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Sexual Health Education: A Comparison Between Denmark and the United States

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I. Introduction

The topic of sexual health education has been disputed for decades. It involves not only governmental institutions, but parents and guardians, students, religious groups, non-governmental organizations, health care providers, and other sectors. Currently, Denmark requires that sexual health be taught in all of its primary and lower secondary schools, and students' guardians cannot opt out of this aspect of the school curriculum. (1) By comparison, the United States has state-by-state legislation, but no federal law concerning sexual health education. Some states require no sexual health education, while others have an abstinence-only curriculum, and a minority have a comprehensive sex education curriculum. (2) Several states mandate that a parent or guardian be informed that their child is receiving sexual health education, three states require parental or guardian consent, and the majority of states providing sexual health education allow parents or guardians to opt out of sex or human immunodeficiency virus (HIV) education on behalf of their child. (2)

a) Research Questions

Although the United States and Denmark are considered highly developed, progressive countries, they differ considerably with regards to sexual health education. Through a thorough investigation, this paper will address the following questions: How does Denmark compare with the US with regards to sexual health and consent education today? How have attitudes towards sexual health and sexual health education changed over the past century in the two countries? What are the implications for the overall sexual health and wellbeing of young women?

It is important to ask these questions because research shows that comprehensive sexual health education can reduce teen pregnancies, sexually transmitted infections (STIs), and abortion rates among teens. (3) Yet countries like the US are still funding abstinence-only curricula. (4) We must question why the majority of parents in the US want comprehensive sexual health education for their children and yet state legislatures prohibit it. (5) Furthermore, we must consider that young women and girls often suffer the consequences of inadequate or absent sexual health education about contraceptive measures, abortion, and sexual rights. Although people of all genders can be vulnerable, females are most often victims of sexual assault. (6) For this reason, among others, it is important that all students receive proper sexual health education. We must ask our educators why students in some countries of the Global North are given the necessary information to make healthy choices while students in other Global North countries are not.

b) Methods

To answer these questions, I examined several peer-reviewed articles, along with fact sheets from reputable online sources such as the World Health Organization (WHO) and the United Nations Educational, Scientific, and Cultural Organization (UNESCO). I also studied the sexual health curriculum mandated by the Danish Ministry for Education. Because legislation in the US is different for each of the 50 states, I selected New Mexico and Texas for comparison with Denmark. Texas has one of the least comprehensive sexual health curricula, while New Mexico has one of the most comprehensive, (2) which allows us to compare Denmark with both ends of the spectrum of sexual health education in the US. I determined the level of comprehension of the curricula based on the following: whether or not the curriculum taught about contraceptives; taught how to protect oneself against HIV and other STIs; used inclusive language towards the lesbian, gay, bisexual, trans, queer, and asexual community (LGBTQA); stressed abstinence or simply suggested it as a viable option; and finally, stressed sex only within marriage, or highlighted only the negative outcomes of sex. I thus also used Texas and New Mexico legislation on sexual health education as sources.

The remainder of this paper will: define concepts and terms; outline the histories of sexual health and sexual health education in Denmark and the US; summarize current sexual health curricula in Denmark, Texas and New Mexico; comparatively analyze sexual health-related outcomes in Denmark and the US; and examine the impact of the quality of sexual health education on young women and girls.

c) Concepts and Terms

UNESCO describes comprehensive sexual health education as "an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision making, communication and risk reduction skills about many aspects of sexuality." (7, p2) Comprehensive sexual health education is often referred to as abstinence-plus in the US. Abstinence-only education does not provide students with information on contraceptive methods but rather teaches that abstinence or abstinence-until-marriage is the only way to practice a healthy lifestyle and safe sex. (8)

Another term that will be used periodically is ‘consent education’. Consent education involves teaching students about what is defined as a consensual act and what is not. Specifically, I will refer to consensual sexual acts or consensual physical contact. Consent education is often not taught in schools and instead curricula may include lessons on ‘avoiding sexual coercion’. (2, p4) Avoiding sexual coercion is important; however, it focuses on teaching students how to avoid becoming victims. A 2014 study suggests that teaching students how to take action against sexual assault and to avoid being bystanders or perpetrators of sexual violence is a more important lesson to learn as a young adult when attempting to decrease sexual violence. (9)

II. A brief history of sexual health education in Denmark

As early as the start of the 20th century, Danish schools have discussed sexual health, although sexual health education was not mandatory until 1970. (10) The mandated curriculum gave a lot of freedom to teachers, banning only vulgar terminology, pupil counselling, information on how to complete sexual acts, and erotic pornographic images. (10) The general public offered little resistance, although a group of parents took the Danish government to court for making sex education compulsory. However, the Danish government won the case and schools carried on teaching sexual health. (10)

By 1973, abortion on demand was legalized for all women over the age of 17 and for all minors with consent from their guardians. (11) In 1984, Denmark held its first public education event on the topic of HIV and acquired immune deficiency syndrome (AIDS). (12) In 1991, the Danish curriculum introduced three new principles: sexual health education could now be integrated into any subject of learning, students could ask sexual health related questions during any of their courses, and teachers could integrate a discussion on sexual health in any of their classes. Furthermore, guest speakers such as sex workers and people living with HIV/AIDS could now come into the classroom and speak with the students about their experiences. (13)

The Danish sexual health curriculum met again with controversy in 2004 when classroom sexual health educational DVDs were banned by the Danish government for containing what was deemed inappropriate material. However, the DVDs were then made available on the Internet and became more widespread than they would have been in the classroom. (10) In 2007, the government mandated all colleges to offer a course on sexual health, although they did not mandate the course for students. (13) Currently, sexual health education in Denmark is considered extremely

comprehensive, covering topics such as contraception, HIV/AIDS, STIs, abortion, puberty, sexual rights and freedoms, gender, sexuality, diversity, and acceptance. (14)

III. A brief history of sexual health education in the United States

Prior to the early 1900s, sex education in the US was often seen as deviant and anti-Christian. A law implemented in the 1870s forbade the distribution of any information about contraception. (15) Begun in 1905 and led by medical professionals, the social hygiene movement taught the public that sex-related problems, such as STIs, were caused by a lack of accurate scientific information rather than a consequence of "evil human nature." (15, p27) Social hygienists discredited the myth that men had uncontrollable sexual urges and could not be held accountable for the rampant spread of STIs. (15)

In the coming years a few radical individuals argued that sexual health education in schools should not only define STIs but also discuss STI prevention methods, and present the option of pre-marital sex as a possibility for both men and women. (15) Around this time Margaret Sanger, an American nurse, opened the first ever birth control clinic. (15) Then, towards the end of the First World War, the government mandated the first community-wide educational program on ways to avoid contracting STIs in order to keep soldiers healthy and ready for combat. (15)

Although some parents and religious organizations opposed the implementation of sex education in high schools, roughly $40^{\%}$ of all high schools had some sort of sex education by the end of the 1920s, (15) though it largely promoted abstinence as the only method of safe sex. By the 1940s, sex education had been renamed 'family life education' in order to draw less controversy. With the 1960s and 70s came the sexual revolution, widespread access to the birth control pill, and the legalization of abortion in 20 of 50 states. (15) In the 1960s, sex education expanded to include a more comprehensive and 'value-neutral' curriculum. The Sexual Information and Education Council of the United States (SIECUS) aided in implementing this new curriculum, providing information on topics such as contraception and access to abortion. (15) In 1965 the Supreme Court ruled that the use of contraceptives was a constitutional right. (15) By 1977 minors in the US gained the right to access contraception without parental consent and by 1978 abortion and contraceptive methods were legal topics of discussion in the classroom. (15)

Over the next few years the fight for abstinence-only sex education blossomed and the first federal funding of abstinence-only education occurred under the Reagan presidency. (15)

Throughout the next decades several states mandated a comprehensive sexual health education curriculum in their school systems. Abstinence-only education has been given very strong funding, although comprehensive sex education has generally been prioritized. (15) Currently, 18 states and the District of Columbia require that schools teach about methods of contraception, however eleven of those states also require that teachers stress the importance of abstinence rather than other forms of contraception. (2)

IV. Comparison of current sexual health curricula in Denmark and the United States

a) Sexual health curriculum in Denmark

The sexual health curriculum currently in place in Denmark is universal and federally mandated. It is a decentralized system in which the government provides guidelines for what educators must teach in their classrooms; however, there is no set curriculum in place that teachers must follow. (16) This gives each school the freedom to create its own curriculum and teach the required information in the way that it sees fit. Sexual health is not given its own course, but rather is integrated into compulsory lessons such as biology and Danish. Teachers may opt to bring in non-governmental organizations to supplement their teaching such as Sex og Samfund, the Danish branch of the International Planned Parenthood Federation; SafeSex, a Danish organization that teaches safe sex to adolescents between the ages of 13 to 18; or Normstormers, an organization that works to break the norms surrounding gender and sexuality. They may also have guest speakers, such as sex workers and people living with HIV/AIDS, talk to the class about their personal experiences, as previously mentioned. Parents may not remove their children from sexual health classes or prevent them from receiving information on sexual health. (12)

Sex education in Denmark is included in the Danish Ministry of Education under the heading 'Health, Sexuality, and Family Life Education'. This is then split into two categories: Health and Wellbeing and Gender, Body, and Sexuality. Health and Wellbeing focuses on the physical and mental health of the student. It is intended to provide students with information regarding their mental health, general physical health, rights, and sexual health. (14) Under the category of sexual health, the Ministry of Education simply states that the teachers should organize their lessons based on the following quotation from the World Health Organization:

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not only a question of the absence of disease, disability or weakness. Sexual

> health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. A prerequisite to achieve and maintain sexual health is that every individual's sexual rights be respected, protected and fulfilled. (14, subheading 4.1)

Although this quotation covers important topics about sexual health, it is vague and allows for educators' broad interpretation. The Danish guidelines on Gender, Body, and Sexuality are more thorough, requiring that all students are able to speak about diversity in terms of the body and gender by the end of the third grade. (14) The guidelines require that teachers instruct their students to "meet diversity with recognition and respect," (14, subheading 4.2) and specifically emphasize diversity of sexuality, gender, body, ethnicity, religion, social background, and age. (14) Finally, teachers must instruct students on their sexual rights.

Generally speaking, the guidelines for teaching sexual health in Denmark are very comprehensive in comparison with the United States. However, because teachers are able to interpret the guidelines on their own terms when creating and implementing the curriculum, the information often gets condensed or skimmed over. (12) As a result, student knowledge varies greatly across the country because there is no universal curriculum. Moreover, not all teachers are trained in sexual health education, (12) and so they often avoid teaching about the emotional aspect of sexual health and only teach the biological and anatomical aspects. (12)

An ongoing study conducted in Viborg, Denmark found that as recently as 2007, 41% of students between the ages of 14 and 16 years reported that they were unsatisfied with their sex education. (17) The majority of these students also reported that school is their main source of information about sexual health. (17) Furthermore, although the majority of students in primary and lower secondary school attend a public school, almost 100,000 students in Denmark attend private schools. (18) Private schools are required to teach the same subjects as public schools. However, according to the Ministry of Education, "it is not up to any government authority but to the parents of each private school to check that its performance measures up to the demands of the municipal schools." (18) If a child in a private school is receiving poor sexual health education, it is unlikely that this will change in the near future. Topics relating to sexual health such as abortion, contraceptives, and sexual debut are not something that adolescents typically speak freely about with their parents. In the aforementioned Viborg study, only 10-20% of students reported their parents as sources of information on sexual health, indicating that the majority of students are not

speaking with their parents on matters of sexual health. (17)

b) Sexual health curriculum in Texas and New Mexico

Sexual health education in the United States differs significantly from Denmark. It differs primarily because the sexual health curriculum used is different in each of the fifty states, and several of the states do not teach sexual health whatsoever. Twenty-four states and the District of Columbia mandate some form of sexual health education and thirty-three states and the District of Columbia mandate that there must be some form of HIV/AIDS education. (2) Only thirteen states require that the information being taught is medically accurate and thirty-six states allow parents to opt their child out of sexual health education. (2) Because of the diversity in education in the states, I have chosen Texas and New Mexico to examine more closely.

Texas has an abstinence-only approach to teaching sexual health. Health studies are required to be taught in grades one through eight and must be offered at the high school level. However, the legislature does not require that sexual health be included in health studies; that is up to each individual school district. (19) If a school district chooses to include information regarding sexual health, parents or guardians are given a complete list of topics to be covered in the lesson, and they can decide if they want their children to partake in the class or be removed from all or part of the lesson. (19) Topics regarding sexual health are introduced in the sixth grade when students are around eleven years old. All school boards choosing to teach sex education must follow the curriculum provided by the Texas Education Agency; however, they can use their own resources and may add to the curriculum. (19) The information provided to students is not required to be medically accurate or derived from a scholarly source. (2)

The Texas Education Agency covers information regarding changes during puberty, mental and physical changes, menstruation, HIV/AIDS and other STIs, sexual rights, and the prevention of sexual violence, among other things. However, it also teaches students how to "explain the consequences of sexual activity and the benefits of abstinence … [and] describe strategies such as abstinence for communicating refusal to engage in unsafe behaviors." (20, section 115.22.b5,b7) They also learn how to "discuss abstinence from sexual activity as the only method that is 100% effective in preventing pregnancy, sexually transmitted diseases, and the sexual transmission of HIV or AIDS, and the emotional trauma associated with adolescent sexual activity." (21, section 115.32.b7) The curriculum does not mention other methods of contraception. Furthermore, it teaches students to

respect their peers regardless of race, socio-economic class, and appearance, but says nothing of sexual orientation, gender, religion, or anything else that might cause discrimination. (20) Finally, the curriculum does not mention diversity.

New Mexico has a more progressive sexual health education curriculum, mandatory in all schools, although parents and guardians can choose to remove their children from the lessons. (22) The information provided does not have to be medically accurate, although the teacher has to be certified in health education. (22) The curriculum for sexual health is comprehensive in teaching contraception. (23) It stresses abstinence to prevent unwanted pregnancies, STIs, and HIV/AIDS, but not above other methods of contraception. Teachers also provide information on where to get tested for pregnancy and STIs, including HIV. The curriculum discusses the effects of peer pressure in relation to sexual activity or sexual acts and informs students on STIs and HIV/AIDS. (23) Furthermore, the curriculum requires that teachers discuss "gender roles and media portrayal of sexual behaviours of both genders" (23, p6) and "create positive health messages in the areas of sexuality." (23, p10)

However, the New Mexico curriculum does not explicitly require discussions surrounding sexual orientation or gender, and its language is not trans-inclusive. The curriculum briefly mentions "consideration and respect for self and others in the areas related to sexuality," (23, p7) but also implies that sexuality is synonymous with sexual activity and all topics relating to sex and sexual health, so this statement is unclear. Furthermore, the approach to consent education is quite victim-oriented. For example, students must "demonstrate effective negotiation and risk avoidance strategies for avoiding unwanted sexual activity [and] demonstrate refusal skills related to personal safety in the areas of physical, emotional or sexual abuse." (23, p5) This part of the curriculum wrongly implies that one can easily avoid sexual abuse if they simply refuse or negotiate. (24) New Mexico is just one of many states that only provide information on how to "avoid sexual coercion". Thirty states do not mention anything relating to consent or sexual coercion. (2)

c) Comparative Analysis

Teen birth rates in the US are leading the developed world at 24.2 births per 1000 girls aged 15 to 19. (25) This is a drastic decrease from the year 2000, when the birth rate was 47.7 per 1000 girls aged 15 to 19. (25) Meanwhile, in Denmark, the teen birth rate is extremely low at 4 per 1000 girls aged 15 to 19 (compared to 7 births for every 1000 girls in 2000). (26) The

percentage of people living with HIV/AIDS between the ages of 15 and 49 is between 0.1 and 0.2 percent in Denmark and between 0.4 and 0.8 percent in the US. (27) The US restricts access to abortion and limits health insurance in several states so as not to cover abortion procedures. (28) Conversely, Denmark offers free abortions on demand to all women aged 18 and older who are twelve weeks pregnant or less and offers the same to all girls under the age of 18 with a guardian's consent (past twelve weeks a woman must present a reason as to why it would not be reasonable for her to give birth). (29) Between 2010 and 2011 the abortion rate in the US was 15 per 1000 girls aged 15-19 and in Denmark it was 14 per 1000 girls aged 15-19. (30) These statistics suggest that comprehensive sexual health education and universal access to free abortions does not increase sexual activity, teen pregnancy, or abortion rates, contrary to the arguments of abstinence-only educators and supporters.

Studies show a direct correlation between the type of sexual health education and regularity of sexual risk behaviour. A peer-reviewed article in the *Journal of Sexuality Research and Social Policy* found that only three of the nine abstinence-only curricula studied showed any behavioural evidence suggesting that the curriculum was effective in certain areas. In the majority of abstinence-only programs, "the curricula had no effects on initiation of sex, age at initiation of sex, abstinence in the previous 12 months, number of sexual partners, or condom use during sex." (3, p20) Of the three programs that improved sexual health, two delayed sexual initiation and frequency of sex and one decreased the number of sexual partners. (3) In the comprehensive sex education curricula studied, there were significant decreases in age at initiation of sex, frequency of sex, number of partners, and sexual risk behaviours, while there was an increase in condom use and contraceptive use. (3) In one of twenty-four comprehensive programs there was an increase in the number of sexual partners, and in one of nine there was a decrease in contraceptive use. (3) This study supports the positive impact that a comprehensive sexual health education can have on the sexual health of students. It confirms that teaching students about their bodies, their rights, and ways to maintain their health will have a positive effect in the majority of cases, and that the likelihood of comprehensive sex education increasing sexual activity or risk behaviour is low.

V. Impact of sexual health curricula on young women

Although sexual health affects all genders, women have the most to gain from comprehensive sexual health education, for they must deal with the direct consequences of unwanted pregnancies. Abstinence-only education does not teach high school students the proper methods of birth control, and they are then left to get their information from friends, peers, parents

and guardians, and magazines, which often include pornography. (17) Apart from frequently citing incorrect information, pornography imposes impossible and unhealthy standards on young girls and normalizes the sexual objectification of women. Additionally, relying solely on one's parents for sex education is not an adequate method of learning what can be life-saving information.

Furthermore, North American culture often stigmatizes young women who have sex and are open about their sexuality, for instance through the social practice of 'slut shaming', a term that condemns women who have sex or even express an interest in sex. Abstinence-only education pressures women to refuse sexual activity, or implies that women have no sexual desire and must say no to sex because men are incapable of controlling their own sexual appetite. (5)

Moreover, the lack of consent education in most curricula in the US and Denmark shows how poor sexual health education impacts young women. Although males are often victims of sexual assault, the probability of teenage females in high school in the US having been raped at some point in their lives is almost three times that of teenage males. A survey conducted by the Centre for Disease Control and Prevention in the US (CDC) found that 11.8% of girls and 4.5% of boys in high school were raped at some point in their lives. (6) A Danish study confirms that females in Denmark are targets of sexual violence at a much higher rate than males. (31)

As indicated in the sexual health curriculum in New Mexico, students are often taught how to avoid sexual coercion by using refusal and negotiation. However, that is not going to prevent rape. In New Jersey's otherwise comprehensive sexual health education, state curriculum requires teachers to "correlate the use of alcohol and other drugs with incidences of date rape, sexual assault, STIs, and unintended pregnancy [and] relate the use of alcohol and other drugs to decision-making and risk for sexual assault, pregnancy, and STIs."(32) Sexual assault and date rape may be more likely if the victim is under the influence of alcohol or drugs; however, it is more intuitive to teach boys in high school simply not to attempt sexual contact with a girl who is drunk, has taken drugs, or is incapacitated in any way. Teaching women never to drink alcohol is unrealistic and makes the woman responsible for avoiding rape. Teaching high school students exactly what consent is and when a person is not equipped to give consent (i.e. when the person is inebriated) has proven to be more beneficial in reducing sex-related crimes. (9)

The Division of Violence Prevention within the CDC outlines three different targets when teaching about sexual assault. In an assault there is often a victim, a perpetrator, and one or several bystanders. It is important to teach students risk reduction strategies such as self-defence in the

event that they are targeted for an assault of any kind. Students must also learn about the concept of consent and societal factors that contribute to the normalization of rape in order to reduce the number of sexual predators that high schools are filtering through their systems. Finally, students must learn to intervene in the event that they see a sexual assault taking place or they witness something that looks like it could lead to a sexual assault rather than being a bystander. (24)

In a review of over 100 studies examining the effects of sexual assault prevention programs at middle schools, high schools, and colleges, the programs that proved effective were the programs that were most extensive. Programs targeting entire schools by putting up posters, changing school rules surrounding sexual assault, providing plays and interactive online programs for students, and so on, were the only programs that proved effective in lowering rates of sexual assault in the months that followed the implementation of the programs. (9) These programs not only lowered sexual assault rates, but in some schools they also reduced bystander effect, dating violence, and sexual harassment. (9) The results of this survey suggest that schools must foster an environment for their students that actively prevents sexual violence and teaches about every aspect and every actor involved in a sexual assault in order to begin reducing the number of people being sexual assaulted. Teaching students how to avoid sexual coercion or simply teaching them that they have "the right to be protected from human violations," (14, subheading 4.2) as done by the Danish Ministry of Education, is not an effective way of reducing instances of sexual assault. The lack of interest in consent education is global and widespread and needs to be changed if schools wish to foster a safe environment for all of their students during their youth and throughout their lives.

VI. Conclusion

The United States and Denmark have vastly different approaches to sexual health education. While Denmark has a localized system with general guidelines of what students should learn about sexual health, the United States is decentralized with a greater emphasis on what the students should not be learning from their educators. Danish parents or guardians have no choice but to allow their children to learn about contraception, STIs, HIV, pregnancy, sexual rights, diversity in all forms, and several other sexual health related topics, while the majority of states allow parents or guardians to withdraw their children from such lessons. However, the two

countries are not entirely in opposition. Both put an emphasis on teaching their students about HIV and methods of protecting oneself from the virus. This is a mandatory topic in Denmark and the majority of the states also require students to study HIV/AIDS. Denmark and the US are also similar in their lack of adequate sexual consent education. The impact of the different approaches to sexual health education between the two countries is reflected in the higher frequency of unwanted pregnancies, STIs, and rates of HIV among American teens compared to Danish teens. The statistical evidence suggests that a comprehensive sex education curriculum gives students far more actionable skills that they can use to protect themselves mentally and physically from the consequences of unsafe and uneducated sex.

The comparative histories of sexual education in Denmark and the US suggest that their ideas towards the importance of sexual health did not diverge until the mid-twentieth century. Denmark continued to teach comprehensive sex education, while the US began to shy away from the realities of sex and instead began to push abstinence-only education. Although the US began to shift away from abstinence-only education under the Obama administration, the country still has a long way to go if it wishes to match the positive sexual health statistics of Denmark.

Sexual health affects the mental and physical health of everyone and should be a top priority of every country. In order for sexual health curricula to achieve maximum benefits, they must be comprehensive and include a rigorous and extensive focus on consent, which targets all students, not simply those most likely to be victims. Only then will students be equipped with the knowledge needed to make healthy and informed decisions about their bodies and fully comprehend their right to bodily agency.

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