned about sex education in Montgomery County, Maryland signed a petition for the Board of Education that stated:

"...We the undersigned recognize that anal intercourse (A/I) is a particularly high risk sexual practice and it is associated with the highest risk of HIV infection. We further recognize that although there is strong evidence that condom use generally reduces sexual transmission of HIV, solid data showing the effectiveness of currently available condoms during A/I, a particularly high-risk sexual practice, still are lacking.

"As physicians, we are concerned for the health of the students and recommend that...students [be warned] of the risks of anal intercourse and of the risks of condom failure during anal intercourse."⁵⁷

Many adolescents do not recognize anal intercourse as risky; one study on urban minority females indicated 41% engaged in anal sex to avoid pregnancy and 20% thought HIV could not be transmitted through anal sex;⁵⁸ some don't even consider anal sex 'sex'.⁵⁹

Is there reason to believe that condoms are more likely to fail during anal intercourse? Yes.⁶⁰ In the United States, this likelihood is acknowledged by the government body responsible for the safety and efficacy of medical devices. On the Food and Drug Administration's website, the question is posed, "are condoms strong enough for anal intercourse?" The answer:

"The Surgeon General (C. Everett Koop, Surgeon General 1982-1989) has said, 'Condoms provide some protection, but anal intercourse is simply too dangerous to practice.'

"Condoms may be more likely to break during anal intercourse than during other types of sex because the greater amount of friction and other stresses involved. Even if the condom doesn't break, anal intercourse is very risky because it can cause tissue in the rectum to tear and bleed. These tears allow disease germs to pass more easily from one partner to the other."⁶¹

Companies that manufacture condoms warn consumers about these dangers. Package inserts for Durex condoms caution users that "non-vaginal use of condoms can increase the potential for them to slip off or be damaged."⁶² The following statement is found on boxes of LifeStyles brand condoms, under the heading "Effectiveness": "Condoms are primarily intended for use in vaginal intercourse; other uses can increase the potential for breakage."⁶³ In Europe and the United Kingdom, concern about condom failure during anal intercourse led to the design of a sturdier version of the device, marketed specific to this use.⁶⁴

All the publications and resources reviewed in this analysis fail to adequately alert the student to the well-established dangers of anal intercourse, with or without a condom.

At least two sites, getiton.org.nz and the old curious.org.nz, actually celebrate this high risk behavior.

Condoms provide some protection, but anal intercourse is simply too dangerous to practice.



All the publications and resources reviewed in this analysis fail to adequately alert the student to the well-established dangers of anal intercourse.

57 <http://www.mcpscurriculum.com/PDF/Ruthanalsexpetition.pdf>

58 Boekeloo, Bradley O. and Donna E. Howard. "Oral Sexual Experience Among Young Adolescents Receiving General Health Examinations." *American Journal of Health Behavior* 26.4 (2002): 306-314. Print.

59 Sanders, Stephanie A. and June Machover Reinisch. "Would You Say You 'Had Sex' If...?" *JAMA* 281.3 (1999): 275-277. Print.; Rawlings, M. Keith et al. "Differences in Perceptions of What Constitutes Having 'Had Sex' in a Population of People Living with HIV/AIDS." *JAMA* 98.6 (2006): 845-850. Print.

60 Silverman, Barbara G. and Thomas P. Gross. "Use and Effectiveness of Condoms During Anal Intercourse: A Review." *Sexually Transmitted Diseases*. 24.1 (1997): 11-17. Print.

61 "Condoms and Sexually Transmitted Diseases: Brochure." US Food and Drug Administration. US Department of Health and Human Services. 22 July 2010. Web. <<http://www.fda.gov/ForConsumers/ByAudience/ForPatientAdvocates/HIVandAIDSActivities/ucm126372.htm#strong>>

62 Durex Pleasure Pack [package insert]. Norcross, GA. Durex Consumer Products, Inc.

63 LifeStyles SKYN [package]. Dothan, AL: Ansell Healthcare Products LLC. 2011.

64 Silverman, B.G., et al, op. cit.

V. High Risk Behaviours⁶⁵

Why is it easier to transmit HIV during anal intercourse? It's due to the anatomical and physiological differences between the vagina and the rectum.

The rectal lining is only one cell thick,⁶⁶ and there is no elastic or natural lubrication.⁶⁷ As a result, it's not unusual for the lining to tear and bleed, allowing HIV to enter the body. The pH is higher (a condition that is friendlier to HIV),⁶⁸ and M-cells are abundant.⁶⁹

In contrast, protective factors are built in to the vagina;⁷⁰ one of the functions of the vaginal lining, in fact, is protection from infection.⁷¹ The lining is 20-45 cells thick,⁷² elastic tissue is abundant and allows for stretching, there is natural lubrication and a low pH that inactivates HIV.⁷³ Moreover, vaginal mucus has anti-HIV proteins.⁷⁴ There are no M-cells in the vagina, but Langerhans cells in the cervix may have the ability to destroy the virus.⁷⁵ These are all indisputable biological truths that are not open to debate.

Vulnerable Minorities

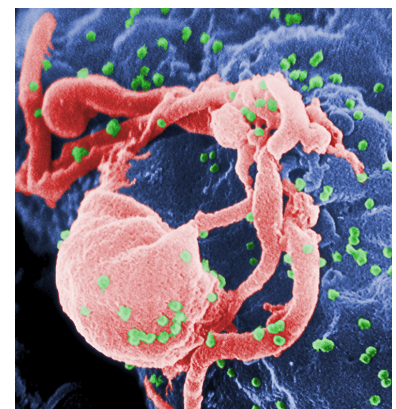
Sex with Attitude notes, "In the Youth 2007 survey, 4.2% of secondary school students in New Zealand reported being same-sex attracted or both-sex attracted."⁷⁶

These young people are particularly vulnerable to STI's, including HIV. They must be warned. If resources like iwannaknow.org, curious.org.nz, and **Sex with Attitude** don't do it, who will?

Men who have sex with men (MSM) have a high prevalence of sexually transmitted infections, including HIV. This is related to the risk behaviours that characterise this group: early age of sexual debut, high numbers of sexual partners, concurrent partnerships, higher likelihood of using the internet to recruit partners, and infrequent condom use.⁷⁷

How much higher is the prevalence? In the US, the rate of new HIV diagnoses among MSM is 44 times that of other men and more than 40 times that of women. Their rate of primary and secondary syphilis is more than 46 times that of other men and more than 71 times that of women.⁷⁸

Men who have sex with men (MSM) have a high prevalence of sexually transmitted infections, including HIV.



65 Grossman, Miriam. New York City Sexuality Education Report. August 2011. Pgs. 18-19.

66 Sternberg, S.S. ed. *Histology for Pathologists*. 2nd edition. Lippincott Williams & Wilkins, 1997.

67 Sherwood, L. *Human Physiology: From Cells to Systems*. 7th ed. Brooks, Cole, 2008.

68 Voeller, B. and DJ Anderson. Letter. *Journal of the American Medical Association* 267 (2003): 1917-18. (from Brody, Stuart. *Sex at Risk*. Transaction Publishers, 1997. 216. Print.)

69 O'Leary, A.D. and E.C. Sweeney. "Lymphoglandular Complexes of the Colon: Structure and Distribution." *Histopathology* 10 (1986): 267-83.

70 Junqueira, Luis Carolos and Jose Carneiro. *Basic Histology: Text and Atlas*. 10th ed. Lange Medical Books McGraw-Hill, 2003.; Belec, L. et al. "Cervicovaginal overproduction of specific IgG to human immunodeficiency virus (HIV) contrasts with normal or impaired IgA local response in HIV infection." *Journal of Infectious Diseases* 172.3 (1995): 691-7.; Levy, J.A. "The transmission of HIV and factors influencing progression to AIDS." *American Journal of Medicine* 95.1 (1993): 86-100.

71 Greenhead, Peter et al. "Parameters of Human Immunodeficiency Virus Infection of Cervical Tissue and Inhibition by Vaginal Virucides." *Journal of Virology*. (2000): 5577-5586. Print.

72 Robboy, S.J., M. Prade and G. Cunha. *Histology and Pathologists*. Ed. S.S. Sternberg. New York: Raven Press, 1992. 881-892. Print.

73 Voeler, B., op.cit.

74 Moriyama, A. Et al. "Secretory leukocyte protease inhibitor concentrations in cervical mucus of women with normal menstrual cycle." *Molecular human Reproduction* 5.7 (1999) 656-61. Print.

75 Lot de Witte, et al. "Langerin is a natural barrier to HIV-1 transmission by Langerhans cells." *Nature Medicine* 13.3 (2007) 367-371. Print.

76 *Sex with Attitude*. Pg. 14.

77 Levin, EM et al. "Characteristics of Men Who Have Sex With Men and Women and Women Who Have Sex With Women and Men: Results from the 2003 Seattle Sex Survey." *Sexually Transmitted Diseases* 36.9 (2009): 541-546.

78 "CDC Analysis Provides New Look at Disproportionate Impact of HIV and Syphilis Among U.S.

Men who have sex with men and with women (MSM/W) – also called bisexuals – are also a vulnerable minority. Again, this is due to their high risk behaviors: high numbers of partners, more casual partners, higher likelihood of using the internet to find partners, and less condom use.⁷⁹

Research at the University of Otago revealed that the number of gay and bisexual men diagnosed with HIV from 1999 to 2009, the decade following the widespread introduction of subsidised anti-retroviral drugs (ARVs), increased by 137 per cent.⁸⁰

Adolescents and young adults should be taught that MSM/W bridges two populations: MSM, a group with a high prevalence of STDs, and heterosexual females, a group with a lower prevalence of STDs.⁸¹ Therefore when a female has sex with a MSM/W, she is at increased risk of acquiring a STD, compared to a sexual encounter with a man who is virginal or has sex only with women (MSW). Similarly, when a man has sex with a WSM/W, he is at higher risk of acquiring an infection compared to an encounter with a woman who only has sex with only MSW.

Critical to adolescent welfare and ability to make informed choices about their sexual behaviour is the fact that people often lie about past behaviours⁸² and HIV status. This occurs with greater frequency than people, especially young people, may imagine, and it occurs with higher frequency among MSM and MSM/W. For example, between 33% and 75% of MSM/W do not disclose to female partners that they have sex with men.⁸³ These women cannot make an accurate assessment of the risks posed by a sexual encounter.

More alarming is when people do not disclose when they are HIV positive. A 2003 survey of individuals found that 42% of those who were MSM or MSM/W reported having sex without disclosure of their status.⁸⁴ The rate of non-disclosure is lower among those who identify as heterosexuals, but it is still high.⁸⁵ Sex education curricula encourage young people to communicate with their partners,⁸⁶ but they must also emphasise to students that people lie about their sexual histories.

Anal Sex

In the previous section, we highlighted the overstated effectiveness of condoms – particularly in relation to anal sex. Adding to the danger is the indisputable fact that anal intercourse itself is significantly more dangerous than vaginal intercourse for transmission of HIV.⁸⁷ For anatomical and physiological reasons, receptive anal intercourse has been estimated to be about thirty times riskier than receptive vaginal intercourse.

In 2010, New York City's Department of Health announced that "*women who have*

Critical to adolescent welfare and ability to make informed choices about their sexual behavior is the fact that people often lie about past behaviours and HIV status.



Gay and Bisexual Men." Center for Disease and Control Prevention. 10 March 2010. Web. 21 May 2011. <<http://www.cdc.gov/nchhstp/Newsroom/msmpressrelease.html>>

79 Levin, EM et al. "Characteristics of Men Who Have Sex With Men and Women Who Have Sex With Women and Men: Results from the 2003 Seattle Sex Survey." *Sexually Transmitted Diseases* 36.9 (2009): 541-546.

80 *International Journal of STD and AIDS* (May 2012)

81 *Ibid.*

82 Potterat, JJ, L. Philips, J.B. Muth. "Lying to military physicians about risk factors for HIV infections." *JAMA* 257 (1987): 1727. Print.

83 Kalichman, S.C. et al. "Risk for HIV infection among bisexual men seeking HIV-prevention services and risked posed to their female partners." *Health Psychology* 17 (1998): 320-327. Print.; McKirnan, D.L. et al. "Bisexually active men—Social characteristics and sexual behavior." *J Sex Res* 32 (1995): 65-76. Print.

84 Levin EM et al., (2009), op. cit.

85 Ciccarone, D.H. et al. "Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infection." *American Journal of Public Health* 93 (2003): 949-954. Print.

86 Barth, Richard P. *Reducing the Risk: Building Skills to Prevent Pregnancy, STD & HIV*, op. cit., p. 53-97.

87 Golombok, S., J. Sheldon. "Evaluation of a thicker condom for use as prophylactic against HIV transmission." *AIDS Education and Prevention* 6.5 (1994): 454-8. Print.

unprotected anal sex with an HIV-infected man even one time are about 30 times more likely to get HIV than if they had unprotected vaginal sex once.”⁸⁸ Obviously, the same elevated danger exists when the receptive individual is male.

When asked about anal intercourse, this is how one expert, the Director of STD/AIDS Programmes in Colorado Springs for thirty years, and author of over two hundred scholarly publications put it:⁸⁹

“The anus is an exit, not an entrance. This is not the Bible; this is science. Unlike the vagina, nature put a tight sphincter at the entrance of the anus. It’s there for a reason: keep out!”

Instead of Warnings, Risky Behaviours are Promoted

The mission of **curious.org.nz** is “to support the queer and trans youth of Aotearoa and New Zealand.”⁹⁰

One would therefore expect the site to be packed with health alerts for those vulnerable groups, but it has not a single warning. Young people who turn to this site for guidance remain ignorant of hazardous behaviours that endanger their lives. Instead, **Curious.org.nz** promotes social events such as “Get it On! Big Gay Out”⁹¹ sponsored by **getiton.org.nz**.

Similarly, **rainbowyouth.org.nz**, which runs **curious.org.nz**, does not list any medical data or warnings for youth who identify as MSM or MSM/W. The organisation’s site has a page called “**Keeping Safe**”,⁹² but the content is not related to health. It’s a guide to meeting other members of the ‘queer’ community, and includes a list of support groups, including one for minors. The page provides valid recommendations for making new contacts, including suggestions to meet during the day in a public place, tell someone where you are going, make sure you have a way to get home, and so on. While this information may help young people feel less isolated, it also likely facilitates sexual encounters that place their lives at risk.

Receptive anal intercourse has been estimated to be about thirty times riskier than receptive vaginal intercourse.



The anus is an exit, not an entrance. This is not the Bible; this is science.

“Your Choice” pamphlet

88 Baggaley, Rebecca F. et al. “HIV transmission risk through anal intercourse: systematic review, meta-analysis and implications for HIV prevention.” *International Journal Epidemiology* 39.4 (2010): 1048-1063. Print.

89 <http://home.earthlink.net/~jjpotterat/publications.html>

90 Curious. <http://curious.org.nz/>

91 “Meeting People” <http://curious.org.nz/uncategorized/meeting-people/>

92 “Keeping Safe.” <http://www.rainbowyouth.org.nz/queer-youth/keeping-safe/>

Lastly – and perhaps most shocking – are the resources recommended to students. For example, iwannaknow.org refers young people to the website goaskalice.com, a creation of Columbia University in the United States. While ‘Alice’ has a lot of solid, helpful health information, the reader is urged to visit a Q&A category called “Sexual and Reproductive Health”. A sampling:

[WARNING: offensive material]

- **What is Rimming?**

“Our bodies contain a rainbow of pleasure potential. Even seemingly unlikely body parts can be intense pleasure centers when fully aroused. Rimming... refers to making oral-anal contact. While sometimes a precursor to anal sex, rimming is a form of stimulation that can be its own means to an erotic end.”⁹³

- **What is S/M roleplaying?**

“...S/M... stands for sado-masochism...S/M may include any of the following, depending on the likes and dislikes of the people involved:

Bondage and restraint. Many people find bondage to be a blast. Why? For the bottom, giving over control by being tied up is a total turn-on. For the top, the act of tying up and/or over-powering their partner is the turn-on. Partners may use rope, cuffs (made of nylon, leather, or rubber), scarves, handcuffs, handkerchiefs, or any variety of material.

Flogging, whipping, paddling. For players who enjoy giving and/or receiving pain, there are a tremendous variety of tools and tricks to try....”⁹⁴

- **Ben Wa balls: Do they work and are they pleasurable?⁹⁵**

There is no lack of other disturbing examples. The point is that this site is a ‘how-to’ manual on behaviours most parents wouldn’t want their children to know about, let alone practice. So why direct young people to this site? Why make information of this type available to them? What does any of this have to do with remaining free of disease?

These are questions that must be asked, and answered.

VI. Whitewashing the Dangers of Sexually Transmitted Infections

Chlamydia

Chlamydia is one of the most common sexually transmitted bacteria. It can inflict serious damage on a young woman’s reproductive system, and can result in infertility. According to New Zealand’s Institute of Environmental Science and Research (ESR): “*Chlamydia was the most commonly reported STI in 2011 in both the laboratory and clinic settings. A national estimated chlamydia rate (based on 15 DHBs) of 786 per 100 000 population was calculated from laboratory surveillance data. Over 70% of cases reported through laboratory surveillance data were aged between 15 and 24 years.*”⁹⁶

Teens are taught that chlamydia can damage the reproductive organs, but only if untreated. They are reassured that the infection is easily cured with antibiotics.

This site is a ‘how-to’ manual on behaviours most parents wouldn’t want their children to know about, let alone practice.

Teens are taught that chlamydia can damage the reproductive organs, but only if untreated.

93 “What’s Rimming?” <http://goaskalice.columbia.edu/whats-rimming>.

94 <http://goaskalice.columbia.edu/sm-roleplaying>

95 <http://goaskalice.columbia.edu/ben-wa-balls-do-what>

96 “Sexually Transmitted Diseases in New Zealand in 2011.” Institute of Environmental Science and Research. http://surv.esr.cri.nz/PDF_surveillance/STISurvRpt/2011/2011AnnualSTIRpt.pdf. Pg. 3

From iwannaknow.org:

- **"Is there a cure for chlamydia?"**
Yes! Luckily, chlamydia can be cured with antibiotics."
- **"How do I find out if I have chlamydia?"**
Once you start having sex, make sure you ask your healthcare provider to test you for chlamydia at least once a year. A simple test using urine or a swab from the infected area can determine if you or any of your partners have chlamydia."⁹⁷

Family Planning⁹⁸ and **theword.org.nz**⁹⁹ give students the same misinformation.

Unfortunately, it's not so simple. If the damage is done before antibiotics are given, it cannot be reversed.

How long does it take for chlamydia to damage a woman's reproductive system? Unfortunately, we don't know. In fact, being tested for STDs once, or even twice a year, may not suffice¹⁰⁰ and treatment with antibiotics is not always a cure.¹⁰¹

Chlamydia infection is complex and there are many unknowns. Giving young people false reassurances is inaccurate and unethical."¹⁰²

Emotional Consequences

Sexuality educators do not describe the complex psychological issues that often follow the diagnosis of a sexually transmitted infection. Research indicates, however, that they can be substantial, especially when the infection is with an incurable virus such as HPV or herpes.

In a US study, nearly half of people with genital warts reported an adverse effect on their overall emotional state.¹⁰³ Research from New Zealand showed seventy-five percent of patients experienced depression and anger following their HPV diagnosis, and for one-third of these, the feelings persisted for years.¹⁰⁴ Other research indicates that episodic outbreaks of herpes – most people have at least three to four outbreaks per year – can cause people to feel less sexually desirable, and reduce their enjoyment and frequency of sexual contact. It can cause a 'major negative impact on quality of life', greater than the impact of asthma or rheumatoid arthritis.¹⁰⁵

While the research is telling, there's also powerful anecdotal evidence. Take for example the handles people chose when they join STD support sites: *HatingMyself*, *worried guy*, *verysad*, *givinguphope*, *scaredzdeath*, *help-me18*, *tryingtobestrong*, *extraordinarilystressed*, *omg*, *tiredofthiscrap*, *FreakedAboutWarts*, *feelinscrewed*, *PrayingForACure*.¹⁰⁶ These made-up names express the anxiety, anger, and hopelessness some individuals with sexually transmitted infections experience.

Young people deserve to know.

Sexuality educators do not describe the complex psychological issues that often follow the diagnosis of a sexually transmitted infection.

97 "Chlamydia" <http://www.iwannaknow.org/teens/sti/chlamydia.html>

98 <http://www.familyplanning.org.nz/LinkClick.aspx?fileticket=EFQjNXahwiw%3d&tabid=930>

99 <http://www.theword.org.nz/site/elaboration/faq>

100 Witkin, Steven et al. "Unsuspected Chlamydia trachomatis infection and in vitro-fertilization outcome." *American Journal of Obstetrics and Gynecology*. 171.5 (1994): 1213

101 Debattista, Joseph et al. "Immunopathogenesis of Chlamydia trachomatis infections in women." *Fertility and Sterility*. 79.6 (2003): 1273-87.

102 Grossman, Miriam. *New York City Sexuality Education Report*. August 2011. http://www.miriam-grossmanmd.com/wp-content/uploads/2012/11/sex_ed_report.pdf. Pg. 26.

103 Michael Reitano, "Counseling Patients with Genital Warts," *American Journal of Medicine* 102, 5A (1997): 38-43.

104 H.M. Conagelen, R. Hughes, J.V. Conaglen, J. Morgan, "A prospective study of the psychological impact on patients of first diagnosis of human papillomavirus," *International Journal of STD & AIDS*, 12 (2001): 651-58.

105 R. Patel et al, "Patients' perspectives on the burden of recurrent genital herpes," *International Journal of STD & AIDS* (2001): 640-45.

106 Miriam Grossman, *You're Teaching My Child What?* Washington, D.C.: Regnery Publishing, 2009. Pg. 106.

Giving young people false reassurances is inaccurate and unethical.

VII: Conclusion and Recommendations

It is our conclusion that the sexuality education programmes that have been reviewed are seriously flawed, with both sins of commission, and sins of omission.

The information is not accurate, comprehensive, or up-to-date. Sex is seen as risky only when it's 'unprotected'. The efficacy of condoms is overstated, in some cases vastly so. The quantitative data about their use is absent. The vulnerability of the immature cervix and the hazards of anal intercourse are omitted. Chlamydia is incorrectly described as 'easily cured'. Young people are led to believe that sex is easily divorced from emotional attachment. Worst of all, critical life and death information is distorted or ignored.

Students are left misinformed, and with a false sense of security. Surely this is the last thing we want.

We cannot expect teens to delay sexual activity while instructing them, "*only you know when you're ready*". It is the nature of adolescence to feel 'ready' for just about anything.

Is every young person going to postpone sex? Of course not.

But we are still obligated to inform them of the grave risks they face, to teach them biological truths about their physical and emotional vulnerabilities, to warn them in a no-nonsense manner about avoiding high risk behaviours, and to encourage the highest standard.

That is what we do in every other area of healthcare. But when it comes to sexuality, kids are being taught they can play with fire – and the waiting rooms of doctors and therapists are filled with people who've been burned, inside and out.

The approach to teen sex upon which these programmes are based can harm children. We need, instead, a different model for sex education in the 21st century. This model should have one goal: to keep young people out of the offices of doctors and therapists and to keep students free from unnecessary physical and emotional distress.

It will require straight talk with all the sobering facts. *We are fighting a war against a horde of bugs, we should explain to students, and the bugs are winning. Sure, sex is great, but it's an appetite, and just like all appetites, it must be restrained. You have urges, and they are healthy urges – but it is not healthy for you to act on them, not at this time in your lives.*

We must make teens understand that sex is a very serious matter and that a single encounter can change their lives forever. Our message must be consistent and firm: the only responsible choice is to delay sexual behaviour until adulthood. We must provide students with an ideal to strive for, one that offers them the healthiest option physically and emotionally. The healthiest ideal is to postpone sexual activity until adulthood and, ideally, until marriage.

Of course, students must be told it's not easily achieved. Reaching that ideal isn't easy, of course, and this fact should be acknowledged. But just as in other areas of education, where the ideal is presented as the point of excellence towards which we encourage young people to strive, the same holds true with our sexual activity and choices. Keeping the ideal in front of young people and supporting them in achieving it should be the first priority of sexual education programmes.

Adolescents look to adults for authoritative guidance. It is our responsibility to do precisely that – guide them with authority, firm rules, and high expectations. That is not accomplished by telling them "*only you know when you're ready*". When we provide that message, we fail young people. When we teach them to rely on latex, we fail again.

The rates of disease and distress are soaring. The stakes are high. Will we respond to the crisis with honesty, authority, and courage? That is the question.

The awareness of this risk, along with communication skills, may help her begin saying "no".

Young people are led to believe that sex is easily divorced from emotional attachment. Worst of all, critical life and death information is distorted or ignored.

We must provide students with an ideal to strive for, one that offers them the healthiest option physically and emotionally.

Appendix 1

What Happens When We Stand Up and Fight: A curious Story

In June 2012, I visited NZ for a week of lectures about the dangers of sexuality education. Two notable things occurred during those days:

1) One of the websites we would be highlighting, and encouraging people to examine, was curious.org.nz. Here's a sampling of the site's troubling content prior to that week:

[WARNING: offensive content – coarse language has been masked]

"Be happy with your a**."

"You have probably been told ... that you're a** is a dirty place and shouldn't be touched.

This is silly. People should be happy with all parts of their bodies.."

"It is true that you get rid of waste out of your anus, but that's not the only thing that it's good for. You p**s out your penis, but you can do more things with your c**k than that."

"Your anus is only dirty when it hasn't been cleaned - just like any other part of your body."

"There are some men who only enjoy being the "top" (doing the f**king), and some men who only enjoy being the bottom (getting f**ked). But most like it both ways. It's good taking turns at being top and bottom."

Curious.org.nz went offline when I arrived in NZ, and stayed offline for six months. In December of 2012, it re-launched with much of the objectionable material removed.

2) While being interviewed on *Newstalk ZB* with Leighton Smith, I challenged the head of **Family Planning** to a debate. Leighton Smith offered an hour on his show any day of the week, and also offered to moderate. There was no response. Similarly, TVNZ's *Close Up* programme tried to get a **Family Planning** representative on their show to debate me – but without success.

These may appear to be minor incidents, but they demonstrate a critical point: in the battle against groups that promote radical social agendas, sometimes all that's needed is to expose their work, and challenge them to a debate, to have them run for cover.

In the battle against groups that promote radical social agendas, sometimes all that's needed is to expose their work, and challenge them to a debate, to have them run for cover.



Dr Grossman with *Newstalk ZB*'s Leighton Smith (25 June 2012)

Appendix 2

An Analysis of Sex with Attitude

Sex with Attitude: A Relationship Handbook is for year 9-13 students attending New Zealand Schools.¹ Most of the advice in the handbook is sound, and shows an authentic concern for the sexual health and well-being of young people.

This appendix will highlight areas of excellence found in **Sex with Attitude**, as we hope it will serve as a model for other groups and resources. It will also highlight a number of misleading statements in need of correction.

Thumbs Up

Unlike most of the resources we examined, **Sex with Attitude** encourages young people to wait until they have found a lifelong partner – ideally in marriage – before having sex. A lifelong commitment, the guide notes, does not just offer happiness, it also ensures health.

In a section titled "**Good Sex Takes Time**", the authors provide sound advice: "*If both you and your partner have waited for marriage before sex, then there is absolutely no risk of any STI or 'ghosts' from the past.*"²



Dr Grossman appears on *Close Up* (25 June 2012)

¹ Sex with Attitude. 2012 Revised Edition.

² Ibid, pg. 40.

Later on, they offer a powerful exhortation:

*"In the 60's there was a big movement towards sexual freedom. Want to know what true sexual freedom really is? It's marriage... By freedom, I mean, it leaves you free from worry. Worrying about STIs, or if you'll still be together tomorrow, or having to grab sex quickly before anyone comes home, or the pressure to perform sexually or being compared to other partners. You are free to just relax and enjoy a lifetime of sexual intimacy and adventure. That's real freedom."*³

Testimonials are provided from a range of individuals who have been married from six months to sixty years, attesting to the joys of marriage and a lifelong commitment to one's sex partner. While other resources consider having multiple partners in adolescence an acceptable option, **Sex with Attitude** is clear: *"Sex outside of marriage is running a big risk, not just with your life but with the life of the children that could result."*⁴

We applaud **Sex with Attitude** for their bold acknowledgement of the many significant benefits of delaying sexual activity, ideally until marriage.

Thumbs Down

Sex with Attitude has a number of medically inaccurate statements about condoms, STIs, and HIV.

One example: the *"best protection against chlamydia is not to have sex or use a condom during sex"*⁵, and the *"best protection against gonorrhea is to use a condom during sex, or not have sex."*⁶

This advice is problematic. It implies that using a condom is as good, or nearly as good, as abstaining from sex altogether. In other words, these materials posit two effective choices to prevent STIs: refraining from sexual activity, and intercourse with a condom. But this is far from accurate. The consistent failure to highlight and reinforce the differences between abstinence, which confers 100% protection, and sex with condoms, is one of the major flaws of all the resources reviewed, including this handbook.

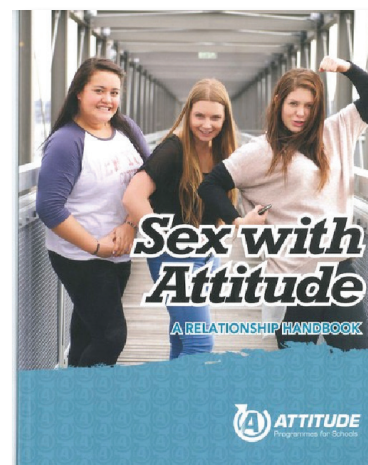
Another example: *"HIV is spread through infected blood, semen, vaginal fluids and sharing needles."*⁷ A reader is likely to assume that the risk of infection is the same, or nearly the same, during various sexual acts and through sharing needles. In truth, the risks are vastly different. HIV is most easily transmitted when intravenous drug abusers share needles, and through receptive anal intercourse. As previously described in our report, anal intercourse is far more dangerous than vaginal intercourse due to anatomic and physiological differences between the rectum and the vagina.

Sex with Attitude should be more direct in stating the risks of condom failure and the dangers of anal intercourse compared to vaginal intercourse. This information is necessary for young people to fully understand biological truths that can have profound health consequences.

Appendix 3

Can You Rely On Family Planning's Latest Advice?

Describing their new pamphlet **"Finding Yourself: A guide for young women**



Sex with Attitude encourages young people to wait until they have found a lifelong partner – ideally in marriage – before having sex.

We applaud Sex with Attitude for their bold acknowledgement of the many significant benefits of delaying sexual activity, ideally until marriage.

³ Ibid.

⁴ Ibid.

⁵ Sex with Attitude. Pg. 47.

⁶ Ibid.

⁷ Sex with Attitude. Pg. 48.

thinking about their sexual identity”, released on 17th May 2013, **Family Planning’s** Director of Health Promotion said, “It is important young women get honest information from a reliable source that supports them to work out who they are.”⁸ Unfortunately, like the many sexuality education resources reviewed here, **Family Planning’s** new pamphlet fails to deliver what it promises.

The problematic advice includes, but is not limited to, the following issues.

While sexual activity between girls is low risk, experimenting with both girls and boys places young women at significant risk for genital infections and HIV. Research indicates a majority of lesbians have also had sex with men.⁹ Young bisexual women have the highest rates of sexually transmitted infections of any group, second only to gay men. ‘Honest information’ for young women would emphasize those facts.

For this reason alone, **Family Planning** should provide girls questioning their sexual orientation with a stern, no-nonsense message of self-restraint. “It’s critical that you delay sexual relationships”, they should say. “Exploring sexual behaviour with both girls and boys can be particularly dangerous.”

But **Family Planning** gives an enthusiastic green light to high risk casual sex; “Hooking up is natural and nothing to be ashamed of.” It should be noted that the term ‘hooking up’ refers to an unplanned sexual encounter between two people who have no plans to meet again. This is precisely the lifestyle health professionals are obligated to advise their patients to avoid.

The pamphlet reassures young women that condoms are “good” for preventing both STI transmission and pregnancy. As already explained in these pages, this is not always the case.

Regarding figuring out their sexual orientation, girls are told, “listen to your feelings”. But no responsible adult would instruct anyone, let alone a teen, to listen to only their feelings regarding other appetites - eating, smoking, or drinking. The appropriate guidance is to advise girls to make important decisions with their heads, not their hearts. One sexual encounter, unlike one cigarette, can change the rest of their lives.

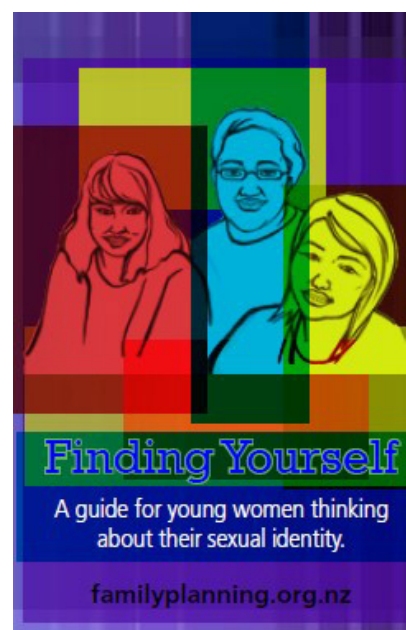
“Lots of young people like people of the same sex”, girls are told. That may or may not be so, but it’s fair to ask how many of those girls go on to identify as lesbian or bisexual as adults?

A recent Gallup poll of women age 18 and older in the US found that only 3.4% identify as lesbian or bisexual.¹⁰ Other research demonstrates that early same-sex attraction in girls does not predict lesbian orientation later in life. Given those findings, **Family Planning** should be telling girls not to reach any conclusions about their desires until they are adults. Instead of “listening to their feelings”, they should wait and see, preferably while abstaining from sexual activity.

The young women targeted by this pamphlet are particularly vulnerable to the negative consequences of casual sex. It is irresponsible for an authority such as **Family Planning** to tell them that “hooking up is natural” and they should listen to their feelings.

The resource fails to provide ‘honest information’, and indicates that **Family Planning** itself is not a reliable source for the young people of New Zealand.

The consistent failure to highlight and reinforce the differences between abstinence, which confers 100% protection, and sex with condoms, is one of the major flaws of all the resources reviewed.



Family Planning gives an enthusiastic green light to high risk casual sex.

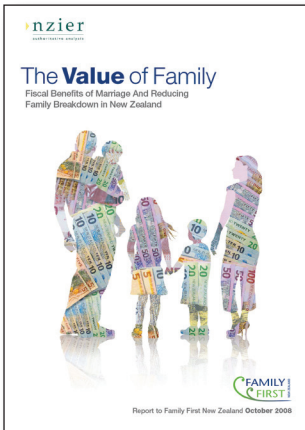
Family Planning itself is not a reliable source for the young people of New Zealand.

8 http://www.gaynz.com/articles/publish/2/article_13350.php

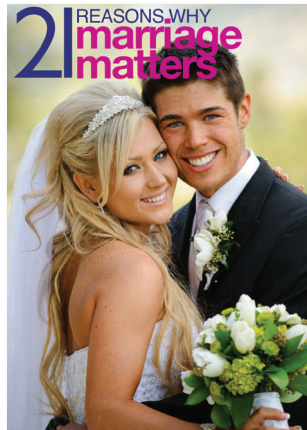
9 Lisa M. Diamond, *Sexual Fluidity: Understanding Women's Love and Desire* (MA: Harvard University Press, 2008)

10 <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf>

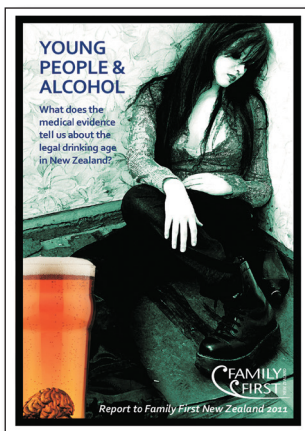
Previously published by Family First NZ



2008



2009



2011



2012

About Family First NZ

Family First NZ is a charitable organisation registered as a Charity with the Charities Commission and was formed in 2006. Its purposes and aims are:

- to promote and advance research and policy regarding family and marriage
- to participate in social analysis and debate surrounding issues relating to and affecting the family
- to produce and publish relevant and stimulating material in newspapers, magazines, and other media relating to issues affecting families
- to be a voice for the family in the media speaking up about issues relating to families that are in the public domain

For more information, go to www.familyfirst.org.nz

For additional copies, please contact Family First NZ:

tel: 09 261 2426

fax: 09 261 2520

email: admin@familyfirst.org.nz

web: www.familyfirst.org.nz

post: PO Box 276-133, Manukau City 2241, New Zealand

