Deconstructing the Dutch Utopia

Sex education and teenage pregnancy

in the Netherlands

Joost van Loon

with additional research by

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Joost van Loon is a Dutch citizen who lives and works in the United Kingdom as a reader in social theory at Nottingham Trent University. In 1996 he obtained a PhD in sociology at Lancaster University and has since then worked in Cardiff and Amsterdam, before coming to Nottingham. His current research projects are organised around the themes of risk and evil, with reference to infectious diseases and epidemiology, religion, space and time, and media technologies. Published works include *Risk and Technological Culture* (Routledge, 2002); *The Risk Society and Beyond* (co-edited with Barbara Adam and Ulrich Beck, Sage, 2000); and *Trust and Cooperation* (co-edited with P. Smets and H. Wels, 't Spinhuys, 2000). With Rob Shields and Greg Elmer, he is also co-editor of the interdisciplinary journal *Space & Culture*. He is married and has three children.

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Although the Family Education Trust commissioned this research and has paid for all expenses incurred, they have at all times respected the importance of autonomy in scientific research and have never sought to interfere with the outcomes of this research project. Hence, whereas all the good parts of the report are the product of lively and open debates and discussion between countless people, many of whom are indeed friends and with whom I may not always agree, any errors, mistakes and faults are all mine, and only I can claim responsibility for those.

Joost van Loon
Nottingham, January 2003

Foreword

The Paradigm of the Dutch Utopia

The disastrous record of the UK with regard to teenage pregnancy is now well known: we have the highest rate in Western Europe, and almost in the world. At the same time, it is almost equally well known that the Netherlands has an extremely low rate of teenage pregnancy. Many campaigners and social policy analysts have concluded that they must be doing something right, and, whatever it is, we should try to imitate it.

This 'something' is widely held to be sex education. It has become part of the accepted wisdom, amongst those who specialise in the issue, that sex education in the Netherlands is exemplary. It begins at young ages, it is explicit, it is pervasive throughout the school career, and it is unproblematic. Everyone is happy. In the repressed UK, on the other hand, sex education is patchy, it is mealy-mouthed, it starts too late, and, because of the influence of the powerful 'moral right', it fails to give young people the knowledge and skills which they need.

This explanation of the difference between the teenage pregnancy rates of the two countries (which is real enough) is problematic, largely because it is untrue. As Dr van Loon shows in his study, this interpretation of sex education in the Netherlands is false on almost every important point. The extraordinary thing is that so many people have wanted to accept the scenario at face value that they have failed to ask for proof. As Dr van Loon points out, people seem to feel able to make the most sweeping statements about the Netherlands without producing any evidence whatsoever to support their theses.

The view of the Netherlands as a permissive Utopia emanates primarily from birth control and abortion campaigners and their lobbies. Organisations such as the Family Planning Association, the Brook and – more recently – the Sex Education Forum, are endlessly controversial. The people who work for them – to judge by their writings, at least – feel beleaguered and under-appreciated. As a bulwark against criticism they have constructed an imaginary paradise across the English Channel where all of their dreams are realised – explicit sex education from infancy, easy access to contraception, abortion without stigma and every type of living arrangement validated by the state and the education system. This is what Britain could be like, they tell us, if only we would listen to them and stop carping about the corruption of our young people.

The lobbyists feed the story to journalists. To take just one example, an article that appeared in the *Observer* in February 1999, just before the publication of the Social Exclusion Unit's report on teenage pregnancy, was headed 'UK eyes Dutch sex lessons'. It claimed that: 'Radical Dutch sex education policies are to be introduced in British schools in an attempt to tackle rocketing levels of teenage pregnancy … members of Downing Street's Social Exclusion Unit ... are impressed by evidence that the more liberal Dutch approach has contributed to some of the lowest teenage pregnancy rates in Europe … Sex education there begins in primary school … at secondary school they … are told that sex is fun and exciting' (Bright, 1999). As Dr van Loon's research shows, this account is not only misleading as to the nature of Dutch sex education, but also on the question of the supposed 'radical' differences between what is taught in Dutch and in UK schools.

Journalists are not researchers, and it is not to be wondered at if they accept, perhaps too unquestioningly, information which they receive from government-funded organisations. What is harder to understand is the extent to which even the most

respected social-policy academics have difficulty in getting outside the paradigm of the Dutch Utopia.

An article comparing sex education policy in England and Wales with that in the Netherlands by Jane Lewis and Trudie Knijn, published in the *Journal of Social Policy* in October 2002, was considered to be of such importance that it was receiving media coverage a full nine months before it was even available to the general public (Walker, 2002). Professor Lewis and Dr Knijn concentrate on the political debate surrounding sex education, contrasting calls for moral values and support for the traditional family in Britain with the more open and permissive attitude in the Netherlands. They begin their article by admitting that 'sex education is of course only one of a number of inter-related explanatory factors when it comes to teenage pregnancy' – but then say virtually nothing about any other important factors. They do not mention the fact that welfare benefits for teenage mothers in the Netherlands are low, nor the fact that the family is more intact in the Netherlands, except a mention in the final paragraph of the fact that 'traditionalist politicians in the UK' have mentioned lower divorce rates and low rates of female employment in the Netherlands. Such factors – divorce, out-of-wedlock births, lone-parent families – are, in fact, crucial elements in the equation, and do not deserve to be so lightly dismissed. But then, 'traditionalist politicians' and 'family values' organisations figure largely in the Lewis/Knijn analysis, which relies upon setting up an antithesis between the repressed, sex-fearing Brits and the easy-going, permissive Dutch. Much of the article is taken up with accounts of parliamentary debates and speeches by British politicians advocating marriage and moral values, as if this point of view were dominant in sex education. British politicians are supposed to be afraid of those championing 'traditionalist views', with the result that they find themselves forced into 'trade-offs and U-turns' to 'appease the moral right'. Hence the low quality of sex education in our schools and the high teenage pregnancy rate. Q.E.D.

Speaking as the director of one of the organisations cited as influential champions of traditional values, I can only say that our members would find this analysis absurd. We are very far from feeling that we exercise any significant influence over official sex education policy in this country – quite the reverse, in fact. Professor Lewis and Dr Knijn make the mistake of confusing what politicians say with what they do. Speeches made on the hustings or in the Palace of Westminster are only loosely connected with the real world. The experience of pro-family groups under both Conservative and Labour administrations over the last twenty years has been that the anti-family drift of public policy has been directly related to the volume and intensity of pro-family rhetoric.

Just as Professor Lewis and Dr Knijn caricature sex education policy in Britain by relying on political pronouncements, so they take the permissive views of some Dutch politicians and semi-official bodies like the Dutch Family Council as representing the nature of Dutch sex education – and with even less justification. As Professor Lewis, Dr Knijn and Dr van Loon all acknowledge, Dutch schools are far more independent of the state than their English counterparts. The control of the churches and the involvement of parents are much stronger. Dr van Loon visited a sample of these schools and found that most were not using any sex education material produced by the official bodies, and there was no support for the use of sex education classes to promote a permissive approach to sexuality.

This is why it is so important to go into schools and find out what is actually being taught, away from all the hot air of the politicians and the lobbyists. Dr van Loon's findings, from his sample of primary and secondary schools, form the core of this study, and they seriously undermine the view that sex education can be credited for the big gap between teenage pregnancy rates in the Netherlands and the UK.

For this paradigm to hold true, there would have to be a distinctive Dutch pedagogical approach to sex education. There is no such approach. The differences between the schools visited were probably greater than any differences between sex education in the UK and the Netherlands, considered overall.

However, the more pertinent question relates to why anyone should have thought that sex education could possibly account for such a major difference between two nations. Even if the Netherlands had a coherent, comprehensive and completely excellent sex education curriculum, it is doubtful that it could have more than a small effect on how people actually behave. The evidence that health education – whether related to diet, smoking, drugs or anything else – affects lifestyles is extremely weak (Bloor, 1995). There is a difference between knowing something and acting on that knowledge.

The far more important distinction to draw is between the cultures of the two countries, and the messages that these send out to young people concerning the sort of behaviour that is expected of them. It is here that we find the really significant differences.

Teenage mothers in the Netherlands receive very little support from the state welfare system – until recently, almost nothing – and teenage motherhood is stigmatised. Sylvie Raap, who became a mother herself at 16 and campaigned for more official support for teenage mothers in the Netherlands, told the *Daily Mail* that: 'You have humiliation and discrimination every day. The social services do everything to make your life difficult; no one listens to you or takes you seriously; people give you dirty looks on the street; you are always in debt'.[1] Stigma is one of the most powerful means – probably *the* most powerful – of controlling behaviour considered destructive of the well-being of the community. In Britain we pride ourselves on having done away with stigma. We must therefore live with the consequences.

As Dr van Loon points out in this study, there is a tendency to treat teenage pregnancy as a purely medical issue, rather than a behavioural one. But teenage pregnancy is the result of teenage sexual activity. A society that has more of one, will have more of the other. The question is, what influences the level of teenage sexual activity and, in particular, the age at which young people commence sexual relationships?

There is now a considerable volume of research which links the breakdown of the family based on marriage with premature sexual experimentation. In particular, girls who have grown up in father-absent or unstable households are more likely to become sexually active at young ages. Statistics of divorce, out-of-wedlock births and lone-parent households can therefore tell us a great deal about the size of the population which is at risk of teenage pregnancy. The fact that these important issues have been almost entirely left out of consideration tells us a great deal about the quality of the debate on teenage pregnancy in Britain. The statistics which Dr van Loon cites give a strong indication of where we might more profitably look for an explanation of why Dutch teenage conception rates are so far below those of Britain: the institution of the family is much stronger.

Children in Britain are five times as likely to be living in a family headed by a lone parent. They are more likely to have been born to an unmarried mother or to have experienced the divorce of their parents. They are more likely to be in third-party care, and to find no one at home when they come back from school. These are structural issues of the greatest importance besides which sex education, of whatever quality, is insignificant.

It is time to confine the Dutch Utopia to the bin of exploded sociological myths, along with Margaret Mead's Samoa and the 'Gentle Tasaday' of the Philippines. There is no harm in constructing imaginary places where the sun always shines and no one gets old, as long as we accept that they *are* imaginary and don't try to locate them on the map.

Social policy should confine itself to reality. All the rest, as someone once said, is literature.

Robert Whelan, Director
Family Education Trust

Summary

According to a recently published UNICEF report (UNICEF, 2001), the UK has the highest teenage birth rate in Western Europe. The Netherlands, in contrast, ranks amongst those countries with the lowest rate of teenage births. Whilst the report fails to give sufficient attention to abortion rates and thus presents an inadequate assessment of teenage sexual risk behaviour, it cannot be denied that the difference between the UK and the Netherlands is worthy of further analysis.

UNICEF points towards the pivotal role of both sex education and easy access to contraception, which are believed to contribute to lowering teenage birth rates. However, it is unable to determine the extent to which it is possible to attribute the low teenage birth rate in the Netherlands to sex education and low threshold access to contraception. In this respect, the UNICEF report merely echoes what it assumes to be 'common sense'.

By contrast, in this report, we have attempted to look more critically at the validity of such 'common sense' assumptions. The research we draw upon derives from four different sources: published research findings; official statistics; official documents regarding sex education including text books; and a small-scale qualitative investigation in four primary and four secondary schools, where teachers who were involved in sex education programmes were interviewed.

The main finding of this research is that there is an enormous diversity in didactics, pedagogical strategies and content of sex education in the Netherlands. This is due to the high degree of autonomy of individual schools in terms of curriculum development and policy-making. Given the wide diversity of sex education programmes, it is difficult to identify which strategy of sex education effectively contributes to lower conception rates. However, it is worthy of note that the primary and secondary schools with most difficulties regarding underage conceptions are also those with the most 'open' (student-centred) programmes. The research, however, does not support the hypothesis that open sex education *causes* higher rates of teenage pregnancy, because both schools with the most problems were located in socio-economically deprived areas. Their pupils were also from the lower social strata of Dutch society. Such contextual factors seem far more important than sex education in determining a more general school culture that is unable to resist the 'sexualisation of society'. In the 'problem schools', the open nature of sex education is based on a reaction from teachers to the situation they find themselves in. They therefore use the 'streetwise' culture of their pupils as a learning resource, with a general aim of inhibiting their risk-taking and/or anti-social (e.g. sexually intimidating) behaviour.

The schools that struggle most with the adverse consequences of increased teenage sexual activity have an intake of pupils who, more often than not, come from broken homes and live in weak family structures. Schools where there are hardly any problems operate in areas dominated by two-parent families, who maintain good relationships with the school and are often strongly involved in the development of school policy. These are also families where parents have a central role in the emotional and social formation of their children, which may include aspects of sexuality. Strong families are also more effective in filtering the negative effects of the seemingly irreversible tendencies associated with the sexualisation of society. It is the responsibility of parents to control what children watch on television and view on the internet. For parents to do this effectively, however, they have to be at home with their children and be closely involved in their activities. For obvious reasons, this is more difficult for single-parent families and families where both parents work full-time.

The report concludes that the way in which sex education is taught in the Netherlands closely resembles that of Britain and is not a critical factor in influencing the comparatively low teenage pregnancy rate. Instead, the comparatively low benefits for single parents, the more traditional family structures (with fewer mothers in full-time employment and lower divorce rates), have a direct bearing on the ability of parents to involve themselves in the everyday lives of their children and thus also to contribute constructively to their moral and social development.[2]

Chapter 1

Outline of Research

1.1 The Question

To what extent does sex education in the Netherlands provide an exemplary model for the improvement of the sexual health of teenagers in the United Kingdom?

1.2 The Debate

As teenage pregnancy is widely accepted to be a serious social problem in the United Kingdom, politicians, policy makers and health educators have looked to the Netherlands to find solutions. This is because the Netherlands is seen as having been successful in reducing teenage pregnancy rates since the early 1970s, whilst having maintained comparatively low abortion rates. The Netherlands is claimed to have:

> an earlier and more open approach to sexual issues in schools and in families. This is associated … with greater levels of discussion and forward planning between partners, later ages at first sexual intercourse, more effective contraceptive use, and lower levels of subsequent regret (Ingham, 2000: 1522).[3]

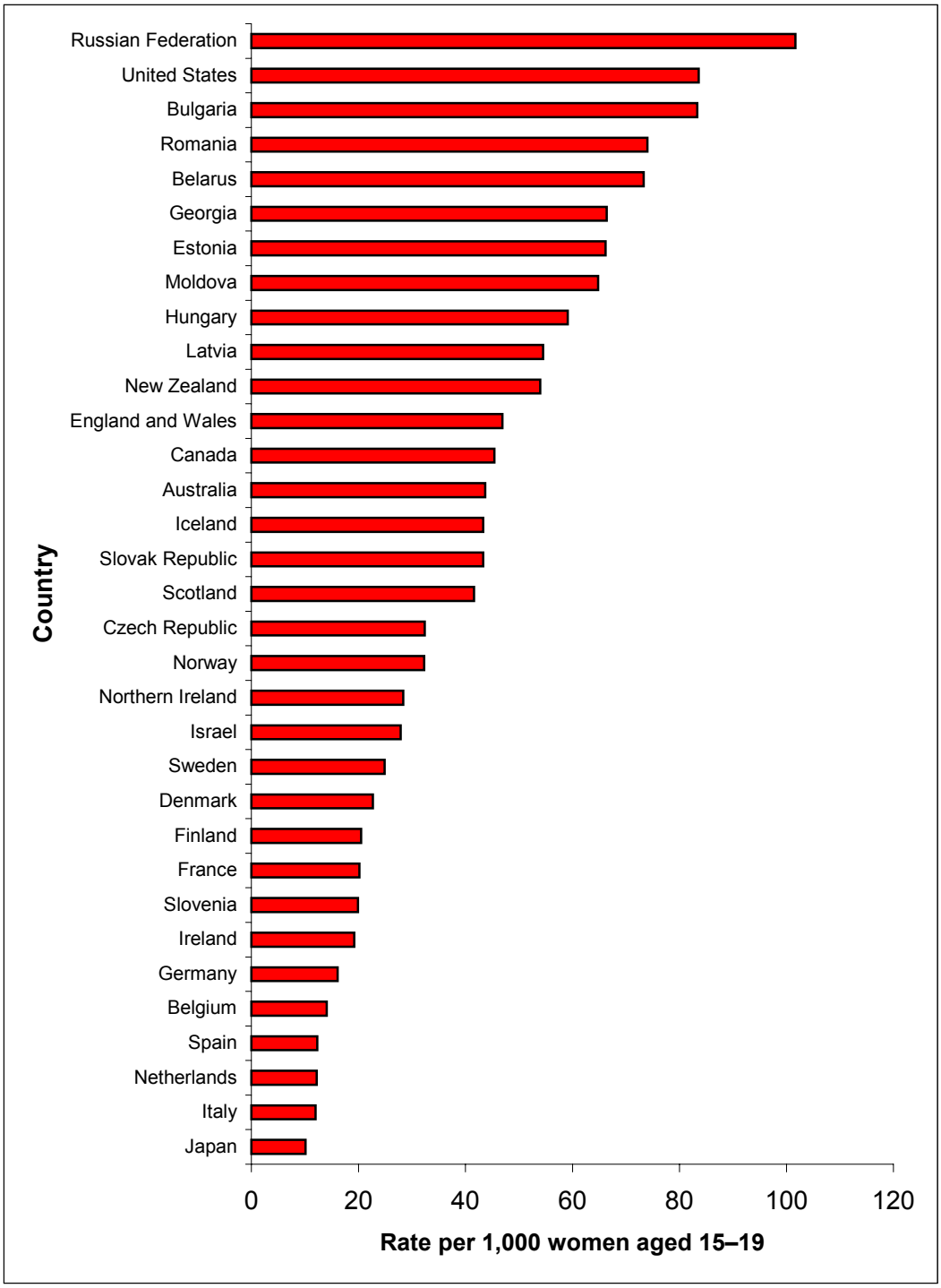
These are commonly accepted views that circulate throughout the expanding files of official publications on the problems of teenage sexuality. The most recent one to have received media coverage is the comparative study published by UNICEF. Although the report was completed in 2001, its publication was delayed until May 2002. The scope of the report was limited to a comparison of *birth rates* among teenage females living in 23 'developed' countries. The aim of this was to highlight the fact that the problem of 'teenage parenthood' is actually concentrated in a small number of nations, among which is the United Kingdom. In this respect, the report suggests that lessons can be learned from countries which have been successful in bringing down teenage birth rates, among which is the Netherlands.

The UNICEF report is based on an analysis of statistical data. European statistics have been drawn from Eurostat's *New Cronos Demographic Database 2000.* It notices huge differences between developed nations, with the UK ranking second highest and the Netherlands fourth lowest in terms of teenage birth rates.[4] However, the report also states that in all of its listed nations, teenage birth rates have dropped considerably over the last 30 years. It explains this by stating that this is part of a wider social transformation in which young people have increasingly postponed marriage and having children, due to increased educational and career aspirations, which have resonated with an increased participation of women in the labour market. It also mentions the increasing acceptance and use of contraception, together with increased levels of information and knowledge about sexual issues, amongst young people. Most interesting, perhaps, are suggestions that associate the lowering of teenage birth levels with:

(a) an increased dissociation of sex from marriage and procreation (2001: 8); and

(b) the birth of the 'sexualised society', which is defined as 'a weakening of traditional attitudes [that] has combined with commercial pressures . . . in which old taboos serve mainly to add to the allure of the formerly forbidden' (2001: 11). Whilst seemingly critical of such a development, the last part reveals that 'old taboos' (which are not specified)

Figure 1: Rates of adolescent pregnancy per 1,000 women aged 15–19 by developed country for the most recent year available



Source: Singh and Darroch (2000). The most recent year is 1995, with the following exceptions: 1996 – Bulgaria, the Czech Republic, Estonia, Finland, Hungary, Iceland, Latvia, Moldova, Norway, Slovenia, Sweden, United States; 1994 – Australia and Georgia; and 1992 – the Netherlands.

have now become counterproductive to the effect that they stimulate sexual activity among young people.

Of greatest interest to this study is a section in the report called 'Dutch lessons' (2001: 20–21). As UNICEF does not believe that a return to traditional values is an option, it has singled out the Netherlands as the model to follow. The Dutch model is favourably contrasted with the Nordic model, because of the latter's high abortion rates, suggesting that as far as 'sexual health' is concerned, teenagers are better off in the Netherlands:

> In general, studies of the Dutch experience have concluded that the underlying reason for success has been the combination of a relatively inclusive society with more open attitudes towards sex and sex education, including contraception. This has paved the way for sexual relationships to be discussed at an early age – before barriers of embarrassment can be raised and before sex education can be interpreted as sending a signal that the time has come to start having sex (*ibid*: 21).

In supporting this position, it refers to Ingham's research (see below) on 'openness' between parents and their children in discussing issues related to sexuality as well as 'the spirit in which sex education is offered'. Finally, referring to statements made by Ingham (2000), the report also suggests that Dutch teenagers have a higher than average age at first intercourse and higher levels of contraceptive use and effectiveness, but does not provide any statistical evidence of this.

Another important comparative case study was commissioned by the Health Education Authority. It was conducted by Kane and Wellings and published in 1999. The report gives a comparative overview of *teenage pregnancy rates*, thus including both live births and abortions. In doing so, it mainly relied on statistics provided by the UN Demographic Yearbook and the Council of Europe. The report focuses on seven European countries, including the UK and the Netherlands. It compares birth and abortion rates for women aged 15–19, first-marriage rates (and age), income distribution, unemployment rates and educational attainment rates (all specifically relating to young people). In addition, it provides an overview of literature on a range of topics related to teenage pregnancy. Using statistical correlations (from a sample of a maximum of 24 countries), Kane and Wellings suggest that low teenage conception rates are associated with a postponement of marriage, less economic inequality, higher average income and higher educational aspirations (measured in terms of the proportion of females aged 15–19 in full-time education). However, the statistics used in the report also suggest that abortion rates have their own dynamic. They are, for example, less linked to poverty and economic inequality, but strongly associated with employment and the nation-state's relative expenditure on social welfare and health provisions (Kane and Wellings, 1999: 12–27).

Kane and Wellings compare the Netherlands and the UK. Using statistics from the Council of Europe (1997), they describe how teenage pregnancy rates have continued to fall in the Netherlands since 1960.[5] At the same time, the first marriage rate for teenage females has also considerably decreased, and the age of first marriage has increased. They discuss the widespread availability and use of contraception in the Netherlands, and its association with the introduction of public health campaigns promoting contraceptive use since the early 1970s. They also mention the role of sex education since the late 1970s and the emergence of sexual health experts who, the authors claim, 'are involved in providing sex education' (*ibid*: 47). The abortion ratio in the Netherlands is considered relatively high but lower than in Scandinavian countries, indicating that abortion is still somewhat less acceptable in the Netherlands. Finally, they refer to the aforementioned 'culture of openness'; however, they place this elusive concept in a slightly different perspective to UNICEF. Rather than stressing parent/child interaction, they state that:

> Agencies in the Netherlands who are concerned with providing youth contraceptive and abortion services meet less opposition than do such agencies in other countries. The cultural climate surrounding sexual health seems generally to be characterised by consensus rather than conflict (Kane and Wellings, 1999: 47).

Kane and Wellings also discuss the UK. Noting that teenage birth rates have fallen since the 1960s, but not since 1978, they stress that the UK has the fourth highest teenage birth rate in the whole of Europe. This is remarkable, given the fact that the age of first marriage has continued to increase and the rate of first marriage of 15–19-year-old women has continued to drop. The only way they can explain this is by referring to 'changing attitudes towards marriage, with an increasing acceptance of extra-marital births' (*ibid*: 59). They mention the availability of family planning services and contraception since the 1970s: oral contraception (the pill) has been available under the NHS since 1974 and emergency contraception since 1983. The authors suggest that scares involving the safety of the pill, generated by the mass media, may have been responsible for the UK's relatively high teenage pregnancy rates. In addition, Kane and Wellings mention that use of sexual health agencies and clinics has steadily increased (1999: 62–4). Finally, the authors mention that sex education was made compulsory for all secondary schools in 1986 (and became part of the basic curriculum in 1993), and that since 1992 primary schools could provide sex education as well. In terms of allocating blame for the persistence of high teenage pregnancy rates in the UK, Kane and Wellings do not focus on education; instead the relationship between teenagers and health professionals (especially GPs) is mentioned (1999: 65).

Perhaps the single most influential recent document on the issue of teenage pregnancy in the UK has been produced by the Social Exclusion Unit in 1999. Its main objective is to illustrate the highly unfavourable position of the UK compared to the rest of Western Europe in terms of teenage pregnancy, and to highlight a range of factors that might be involved. Similar to the aforementioned reports by UNICEF and Kane and Wellings, the methods upon which the analysis is based are a combination of statistics and literature review, but the Unit also includes a sample of statements made by teenagers themselves. There is, however, no clear indication as to how these statements were obtained and from whom; they are simply reported as consultations with young people, conducted by the Unit.

The report presents its conclusions up-front (Social Exclusion Unit, 1999: 7). In this sense, there is no distinction between its conclusions and its arguments, which are that the UK's high teenage pregnancy rates are caused by: (1) low expectations (linked to socio-economic and educational deprivation); (2) ignorance (about contraception and risks of sexual behaviour); and (3) mixed messages (as teenage sex is treated in British culture as both desirable and immoral). The Social Exclusion Unit, however, stresses that these three factors can still be further reduced to one: 'neglect'. The prime responsibility for this neglect is laid at the feet of those who have continued to treat teenage sexuality as a moral issue, thereby enabling a culture of 'blaming the victim'. The Social Exclusion Unit thus proposes instead a pro-active approach, in which governments actively initiate programmes and policies to intervene in the lives and cultures of young people and to change the culture of neglect into one based on care.

This argument is supported by comparing the countries of Western Europe across a range of statistics related to – for example – socio-economic deprivation, educational attainment and family background, thereby suggesting certain patterns without proving whether or not they actually have an impact on teenage pregnancy rates. In comparing teenage pregnancy rates across Europe, it uses the same data as Kane and Wellings. The main concern is why in the UK these rates have not gone down over time as they have in the rest of Western Europe. The report suggests that a number of risk-factors are

involved in teenage pregnancy: poverty, being in institutional care, having a mother who has been a teenage mother herself, educational problems, having been subjected to sexual abuse, mental health problems and being involved in crime. These factors are often correlated, creating patterns of 'socio-economic exclusion' and a cultural breeding ground for teenage sexual risk behaviour. In the report's summary, this complexity was entirely reduced to the rather psychologistic term of 'low expectations'.

Because the Social Exclusion Unit ultimately reduces socio-economic variables to, first, the psychological factor of 'low expectations', and then, further, to a political assertion of 'neglect' by (previous) governments and wider society, it has already undermined the value of this hypothesis before presenting its recommendations. It is therefore no coincidence that the vast majority of its recommendations refer to issues of sex education and the provision of contraception, and the few remaining ones to issuing financial and educational support to teenage parents.

In contrast to the socio-economic factors, the ignorance and the mixed-messages hypotheses were not strongly supported by statistical evidence, but relied more heavily on quotes from teenagers obtained during 'consultations'. The report does not really substantiate its 'mixed-messages' hypothesis, but is particularly focused on failing sex education as the main cause of ignorance. It suggests that, as a result, teenagers obtain most of their information and knowledge of sexual issues from the popular media and, to a lesser extent, from friends or relatives. It also reports that many teenagers are misinformed about sexual issues, including risks of pregnancy and STIs. No comparisons are made with the Netherlands or any other country.

Whereas these texts have been produced by official governmental and inter-governmental bodies primarily for the purpose of policy-development, they resonate with a number of studies that have been published within the field of academic research. Some of these studies have had a considerable impact on the aforementioned reports.

The Allan Guttmacher Institute (AGI) published a highly influential study in 1986. It highlighted the growing gap between Western nations in terms of the reduction of teenage parenthood, with both the USA and the UK remaining at very high levels, whereas others dropped considerably (Jones *et al.*, 1986). In the UK, this sparked off a subsequent political debate over the issue of teenage pregnancy that is still continuing. Singh and Darroch (2000: 14–23), both associated with the AGI, have continued this tradition of comparative study in a recent article in the *Family Planning Perspectives*, from which Figure 1 is derived. Using various, not always compatible, statistical data on teenage birth rates, abortion rates, pregnancy rates and abortion ratios, they suggest that nearly all industrialised societies, including the UK, have witnessed a fall in teenage conception rates over the last 25 years. As main reasons for this drop, they mention the increasing importance of education, higher educational aspirations among young people and a reduction of the value of motherhood. However, they also mention increased availability of contraception and abortion and an increased attention to sex education, which are said to have 'had a greater impact on teenagers' (*ibid*: 22).

The main Dutch work, to which most references on the favourable position of the Netherlands regarding teenage pregnancy can ultimately be traced, is that of Ketting and Visser (1994). This seminal work, mainly based on analyses of demographic and medical statistics, gives an account of four parallel trends that have marked the landscape of sexual health in the Netherlands since the sexual revolution of the mid-1960s:

(a) a significant drop in overall fertility rates, but especially teenage conception rates;

(b) a rapid increase in extra-marital sex;

(c) an initial increase but then stabilisation of abortion rates;

(d) a vast increase in the use of contraceptives, with the exception of barrier methods (their figures only refer to pre-1985; i.e. before HIV/AIDS became a public health issue).

It is remarkable that Ketting and Visser do not mention that a gradual decrease in marital sex for under-20s, which took place after 1975 due to a postponement of marriage (also see Kane and Wellings, 1999 and Table 3.3 below), is also likely to have contributed to a decrease in teenage pregnancy rates. Instead they conclude that the rise in sexual activity amongst teenagers has not resulted in an increase in unwanted pregnancies, simply because of effective contraceptive use (for a similar argument, see van Lunsen *et al.,* 1994).

In the UK, the most authoritative study comparing teenage sexuality in the UK and the Netherlands is by Roger Ingham (1998). In a comparative study of sexual attitudes among teenagers in the UK and the Netherlands, based on 200 in-depth interviews, he investigated, among other things, reasons given by the teenagers for their first intercourse. A remarkable difference was shown in that for Dutch boys and girls, a majority gave as their primary reason 'love and commitment'. The other possible reasons, 'opportunity', 'physical attraction' and 'peer pressure' scored much lower. In the UK, however, love and commitment scored high among girls, but extremely low among boys. Instead British boys named peer pressure, physical attraction and opportunity as significant reasons, but they were also significantly present among girls. Because more than one reason could be given, it is significant that in the UK, unlike the Netherlands, teenage girls feel they need to justify their first intercourse with more reasons. Ingham's study suggests significant differences between Dutch and British youth cultures in terms of teenage sexuality; it is obvious that such differences are extremely difficult to tackle by means of government policy.

This is also acknowledged in a very recent publication, which received media attention nine months before its actual publication, by Jane Lewis and Trudy Knijn (2002). It is a summary of comparative research of mainly political debates over sex education in the UK and the Netherlands, supplemented with some suggestions derived from interviews with sexual health experts and sex education teachers, an analysis of sex education curriculum materials and some observations in seven secondary schools (four in the UK, three in the Netherlands). However, very little in terms of explicit analysis of these interviews, curriculum texts or observations has been used to support the main argument of this article, that sex education in the Netherlands has been far more effective because of the pragmatic approach of the Dutch national government, which deferred most of the decision-making to professionals in the field. In contrast, it is claimed that in the UK, and certainly since the mid-1980s, the debates around teenage sexuality and sex education have been highly adversarial and ideological, sidelining sexual health expertise in favour of asserting a traditionalist agenda in which moral and social issues were being conflated, inhibiting a more 'positive' approach.

> In the UK, both the political controversy and the lack of trust generated by policy-making in the field of sex education filter down to the level of what happens in the classroom. In the first place, as a result of the acutely adversarial politics that have surrounded the issue, the treatment of young people under the law is far from consistent on issues to do with sex (Lewis and Knijn, 2002: 683–84).

Lewis and Knijn praise the Dutch system for being based on a system of trust and acceptance of difference, with the government merely facilitating consensus. They particularly stress that, as a result, Dutch sex education is more open, explicit, graphic and less framed by a moral agenda which tries to inhibit reflection on and understanding of other forms of sexuality than those within marriage. It includes 'discussions of feelings

and relationships that are mixed with the physical, biological dimension of sex education' (*ibid*: 687).

However, as Lewis and Knijn's research does not actually engage with everyday expressions of sexual morality, they remain limited to discussing curriculum texts (that may or may not be adopted by schools) and political rhetoric. Indeed, very little comparative empirical research has been done on what this 'typically Dutch culture of openness' might be. The reason for this absence is perhaps not only because it is difficult to quantify, but also because it is nearly impossible to provide any empirically-based evidence of causality of 'openness' in relation to a reduction in sexual risk behaviour. The general assumption, endorsed not only by Lewis and Knijn, but also by the other aforementioned publications, is that a culture of openness makes the dissemination of information regarding sexual issues less ambiguous. It reduces the associations between sex and shame, and thus enables sexual health expertise to influence teenage sexual behaviour on the basis of 'scientific' rather than 'moral' grounds.

It could even be suggested that this 'culture of openness' not only affects relationships between adults and children, but also between parents, teachers and sexual health professionals (the latter has been suggested by Kane and Wellings, 1999). In its most generic form, the assumption underscoring most arguments advocating 'openness' is that it reduces the alienation gap between parents, teachers, sexual health professionals and teenagers, which enables professionals in particular to influence the behaviour of the parents and their children more positively. In an uncanny reversal of the socialisation process, a US-based experimental study claimed that school-based sex education programmes that subsequently involved parents as part of an 'enhanced curriculum' resulted in a reduction of sexual risk behaviour by the teenagers involved (Blake *et al.,* 2001).[6]

It is not clear whether this culture of openness refers to relations between: (a) parents and their teenage children, (b) teenagers and professionals such as teachers, GPs and sexual health experts, and (c) these professionals and parents. Whereas, to our knowledge, no research has been conducted on the latter two, some publications have explicitly focused on the first issue. In a comparative study of relationships between teenage children and their parents in the USA and the Netherlands, Amy Schalet (2000), for example, noticed that there was a distinct difference in the way in which parents and their children interacted regarding issues of teenage sexuality in the two countries. She interviewed a small sample of parents from both countries (17 from the Netherlands, 13 from the USA) and concluded that whereas American parents were more confrontational towards their children regarding issues relating to their sexuality, resulting in an emphasis on control and regulation, Dutch parents were more pragmatic and consensus-oriented, seeking to negotiate with their children over these issues (2000: 78).

In the face of the pervasiveness and endurance of the problem of teenage pregnancy in the UK, there is a widespread consensus among policy-makers and academic researchers that teenage sexuality entails a highly complex set of factors and issues that are not easily disentangled or manipulated. For obvious reasons, most publications have limited their focus to what government policy and/or legislation might be able to address. It is perhaps for this reason that the issues most frequently mentioned relate to the provision of sex education and contraceptive (family planning) services in the realm of public health.

Yet, in specifically comparing the UK with the Netherlands, most publications did suggest that cultural differences (especially 'openness') might play an equally crucial role, alongside the more general issue of socio-economic integration. These factors are far more difficult to tackle through specific government policies and thus have received much less attention in public debates. Moreover, hardly any consideration is being given to

specific issues related to family life, such as divorce rates, dual career families and the provision of (financial) support for families.

Finally, it was evident that whereas comparisons between the Netherlands and the UK are frequently made, these are based on a surprisingly thin basis of empirical evidence, especially in terms of qualitative analysis. There is an almost total disregard of the meaning of sexual morality in the Netherlands and how it affects sex education, for example. Moreover, the Dutch statistics used are often dated (rarely do they go beyond 1992).

This report aims to shed some light on the situation in the Netherlands. Apart from some basic statistics – including the most recent available Dutch statistics – on teenage conception rates, abortions and sexually transmitted infections (STIs), we mainly focus on sex education, using eight case studies to describe what actually goes on in schools. Finally, we will look at various social and cultural contextual factors such as parenting and the role of the family, as well as some historical aspects that may still have a significant bearing on what is otherwise casually referred to as 'a culture of openness'.

1.3 Aim

To map the field of sex education provision in primary and secondary schools in the Netherlands, with a specific focus on the question of whether, and if so how, Dutch sex education has contributed to the apparently low teenage pregnancy rate.

1.4 Hypotheses

When we combine the main findings of the aforementioned publications, we find that there is a generally accepted consensus that the differences between teenage pregnancy rates in the UK and the Netherlands mainly relate to the following three issues:

(a) The superior quality of sex education in the Netherlands;

(b) The Dutch 'culture of openness' in which sex is being discussed with teenagers both in family life and in the public domain;

(c) The widespread availability, easy access to, and adequate use of contraception in the Netherlands.[7]

These can be contrasted with less popular, but equally logical *alternative explanations*:[8]

(d) Teenage parents in the Netherlands receive little financial support from the state (or provision of housing) until they are 18, and even then still depend partially on their parents' support until they are 21;

(e) Levels of poverty and social inequality in the UK are much higher than in the Netherlands. The strong geographical concentration of poverty in certain areas of the UK creates a culture of hopelessness, in which teenage parenthood becomes an alternative career. The socially inclusive nature of the Netherlands reduces both the attractiveness of teenage parenthood and the cultural basis of resistance against mainstream norms and values;

(f) Dutch teenagers have been less engulfed by the sexualisation of culture and have maintained a connection between sexuality and morality. As a result, they abstain from sexual intercourse until a later age than their British counterparts (this may, of course, also be partly the result of successful sex education);

(g) Partly due to lower divorce rates, Dutch families are in general more integrated, resulting in greater degrees of interaction, negotiation and consensus between parents and their children; and the behaviour of children is more directly supervised and monitored (even in the form of negotiation) by one or both parents, as a result of which they have less opportunity for sexual activity.

The first three hypotheses are the main subject of this study. In the next chapter, we will focus more closely on the nature of the Dutch education system and its specific consequences for the way in which sex education is organised and facilitated. In the same chapter, we will also discuss some assumptions regarding the effectiveness of sex education and analyse some of the basic findings from literature reviews. Chapter three will discuss the main statistical evidence regarding differences between the Netherlands and the UK in terms of teenage pregnancy and abortion rates. It will also include some evidence regarding the effectiveness of contraception and the developments of sexually transmitted infections in the Netherlands. Chapter four will provide an analysis of the eight case studies of primary and secondary schools in the Netherlands, and determine how sex education is organised and facilitated in each of them. Drawing on qualitative analysis, the chapter will discuss to what extent Dutch sex education is different from its UK counterpart.

Chapter five will start with an assessment of the extent to which lower teenage conception rates in the Netherlands can be traced back to their system of sex education provision, specifically in relation to its alleged 'culture of openness' and widespread access to and use of contraceptive services. It will subsequently analyse the extent to which the four alternative hypotheses might be able to explain the differences more convincingly.

1.5 Research Design

This proposed research project set out to investigate a number of the hypotheses mentioned in the previous section (which are testable by a simple research design). The research took place between September 2001 and September 2002. It consisted of the gathering and analysis of statistical data and literature on sex education and sexual health in the Netherlands, supplemented with UK data and drawing on the international literature. In addition, eight case studies were conducted: four of primary and four of secondary schools. These schools were differentiated in terms of religious denomination (Protestant, Catholic, secular) and socio-economic composition of the school population. For primary schools, a distinction was made between urban, suburban and rural. The secondary schools were located in the same urban region.[9] At these schools open, in-depth, conversation-style interviews were conducted with teachers involved in the delivery of sex education. In addition, examples of the sex education curriculum material were obtained for more in-depth analysis, not simply in terms of words and pictures, but also in terms of the more abstract levels of 'rhetoric' and 'ideology'. We also obtained information from experts in education policy and social welfare provision. The interviews were all based on a similar framework that included topics varying from general ones such as the phenomenon of teenage pregnancy in the Netherlands as well as the local area, the school climate and changes therein, to specific details about the sex education curriculum, pedagogical focus, didactical strategies, texts used, audio-visual aids, student responses etc. We also asked about the relationships between school and parents, use of external sexual health expertise and possible areas of conflict. Most interviews took the form of open conversations and lasted for one hour or more. Most of the schools were approached via local connections, and none refused to co-operate. Obtaining access was

never a formal affair and was often negotiated with individual teachers to whom we were referred either by the school administration, the director or another teacher.

In terms of the statistical analysis, we have aimed to emphasise an historical perspective to illustrate that teenage pregnancy is not just a recent phenomenon. This should function to provide some counterweight against short-term thinking in the political arena, which often undermines the ability of governments to intervene effectively in society. This also makes us aware of the gradual but persistent social and cultural changes that have affected our society as we have moved into the twenty-first century.

1.6 Limitations

The short time-span in which this research has been conducted made it impossible to undertake extensive surveys of school curricula and teachers' views. As a result, our findings are primarily to be used heuristically. When we provide generalisations on the basis of our case studies, they are logical, theoretical generalisations rather than purely empirical ones. (Statistical generalisations are of course by their very nature empirical.) That is to say, whereas they cannot unequivocally prove or disprove the hypotheses set out in the opening section of this report, they can give strong and logically justified suggestions as to which ones are more plausible. In particular, the findings urge us to be much more cautious when interpreting a few statistical aggregates on the basis of simplistic models. This is particularly true because we have not been able to interview any pupils. The exclusion of actual accounts of sexual experiences and conceptions of morality among teenagers is a serious omission when one wants to ascertain the mechanisms of effective 'sex education'. However, statistical data on rates of conceptions, abortions and STIs can tell us something about the 'end results' of such social interventions. Even without knowing how effective sex education may work in the lives of children, they can tell us a lot more about *ineffective* sex education. To put it simply, whereas it will be difficult to prove that low teenage conception rates and incidence of STIs among teenagers are the consequence of effective sex education, the reverse is much easier. If in any given country where sex education is seen as a central strategy for reducing teenage sexual risk behaviour, conception rates, abortion rates and incidence of STI are increasing, then we can logically and with certainty conclude that sex education has failed.

Chapter 2

Background: Sex Education in the Netherlands

2.1 The Dutch Schooling System

One of the main arguments for sex education in schools has always been that talking to young people about sex will make them more aware of the risks involved. More specifically, in the context of the high teenage conception rates in the UK, it is argued that inadequate sex education is to blame. References are usually made to the Netherlands, where the conception rates are lower. For example, David Walker, referring in *The Guardian* to recent research by Lewis and Knijn (2002), states as if it were a fact that 'low Dutch rates are attributed to more talk about sex between parents and children and more education in schools, both about the physical and the emotional dimensions of sex' (2002: 6).[10] However, he continues that the Dutch and British sex education teaching materials and curriculum are nearly identical, and the only significant difference found is in terms of 'teaching atmosphere' (see also Kane and Wellings, 1999). Another factor often mentioned is the suggestion that Dutch children receive sex education at a younger age, through primary education, and that this is *de facto* compulsory.

However, although a lot of references are being made to the Dutch education system, these count for little if the highly specific context of this system is ignored. Most crucial to understanding the Dutch education system is first and foremost the 'freedom of education', which is constitutionally anchored in article 23 of the Constitution of the Netherlands. This means that parents are free to set up their own schools, according to their own beliefs and values. To get financial support, they merely need to have sufficient numbers of pupils.

Over the years, freedom of education has been primarily interpreted as a freedom of religious education (and freedom from state interference). As a consequence, Dutch education is divided between four groups: secular, Protestant, and Catholic, each taking about 30 per cent, and a category of special schools that base their curriculum on specific pedagogical theories such as those of Montessori or Steiner (10 per cent). There are few general differences between the three main groups, except that, on average, Catholic schools tend to be slightly larger than the other two.

Of central importance here is that the state is the main contributor to the funding of the schools. All schools are entitled to exactly the same system of financial support, which depends on the number of pupils and different indices of deprivation associated with these pupils (based on class and ethnicity). Schools that operate in relatively deprived areas and perform less well than other schools often receive extra financial and non-material support (this is normally referred to as the 'educational stimulation policy'). There are no financial punishments for underachievement and there is no league-table system in which schools' academic performances are ranked hierarchically. Indeed, education has been a key instrument in successive government attempts to increase social inclusion (van Kemenade *et al.,* 1986).

An equally essential feature of the Dutch education system is that there is far greater participation of parents in what goes on inside schools, with teacher/parent consultation commissions having a significant influence on school policies. This is due to an historical phenomenon, which in the Netherlands is called *verzuiling* (pillarisation, see Lijphart,

1974). This process took place between 1870 and 1970. During this period, Dutch society consisted of four main pillars: Liberals, Socialists, Catholics and Protestants. Each of these pillars had its own societies, clubs, associations and institutions. Almost all of everyday social life was contained within one pillar. People did not mingle much across pillar-boundaries, with the exception of élites. Although pillarisation disappeared as a direct result of the secularisation of society during the 1960s, both the mass media and education are still implicitly organised on the basis of the old pillars. Dutch pillarised society was a good example of the Catholic principle of 'subsidiarity', in which power was always devolved to the lowest possible level. This was combined with the Protestant principle of 'sovereignty in one's own circle', which emphasised the maintenance of the autonomy of specific communities. For both religious groups, the legitimacy of the state is derived from supporting autonomy and free will. Even after 30 years of secularisation, these principles are still very significant and are responsible for the high level of local autonomy of schools. Hence the state has an obligation to give financial support to denominational education, without being able to demand much in return.

Comparing the UK and the Netherlands in terms of the way in which education is structured and governed, it can be said that British education (and not just sex education) has been politicised to a far greater extent than Dutch education.

2.2 Sex Education in the Netherlands

Devoid of the ability to impose state-pedagogy or educational ideology, advocates of family planning in the Netherlands could never enter debates on sex education at the level of government policy. Instead, their work has always been more locally focused, providing 'expertise' through the network of mediating agencies that make up the institutionalised 'middle ground' of Dutch civil society. That is to say, whereas in the UK sex education has been primarily a matter of ideology and conflict (also see Monk, 1998), in the Netherlands from its inception it has been a matter of 'discipline' (mainly in the form of what Foucault [1982] termed 'pastoral power') and consensus.

Whereas, in the Netherlands, public information campaigns about sexuality and contraception date back to the early 1970s, sex education was gradually introduced from the mid-1970s onwards in secondary school biology programmes as part of 'human reproduction'. At that time, it barely existed in primary education. By 1990, half of the primary schools still did not provide sex education (Ketting and Visser, 1994: 168); whereas at this time, 85% of secondary schools had a programme of sex education (Kane and Wellings, 1999: 47).

In the UK, the Education (No 2) Act 1986 allowed school governing bodies discretion as to whether sex education should have a place within the curriculum and insisted that where it was taught it should promote moral values, and schools should maintain an up-to-date policy on the subject (Craven *et al.,* 2001). It was not until 1993 that sex education officially became part of the basic curriculum of secondary schools in both the UK and the Netherlands. In that year, Dutch secondary education was reformed under the heading of what is known as *basisvorming*. The national government determined which subjects should be taught in the first three years of secondary education and introduced statutory 'learning objectives' for them. Among the subjects, both biology and 'care' (*verzorging)* had learning objectives related to sex education.

A crucial aspect of the Dutch freedom of education is that, apart from a number of centrally issued and tested learning objectives, both primary and secondary schools have almost complete discretion in *how* they work. There is no national curriculum for primary schools; there are only 'targets'. But targets for sex education in primary schools are not

tested. Hence, sex education cannot be made compulsory for primary education in the Netherlands; in any case, it is up to the schools to decide what is to be done and how.

Although the guidelines for secondary education are stricter and more oriented towards centrally imposed learning objectives, here too freedom of delivery plays a major role. Whereas the government can define the areas that should be taught, which since the Education Act 1993 includes *verzorging* (loosely translated as 'care'), which is the Dutch equivalent of PSHE, the learning outcomes for this subject are notoriously vague and ill-defined. Apart from being able to identify gender differences, students must learn to:

> identify a number of infectious diseases among which are sexually transmitted infections, and specify a number of behavioural options to limit the risks of these.[11]

Indeed, sexuality is only mentioned with reference to the risk of STIs. The main emphasis is more generally on relationships, but neither sex nor contraception is explicitly mentioned in this respect. Perhaps because of its lack of specificity, recent debates in educational policy suggest that the whole subject area may be dropped in the next major educational reform initiatives.[12]

By way of contrast, the learning outcomes for the teaching of biology are more specific. Under the heading of Domain B, which deals with human biology, point five deals exclusively with sexuality and human reproduction:

> In relation to sexuality and reproduction pupils [should be] able to:
>
> (a) describe how human reproduction works; they can describe the processes of conception, pregnancy and birth;
>
> (b) describe means of preventing pregnancies and be able to explain different opinions that people may have about these;
>
> (c) give their own opinion about the use of such means;
>
> (d) articulate different functions of sexuality and opinions thereof. [13]

Although these criteria are more precise, it is obvious that the government is setting very modest requirements for schools in terms of learning outcomes. It is particularly noteworthy that an otherwise rather fact-based subject such as biology must also include a discussion of different (moral) opinions on contraception and sexuality. This is done to enable schools of different denominations to control the content of the curriculum.

A logical consequence of the Dutch education system's strong reliance on local and professional autonomy and consensus (i.e. discipline rather than ideology) is that sexual health experts will enter schools only if they have been invited in by teachers, parents and/or governors, and only if all three parties agree. This could be either in the form of adopting material produced by such organisations as the Netherlands Association for Sexual Reform (NVSH) or the Rutger's Stichting (similar to Brook in the UK), or by inviting such organisations to convene sex education lessons. Indeed, sex education is primarily a matter of school policy, and not something that involves local, let alone the national, government. Because parents are free to send their children to the school of their choice, the development of a symbiotic relationship between school policy and curriculum and parental concerns often becomes necessary. This means that schools will attune their educational strategies to what they anticipate will be the core parental concerns. In terms of sex education, this enables schools to provide more elaborate or restricted programmes, depending on what they perceive as required and acceptable under the circumstances. This means that there are likely to be considerable differences between schools, especially in primary education, in terms of their sex education programmes. We may also expect that quite a few schools will adhere to a more restrictive curriculum; for example, those schools operating in environments where Christianity still has a strong influence.

Referring to examples of such restricted curricula, advocates of extended sexual health education have indeed most vociferously claimed that Dutch sex education is inadequate. In a recent in-depth feature article in the national broadsheet *Het Algemeen Dagblad* (15 February, 2002: 25, 27), Anna Paans cites a number of sexual health experts all claiming that sex is still a taboo subject in the upbringing of children. Even in the Netherlands, claims are made that parents still communicate ineffectively with children and that children are often too embarrassed to address sexual issues with their parents. Schools are also attacked for failing to tackle the implications of the increasing sexualisation of culture. In the same feature article, sexual health expert Willeke Bezemer, for example, claims that parents still approach sexuality too much in the context of committed enduring relationships and that this is too restrictive for teenagers, who may want to experiment with sexual activities without such pressures. Els Standaert, another sexual health expert quoted in the article, promotes her own sexual consultancy agency. Her approach is to emphasise the socio-emotional and relational aspects of sexuality, something which sociologists Bajema and Timmermans (cited in Paans, 2002: 25) have argued is especially lacking in secondary schools. She also emphasises the empowerment of girls to resist sexual intimidation and increase their assertiveness.

The aforementioned feature article shows that sexual health experts are quite *unhappy* about the nature of Dutch sex education and the prevailing influence of parents over their children in developing sexual morality. That is to say, Dutch sex education is perhaps not as open as is sometimes claimed. The residual nature of local autonomy of teachers and parents, whose views on sexual morality are accused of being too conservative, is a source of great concern for the sexual health experts and shows that for them the sexual reformation is far from complete. The possibility that the apparent resilient nature of traditional parenting may have contributed to low teenage conception rates is completely overlooked.[14] Instead, the sexual health experts seem more interested in unhinging sexual morality in favour of increased openness and experimentation.

In other words, claims made by Kane and Wellings (1999) and Lewis and Knijn (2002), that there is a strong interconnectedness between sex education and sexual health provision in the Netherlands, are not shared by experts working in the latter field. Both operate in quite distinctive spheres. Sexual health expertise, however, is readily and widely available to teenagers (but not more so than in the UK), and so are contraception and abortion to anyone over 16. This is not to say that sexual health expertise has no penetration into Dutch classrooms; only that such influence is easily overestimated. We shall return to this in the next chapter when we discuss our eight case studies.

2.3 The Effectiveness of Sex Education

Even if sex education is itself not subject to political debate at the level of national government in the Netherlands, it is still not unequivocally unproblematic at the local level. However, it is widely accepted that sex education has a place within the Dutch schooling system and that it is, by and large, effective (Visser and van Bilsen, 1994: 147). Visser and van Bilsen conducted a literature review and concluded that, whereas sex education contributed to an increased knowledge about sexuality and birth control as well as contraceptive practice, it also engendered more liberal and tolerant attitudes towards sexuality. However, there was no evidence to support the suggestion that sex education improves communication or social skills, or leads to increased assertiveness or empowerment of young people. Visser and van Bilsen also stress that sex education does not result in increased sexual activity among young people, but then admit that 'the real effect of sex education is difficult to demonstrate' (1994: 154). This is because the

research they refer to mainly uses questionnaires and thus describes opinions and self-reported behaviour rather than the consequences of actions.

Similar evidence of sex education effectiveness is given by Douglas Kirby (1997; Kirby *et al.,* 1994). His evaluation studies are mainly concerned with US-based programmes. The reviews suggest that sex education and greater accessibility to family planning services do not lead to increased sexual activity, and can have a positive impact in terms of reducing sexual risk behaviour among teenagers, although the evidence is rather weak. The conclusions of the reviews are not strong because there are only a limited number of evaluation studies, and many of these suffer from methodological difficulties.

In contrast to these findings, DiCenso *et al*. (2002) also provide a review of existing published and unpublished research on the effects of sex education, but mainly focus on clinical evidence, rather than opinions. They conclude that sex education has very little effect on reducing sexual risk behaviour among teenagers, and find that, in some cases, it may even have made a significant contribution to increased sexual activity among girls.

It is obvious that, despite a wealth of research, a lot of assumptions about teenage sexuality have remained unquestioned. Whereas there is an abundance of advice offered to sex educators about how to improve their curriculum and didactics, there is very little compelling evidence of the effectiveness of such educational innovations (cf. Wight, 1997). Most review studies indicate that the impact of sex education on teenage sexual risk behaviour is relatively marginal. Winn et al. (1995), for example, assert that sexual knowledge is a largely neglected variable in sex education research 'because of the poor correlation between knowledge and behaviour and because of the fear of reducing sexuality to a series of facts' (1995: 188). They argue that there is an 'information famine about sex and sexuality' (*ibid*: 189).

Using a questionnaire, Winn *et al.* (1995) established that (factual) sexual knowledge gradually but unevenly increased with years of education, with on the whole greater increases at younger ages and girls being more knowledgeable than boys, especially among higher age groups. This suggests that sex education may be contributing to an increase in factual knowledge about sexuality. However, they also point towards gaps in knowledge, especially about contraception. Their findings suggest that 25 per cent of 15–16-year-olds in the UK have 'inadequate knowledge' about sexual risks (without defining what constitutes 'adequate knowledge'). They see this knowledge-gap as the main cause of the high conception rates among British teenagers. However, their findings do not say whether teenagers are adequately informed about the *failure rates* of contraception. This is all the more important, because it has been reported by Pearson *et al*. (1995) that over 60 per cent of the teenagers who experienced unwanted pregnancies were using contraceptives at the time (also see Paton, 2002 and table 3.5 below).

Whereas there is some research about factual knowledge among British teenagers that supports this aspect of the ignorance hypothesis (Moore and Rosenthal, 1993: 147; Winn e*t al.*, 1995), it does not show whether this lack of knowledge is responsible for the high teenage pregnancy and STI rates. There is hardly any empirical analysis of teenage sexual morality (or 'moral ignorance') and what comes closest in this respect is the aforementioned work of Ingham (1998), who refers to sexual attitudes, which is not the same.

Moral 'knowledge' is, of course, much more difficult to ascertain as – unlike factual knowledge – it is based on specific value systems that are not objective. Following the UK government's own discourse, however, there seem to be some basic values that have taken on a pseudo-objective status. An important aspect of the UK government's moral

discourse is the assumption that sexuality is not to be treated lightly and that it is better 'saved' for very special, lasting, monogamous relationships. Such views do not necessarily suggest that sex is 'dirty', but that it is precious, and that young people are especially vulnerable in the face of the strong and sometimes overwhelming impulses of sexual desire. For sexual health experts such as those cited by Paans (2002: 25), and academic researchers such as Ingham (1998, 2001), Lewis and Knijn (2002) and Kane and Wellings (1999), these views are too traditional, however, and are seen as the cause of ambivalence surrounding sex education.

At any rate, research evidence of the effectiveness of sex education is at best inconclusive. On the one hand, there are indications that it contributes to increased factual knowledge among teenagers about issues related to sexuality and contraception; on the other hand, its contributions to moral and social development are not evidential and, what may be worse, there are suggestions that it may even contribute to increased teenage sexual activity. Given the equally ambivalent role of contraceptive use in relation to teenage sexual risk behaviour (British Pregnancy Advisory Service, cited in Bosely, *The Guardian*, October 13 1999: 13; Paton, 2002; Pearson, 1995; also see Chapter 3), the net effect of sex education will be difficult to predict.

However, if we analyse the data on teenage conception rates historically, we might be able to detect specific 'breaks' and 'turning points'. If sex education has played a major role in reducing the teenage conception rate in the Netherlands, then we should be able to detect its influence when it emerged in the late 1970s, but especially after 1993, when it had become an official part of the secondary education curriculum. We should also expect to find a continued decline of sexually transmitted infections (STIs) since the mid-1970s. Both expectations are based on the assumption that, especially since 1988 during the height of the HIV/AIDS scare, (Kane and Wellings, 1999: 47), sex education in schools in the Netherlands is being provided in close association (either explicitly or implicitly) with sexual health expertise, which advocates the use of contraception against both pregnancy and STIs (Lewis and Knijn, 2002); hence we also expect, if not an increase, then a continuation of contraceptive use amongst Dutch teenagers since the late 1970s and especially after 1988.

On the other hand, if sex education is ineffective, then we should expect no discernable patterns in the decline of teenage conception rates and the incidence of STIs. In this sense, the situation in the Netherlands is similar to the UK in that teenage conception rates have fluctuated only marginally over the last 20 years. However, if sex education is counterproductive, then we should expect an increase in both teenage conception rates and STI incidence, with specific changes after 1978, 1988 and 1993.

Chapter 3

Statistics

3.1 Teenage Pregnancy Rates

In this report, we have defined teenage pregnancy rates as the number of teenage females who have become pregnant within a given year, per 1,000 females aged 15–19. Teenage pregnancy rates, or conception rates, are the sum of the number of conceptions occurring per 1,000 females aged 15–19 which result in births and the number which result in abortions. Table 3.1 gives an overview of birth, abortion and conception rates of 15–19-year-old females in the Netherlands and England and Wales since 1970.

Table 3.1 Birth, Abortion and Conception rates among females aged 15–19 in the Netherlands and the UK.

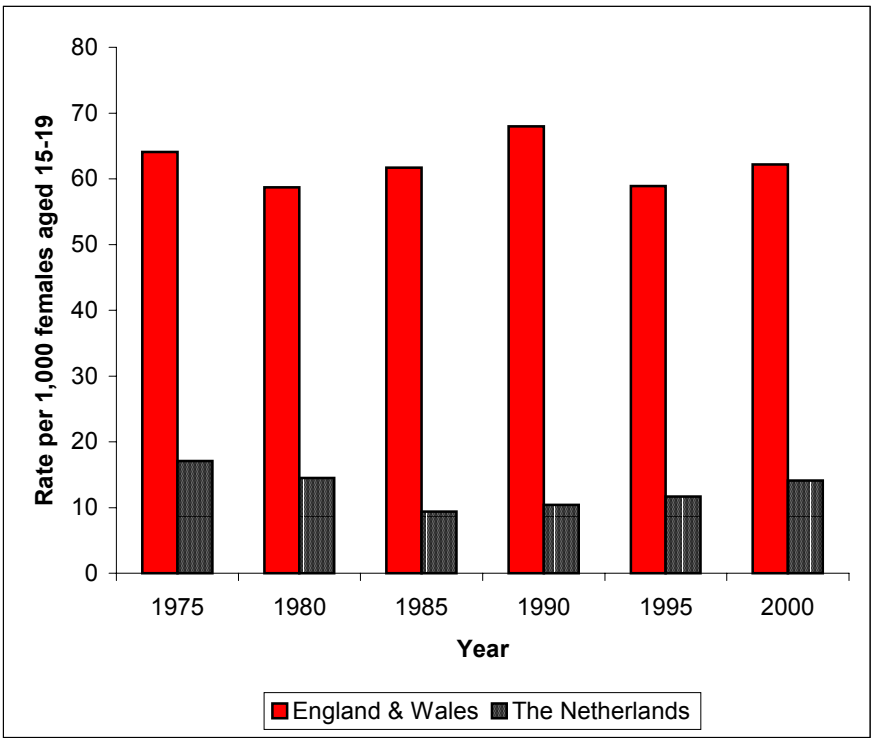
	England and Wales			Netherlands[15]		
	Birth rates	Abortion rates	Conception rates	Birth rates	Abortion rates	Conception rates
1970	71.7	10.9	82.7	22.6	n.a.	n.a.
1975	47.2	17.0	64.1	12.6	4.5	17.1
1980	40.5	18.2	58.7	9.2	5.3	14.5
1985	40.8	20.9	61.7	5.0	4.4	9.4
1990	43.7	24.3	68.0	6.4	4.0	10.4
1995	38.6	20.4	58.9	4.2	7.5	11.7
2000	37.7	24.5	62.2	5.5	8.6	14.1

Sources: Rates for England & Wales are taken from ONS, *Birth Statistics*, various years, and ONS, *Population Trends 109, 2002*. Details of sources for the Netherlands figures are given in the endnote.

The conception rates are represented graphically in Figure 2.

Although some disputes may exist about the exact nature of these figures, especially in the Netherlands where there are some discrepancies between the Dutch Office of National Statistics (CBS) and those given by the Council of Europe that were used by Kane and Wellings (1999), it is clear that the teenage pregnancy rates in the Netherlands are much lower than those in the UK. In the UK, teenage birth rates dropped until 1980, since when they have remained stable with only marginal fluctuations. In 2000, the live birth rate to young women aged 15–19 was 37.7 per 1,000 in England and Wales, compared with 5.5 per 1,000 in the Netherlands – seven times higher, while the conception rate was four times higher at 62.2 per 1,000, compared with 14.1 in the Netherlands.

Figure 2: Conception rates per 1,000 females aged 15–19 in England & Wales and the Netherlands, at five-yearly intervals, 1975-2000.

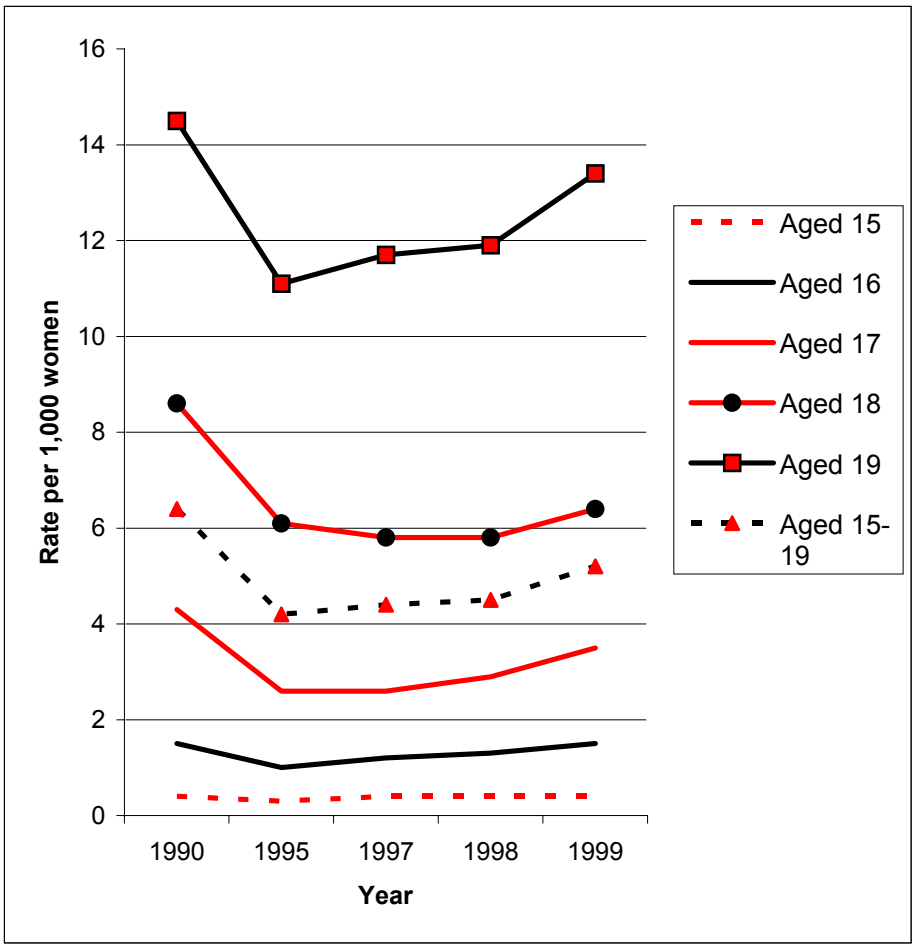


Sources: See Table 3.1 above.

In the Netherlands pregnancy rates continued to drop until 1995, and an increase is noticeable since then (Rademakers, 2002). Indeed, over the last decade, Dutch teenage pregnancy rates have increased by 35%; this is mainly due to a sharp increase in conceptions terminated by abortion (also see Garssen and Sprangers, 2000). The general statistics, however, do not reveal that some areas in the Netherlands, especially the three main cities (Amsterdam, Rotterdam and The Hague), have experienced higher increases in teenage pregnancies (Garssen and Sprangers, 2000: 27). For example, the local government of The Hague recently reported an increase in the number of births among teenagers of 22.1 per cent over the last five years (Jongeren Informatie Punt, 2002).

This increase is also visible when considering the more age-specific distribution of teenage birth rates (Figure 3). Especially among 19-year-olds, teenage motherhood has increased since 1995. This is not often seen as problematic, because these age groups are not regarded as 'teenagers'; they can enter the labour market and qualify for social benefits.

Figure 3: Live birth rates per 1,000 women of designated age-groups in the Netherlands, selected years from 1990-1999



Source: CBS, 2002: 61.

Another possible reason why teenage conception rates are often not seen as problematic in the Netherlands is the fact that a large proportion of teenage pregnancies take place among immigrant groups (Table 3.2). Garssen and Sprangers (2000: 26) note that 60 per cent of all under-20 pregnancies in 1999 were to young women from immigrant groups. Over the past decade, there has been a marked decline in the rate of teenage births to Turkish and Moroccan women (most of which occur within marriage). During the same period, however, teenage maternity rates among those of Surinamese and Dutch Caribbean descent (most of which occur outside marriage) have either remained relatively constant or increased, giving rise to concern.

Table 3.2 Teenage maternity rates (per 1,000 females aged 15–19) in the Netherlands by ethnic group.

	1990	1992	1994	1996	1998	1999
Dutch	4	4	3	3	4	5
Turkish	115	108	96	58	54	52
Moroccan	40	38	32	21	22	20
Surinamese	21	18	17	19	18	21
Dutch Caribbean	30	30	36	30	32	39

Source: Garssen and Sprangers, 2000.

Since 1995, the Netherlands has witnessed more teenage (15–19) births outside marriage than inside (Table 3.3), and, during the years immediately following, teenage parenthood outside marriage has continued to increase, whereas within marriage it has dropped further.[16]

Table 3.3 Marital status of 15–19 year old mothers at time of birth of first child in the Netherlands (estimates)

	1960	1975	1985	1990	1995	1996	1997	1998
Married	4,800	5,200	2,000	1,950	800	650	650	630
Unmarried	900	1,000	1,250	1,300	1,100	1,200	1,300	1,400

Source: CBS, 2000: 26–27

3.2 Abortions

The live birth rate is the most widely used measure when discussing some of the problems associated with teenage sexuality. However, this is somewhat misleading, as it does not take account of pregnancies terminated by abortion.[17] In the Netherlands, abortion rates are often not gathered under general demographic statistics, but as part of public health statistics. This is why it is difficult to make an accurate comparison of conception rates in England and Wales with the Netherlands, particularly as Dutch abortion statistics are seldom broken down by age.

Table 3.1 showed that the teenage abortion rate in the UK is much higher than in the Netherlands. In 2000, the abortion rate in England and Wales was 24.5 per 1,000 females aged between 15 and 19, almost three times the Dutch rate. However, there have been noticeable changes in teenage abortion rates in the Netherlands. According to the Dutch Office of National Statistics, CBS, the most striking features of abortion rates in the Netherlands are: (1) that the number of abortions among (all) women living in the Netherlands has steadily increased since 1985, from 18,000 to 27,200 in 2000 (see CBS, 2002: 91); and (2) that the percentage carried out on women under 20 has also increased. The CBS states:

> The number of women living in the Netherlands who want an abortion has risen considerably… There has been a shift of abortion clients to younger age groups. Whereas, in 1991, ten per cent of all abortions were performed on women under 20, in 2000, it was fifteen per cent (2001: 14; author's translation).[18]

Rademakers (2002: 34), using figures derived from Dutch abortion clinics and hospitals, also suggests that the rate of abortions performed on teenage women in the Netherlands has increased significantly over the past decade.[19] She suggests that the increase in teenage pregnancies in the Netherlands dates from 1997, and has been slow but steady since then. She also notes that it mainly affects immigrant groups (she suggests a figure of over 60%, but this applies only to teenage mothers). This is in line with recent findings produced by CBS (Garssen and Sprangers, 1999; 2000). Most significantly, she writes:

> Because analyses of abortion registration have not been conducted for a number of years, we are only now able to note that there has been *an enormous increase* in the number of abortions among teenage girls (Rademakers, 2002: 34, author's translation, emphasis added).

She describes this increase as 'dramatic' and a sign of an increase in teenage sexual risk behaviour, and calls for more research into this area, which she believes has been neglected due to complacency.

Table 3.4 Abortions among 15–19-year-olds in the Netherlands and in England & Wales, 1992–1999/2000

	The Netherlands		England & Wales	
	1992	1999/2000	1992	2000
Abortion rate (per 1,000 women aged 15–19)	4.2	8.6	21.0	24.7
Abortion ratio (percentage of conceptions to women aged 15–19 terminated by abortion)	43.3%	62.7%	33.9%	39.3%
Abortions carried out on 15– 19-year-olds as a percentage of the total number of abortions	10.6%	12.0%	19.7%	22%

Source: Rademakers, 2002: 13, 26; ONS (2002b).

We should note that the abortion ratio of 62.7 per cent for females aged 15–19 is much higher than the ratio for all age groups in the Netherlands (for whom it is 13.6 per cent with an abortion rate of 9.0 per 1,000; Rademakers, 2002: 26) and in England and Wales (22.7 per cent; 16.1 per 1,000). It is also much higher than the latter's under-20 abortion ratio, which was 39.3 per cent in 2000 (ONS, 2002b). This suggests that, compared with the UK, abortions are more frequently used as a means to avoid teenage parenthood among pregnant teenagers in the Netherlands.

Hence, apart from age- and ethnicity-specific occurrence of teenage parenthood, the phenomenon of teenage pregnancy in the Netherlands is rarely problematised because of a wide acceptance of abortion. This conflicts somewhat with arguments made by Ketting and Visser (1994) and Kane and Wellings (1999), who suggested that, from the early days of the sexual revolution onwards, the emphasis in public discourses on sexual morality has been on preventing teenage parenthood 'by all possible means' (Ketting and Visser, 1994: 170). Whilst abortion is not often considered to be morally wrong, and since the 1970s has been completely depoliticised, it is still deemed problematic within Dutch moral culture. This is why the low abortion rates in the Netherlands are hailed as an indicator of its success (UNICEF, 2001). This is also why contraception is so vigorously advocated. Abortions are seen as a last resort. It is not likely that attitudes change as quickly as

behavioural patterns. Rademakers (2002: 19) echoes this by stating that abortion remains a hot issue in the Netherlands and is still considered to be problematic.

3.3 Contraception

Equally important is the finding that, during the 1990s, the abortion rate rose despite a widespread increase in contraceptive use (CBS, 2001: 91).[20] The Dutch Office of National Statistics (CBS, 2001; 2002); the Netherlands Health Inspectorate (Inspectie van de Gezondheidszorg, 2000: 103) and the Department of Foreign Affairs (Ministerie van Buitenlandse Zaken, 2001) have openly acknowledged this fact. Rademakers (2002: 29) compares CBS figures with data from Dutch abortion clinics and suggests that only 24.8 per cent (20.2 per cent according to CBS) of women (of all ages) did not use any contraceptive in the six months prior to an abortion. For teenage girls, this percentage was only marginally higher (27.4%). In other words, more than 70% of women who became pregnant in 2000 were using a contraceptive. This figure was not much different in 1992 (76.6 per cent). She also presents figures on the kinds of contraceptive failure reported. These are given in table 3.5.

Table 3.5 Explanations for contraceptive failure in women (all ages) in 2000 (percentages)[21]

Method	Method Failure	User-failure	Forgotten to use	Stopped using	Reason unknown	Total failures	% of all abortions in 1992	% of all abortions in 2000
Pill	23.6	21.8	40.9	13.6	0.1	100	33.3	31.3
Condom	50.5	15.7	29.7	3.8	0.2	100	25.0	29.1
Other means (including sterilisation)	59.5	11.3	15.0	10.6	4.1	100	18.2	14.8
No method	–	–	–	–	–	–	23.4	24.8

Source: Rademakers (2002: 29)

These figures call into question the meaning of what is considered to be 'safe sex'. Although we would need figures of teenage abortion rates over a number of years as evidence of a trend, Rademakers herself does not hesitate to interpret her data as an alarming signal that teenage abortion rates are increasing and these relate to contraceptive failure (including negligence). Her research provides a rather different picture of the sexual health of Dutch teenagers to the one suggested by the (dated) figures presented by Ketting and Visser (1994), on which most official documents referring to the situation in the Netherlands still rely. Indeed, Ketting and Visser (1994) do not mention that relying on contraception entails certain risks. However, given a fixed failure ratio of contraceptive practices, increased contraceptive use – when accompanied by increased sexual activity – will clearly correlate with increased numbers of unwanted pregnancies, undermining the argument that wider availability of contraception will automatically reduce unwanted pregnancies.

Research by Dr David Paton published in the *Journal of Health Economics* called into question the claim that easier access to contraception reduces teenage conception and abortion rates:

> On the one hand, teenagers who will engage in sexual activity in any case face a reduced risk of pregnancy. On the other hand, family planning raises the likelihood of engaging in sexual activity in the first place.

Rather than reducing underage conceptions, Dr Paton found evidence that greater access to contraception has a positive impact on rates of underage sexual activity, resulting in an increase in underage conceptions (Paton, 2002; also see Bosely, 1999; Pearson *et al.,* 1995).

3.4 Sexually Transmitted Infections

The increased participation of Dutch teenagers in sexual risk behaviour is most emphatically shown by a continuous rise of sexually transmitted infections (STIs).

The overall incidence of STIs has increased by over 40 per cent compared with 1991, primarily due to a relatively recent (since 1995) surge of chlamydia. Recent epidemiological research for the National Institute of Public Health and the Environment (RIVM) has shown that, in the year 2001, the number of people affected by STIs increased dramatically compared to the previous year (see Table 3.6).

Table 3.6 STIs in the Netherlands 2001 (figures are for men and women in all age groups unless specified otherwise)

	Absolute numbers in 2001[22]	Increase since 2000	Men hetero-sexual	Men homo- or bisexual	Women (%)	Under 20s (%)[23]
HIV-positive	61	+9%	–30%	+41%	0	0
Chlamydia	1,578	+40%	+28%	+22%	+49%	+43%
Gonorrhoea	543	+32%	+30%	+33%	+60%	+18%
Syphilis	139	+22%	–14%	+130%	+15%	–33%

Source: van der Laar, M. Haks, K., and Coenen, T. (2002)

Among the total population in the Netherlands, chlamydia is the fastest growing STI with a 40 per cent increase overall, and a 49 per cent increase for women *in one year* (van der Laar *et al.*, 2002: 293–6). These developments are similar to the UK (e.g. Fenton *et al.*, 2001; Johnson *et al.*, 2001; Nicoll *et al.*, 1999; Public Health Laboratory Service, 2001; Wellings *et al.*, 2001). When we look at age-specific incidence of STIs, we find that, among those infected with STIs, 11 per cent are under 20 years of age. However, they constitute 15 per cent of all cases of chlamydia (Haks and van der Laar, 2001: 412–415), which is the fastest growing STI. The age group with the highest proportion of STIs is the 20–24-year-old cohort (27 per cent of all STI infections and 34 per cent of all chlamydia infections in 2000 – Haks and van der Laar, 2001: 412–415). This means that of all those diagnosed with chlamydia in 2000, 49 per cent were under 25. These are all young people who should have benefited from sex education in secondary schools after the HIV/AIDS prevention campaigns of 1987 and 1988.

High STI incidence among young people is usually interpreted as a sign that they are having 'unsafe sex', meaning sex without condoms. This in turn is blamed on inadequate sex education. The fact that overall STI rates have been increasing since the early 1990s in the Netherlands calls into question the role that sex education is believed to play. After all, if the argument that Dutch teenage birth rates continue to be low because of the quality of sex education is valid, then there should have been no increase in STIs.

Comparisons with the UK are more difficult because of an absence of official figures on incidence rates (per 100,000) in the Netherlands. In 2001, there were 196 clinically diagnosed cases of chlamydia (Haks and van der Laar, 2001) among teenagers aged 15–19 (gender differentiation is not available). This means a rate of 21.1 per 100,000 teenagers of this age group. This is significantly lower than in the UK, where the rates are over 276/100,000 for males aged 16–19 and 941/100,000 for females aged 16–19 (Public Health Laboratory Service, 2001). Although the figures are not accurate enough to make precise comparisons, as it is estimated that only 10% of those infected with chlamydia will be diagnosed, the statistics strongly suggest that STIs in the Netherlands are a marginal phenomenon (the total STI rate among teenagers in the Netherlands is 53.5/100,000; Haks and van der Laar, 2001) compared with a much more serious epidemic in the UK.

3.5 Conclusion

Even if we acknowledge that there has been a considerable increase in conception rates in the Netherlands since 1990, it is clear that both pregnancy and abortion rates are still much lower than in the United Kingdom. Furthermore, while recent figures showing increases in STIs are alarming, the general sexual health of Dutch teenagers is still much better than that of their British counterparts. The question central to this report is whether this can be explained by the way in which sex education is taught in the Netherlands.

The initial statistical evidence is not promising:

(a) Teenage pregnancy rates started to fall most drastically before the introduction of sex education in schools (also see Kane and Wellings: 1999: 48, who pinpoint 1972 as the crucial year).

(b) Although the rates continued to decrease throughout the late 1970s (when sex education was initiated), the rate of decrease diminished over time.

(c) Between 1985 and 1995, teenage pregnancy rates remained relatively stable, showing that the HIV/AIDS awareness campaigns and their related implications for sex education had no additional impact on teenage pregnancy rates.

(d) Since 1995, pregnancy rates have increased, involving a rise in abortion rates, but also (albeit to a lesser extent) pregnancy rates for 18- and 19-year-olds. This shows that the inclusion of sex education in the secondary school curriculum since 1993 actually correlates with the opposite effect of what it was designed to have.

(e) Subsequent reported increases in STI-rates, especially chlamydia, among 15–25 year olds further indicate that young people, most of whom will have been given AIDS-awareness sex education, are increasingly engaging in sexual risk behaviour.

The statistical evidence suggests that there are huge question marks hanging over the effectiveness of Dutch sex education. However, to get a better picture of what sex education entails in the Netherlands, we need to look at what happens in Dutch primary and secondary schools.

Chapter 4

Field Work

4.1 Eight Case Studies[24]

Through in-depth, conversation-style interviews with educational experts and primary and secondary school teachers, we investigated the specific nature of sex education in Dutch primary schools. The purpose of this qualitative research was not to find generally applicable figures about how sex education is being delivered, but rather to trace and map differences and similarities in perspective and approach between different types of schools. We approached four primary schools: one rural (secular), one urban (Protestant), and two suburban ones (Protestant and Catholic) and four secondary schools: two Protestant semi-urban (one comprehensive, one vocational) schools, one Catholic (urban) comprehensive school and one secular (suburban) comprehensive school (all within the same region). Although most sex education in the Netherlands takes place at secondary schools, we have included primary schools. This is because in terms of the British sex education debate, it is where the UK is thought to be most deficient.

We have also tried to select our case studies on the basis of socio-economic differences (for which we use the term 'class' as a shorthand). As in the UK, in Dutch primary schools, class corresponds with geographical area. In secondary schools, class corresponds with school type in that working-class children mainly populate the vocational schools, whereas the internal differentiation of comprehensive schools ensures that the various sections of working and (upper) middle class are also often streamed hierarchically (van Kemenade *et al*., 1986).

If sex education contributes to the persistently low conception rates among Dutch teenagers, then there must be a noticeable consistency across different school types, socio-economic class and regions in the way in which it is being delivered. If there is considerable variation in sex education in the Netherlands, then it will surely have less bearing on teenage sexual behaviour, unless it corresponds with significant differences between various school populations. Moreover, if British sex education is to model itself on the Dutch situation, then factors such as the 'pedagogical atmosphere', singled out by Ingham and Kirkland (1997), Ingham (1998), the Health Education Authority (Kane and Wellings, 1999), UNICEF (2001) and Lewis and Knijn (2002) as a crucial factor in engendering low teenage conception rates, must be present across different types of schools and areas (otherwise, it is difficult to refer to it as 'typically Dutch').

To clarify matters further, we will present a short synopsis of each of the eight schools.

4.1.1 Primary Schools

Primary School 1: Secular, rural, mixed class.

This is a very small school with only three full-time teachers. Sex education is very restricted and limited. It takes place in three or four sessions and is given to children in the highest two groups (ages 10–12) by the head of school (male, 47). He insists that there is a difference between sex education which provides factual knowledge and information (*voorlichting*) and sex education which contributes to a stable, moral social and personal development (*vorming*). He did not see the latter as part of his task. As a consequence,

his programme includes very little of either ‘pleasure’ or ‘mutual respect’, let alone ‘lasting relationships’ or ‘marriage’. He does not offer a moral framework for sex education. This was the job of parents, he said. He does not teach children ‘how to make love’ but explains what happens in terms of their bodies when they enter puberty, how sexual intercourse leads to possible conception, and the risks involved in having sex. He does not use booklets or a fixed curriculum programme but slides and sheets he has made himself. He used to use a video, but as that had been produced in the 1970s, recently switched to another video, which he subsequently rejected for lacking in informational quality. In his own words, ‘the material was too soft’, by which he did not mean that it was not explicit enough, but that it concerned itself too much with the socio-emotional aspects of sex and too little with the biological facts of reproduction. He says that parents usually inform their children about the facts of life well before they come to his class, although he has observed more recent changes with the mass media taking over this role and making young people more aware of sex than they used to be ten years ago. He does not see these developments as necessarily positive.

Primary School 2: Protestant, urban, socio-economically deprived

This was clearly a school challenged by a number of social problems. It was situated in a poor, relatively new housing estate with above-average numbers of single-parent families, unemployment, crime, and drug abuse (this information was given by the head of school, whom we also interviewed). Compared with national averages, ethnic minorities were over-represented, especially Surinamese and Caribbean groups. The teacher (female, 33) who gave sex education was responsible for groups seven and eight (10–12 year olds, equivalent to years six and seven in UK schools).[25] Sex education does not have a fixed place in the timetable, but is part of the curriculum throughout both years. She believes her task is not just to give factual information but also to contribute directly to the social, emotional and personal development of her pupils. She has no fixed curriculum and does not use any books or booklets produced by third parties, although she uses some video material. Her approach to sex education is very liberal: anything should be discussed; there are no taboos. Her approach is unstructured and pupil-led. A main issue for her is contraception and she makes a point of showing the children everything that is available.

She does not believe all parents, especially Muslims, inform their children sufficiently about sex, which may lead to problems. She differentiates between Muslims and Caribbeans: whereas, for Muslim girls, the lack of sexual knowledge does not normally result in negative consequences because of high levels of parental supervision and control, Muslim boys are often unsupervised and behave irresponsibly. However, in her view, Caribbeans are a much greater problem, as many boys and girls come from single-parent families with no adequate parental supervision or family stability to guide them through their adolescence. They often end up on the street, engaging in deviant and criminal activities, including illicit sex. As a primary school teacher, she has direct experience of girls being sexually harassed in the classroom as well as outside the school, and quite a few of her former pupils have become teenage mothers or had abortions. Creating awareness of sexual risks plays a significant part in her lessons. She deploys a moral framework for her sex education classes, derived from a feminist perspective, which stresses mutual and self-respect and empowerment of girls, whom she sees as being at risk from sexual exploitation.

Primary School 3: Protestant, suburban, middle class

This is the school with the most restricted sex education in terms of content, although more time was devoted to it than at Primary School 1. Sex education in this school is exclusively focused on information provision and developing biological knowledge of sexual reproduction, including (but not exclusively) risks. It is taught by two teachers. One (female, 29) is in charge of year sevens (10–11-year-olds), the other (male, 49) of year eights (11–12-year-olds). This is a large school, with predominantly white children (although a few Muslims are now at the school as well). There are no obvious social and economic problems that the school faces on a day-to-day basis. Sex education is not based on any official material, but teachers use their own handouts, some slides and a video. A strong link is made with biology, emphasising the reproductive nature of sex. The teachers are proud to stress their teachings are open, and that everything can be discussed, but equally proud to maintain their core Protestant values of the centrality of the family. The teachers stress that parents usually inform their children adequately about sex, and there is no need to engage in any *vorming* (sex education as personal, social and emotional development). They notice, however, a gradual change in society, with children becoming more and more knowledgeable about sex, due to increased exposure to the mass media. This creates some problems, as issues are raised in class that teachers find inappropriate.

Primary School 4: Catholic, suburban, middle class

This is the largest school in our sample. The teacher (female, 42) has been teaching sex education for more than ten years. She uses her own methods and never a pre-set curriculum. Videos, slides, handouts, magazines and tapes are all used in the classroom. Sex education is integrated into the whole year eight curriculum (11–12-year-olds), but some aspects are also introduced in year seven (by a male teacher, 52). The teacher is very enthusiastic about her work and stresses both information-provision, including risk-awareness, and personal, social and emotional development. Her initial approach is student-led, in which students are urged to ask (anonymous) questions, which she subsequently integrates into an already existing teaching-plan. Health and risk play a major role in her approach. Being a mother herself, she also recognises the risks that teenage girls often encounter when facing pressures to have sex. Although she does not stress it, she does work within a (still quite liberal) moral framework, which emphasises that sex is to be engaged in within lasting relationships. Mutual and self-respect plays an important part in her teaching.

The first and major conclusion of our initial investigation of sex education in primary schools points towards a great variety in curriculum as well as pedagogical climate between the primary schools. These differences do not correspond with what might be expected of the influences of religious denomination. For example, the Protestant school operating in a relatively deprived urban area was offering a far more liberal programme of sex education than the secular school situated in a mixed socio-economic setting. Just as emphatic were the differences between the Catholic and Protestant schools situated just two minutes apart in the same suburban, white middle-class provincial town. The Protestant school taught the most traditional sex education programme of all the schools we visited, whereas the Catholic school had a far more liberal curriculum.

A strong feature of the three denominational schools was that they all deployed some notion of a moral framework. Indeed, Dutch schools are pragmatic but not therefore ‘permissive’. Underage sexual activity is seen as problematic and is certainly not condoned by any of the teachers we have interviewed. Developing risk-awareness plays

a significant part in most schools, but not always to the same extent. Whereas it is central in schools 2 and 3, it is less central in schools 1 and 4. Teachers do not discuss risks of contraceptive failure. It is also important that none of these schools used any official sex education material, booklets or leaflets, except some visual material. None of our case studies based their curriculum on the 'sex education expertise' offered by the professionals. None had received specialist training or staff development sessions on this issue, or were interested in doing so. In other words, this suggests that the use of sexual health expertise is much less widespread than some studies have suggested (Lewis and Knijn, 2002; Kane and Wellings, 1999).

Although there is some indication that the much-famed 'openness' of talking about sex exists in classrooms, this is generally facilitated by the fact that most 10–12-year-olds have already discussed matters of sexuality with their own parents. On the whole, parents are supportive of sex education in schools and it is rarely a source of conflict. However, teachers reported a downside to this openness as well. Without probing, they all stressed the detrimental effects of the increased exposure of young people to sexually explicit imagery and implicit innuendo. They linked this to the increasing commercialisation of the mass media (and loss of control of the traditional pillar-based media-associations). They feared that young children encounter more and more sex through the mass media on a daily basis. No teacher we spoke to thought that children should be encouraged to talk openly about sex through exposure to such mass mediated forms of sexual imagery. Schools did not use much sexually explicit imagery either. They did not show images of people engaged in sexual intercourse; but restricted visual aids to (non-sexualised) images of naked bodies, photographs of a developing baby in the mother's womb and diagrams of the human reproductive organs. Animation was used to show the process of fertilisation from the perspective of internal organs.

In addition, none of the primary schools were offering an integrated sex education programme to children under the age of 10, and most of the sex education was offered to children aged 11 and 12. That is to say, since its inception in the early 1970s, sex education in the Netherlands has retained its focus on young teenagers. Teachers all agreed that, below the age of 11, children were simply not ready to understand issues related to sexual reproduction and certainly not the emotional complexities involved in human sexuality.

In conclusion, from our preliminary investigations we can deduce that there are substantial differences between schools, in what they consider to be adequate sex education and in the atmosphere in which this takes place. There is no fixed curriculum; teachers develop their own specific approach to the matter, mostly depending on their own priorities and moral outlook. Although they deny that they aim to impose this on others, a bit of probing regarding issues of, for example, paedophilia or 'casual sex' reveals that moral frameworks are still in place. Not everything is as 'open' as is often suggested; and sex education in the Netherlands is not entirely unproblematic for the teachers either, especially with the relatively recent increase in highly explicit sexual images in the mass media.

4.1.2 Secondary Schools

In the Netherlands, sex education in secondary education is divided across two different subject areas: biology and the *verzorging* (equivalent to personal, social and health education, or PSHE, in the UK).

Secondary School 1: Secular Comprehensive

This very new school is located on the outskirts of a rapidly expanding suburban town between the cities of Dordrecht and Rotterdam. The school was built because of a rapid increase in pupil numbers. The vast majority of pupils have Dutch parents and there are only few members of ethnic minority groups attending the school. At this school, the biology teacher is responsible for sex education. Remarkably, she says that she is not informed about what is happening in the PSHE classes as she expects them to attune their (much more limited) curriculum, as far as sex education is concerned, to hers.[26] She uses a text book *Biologie Voor Jou* (*Biology For You*) by Smits and Waas (1999), which is the most widely used biology textbook in the Netherlands. All the secondary schools in our sample use it. The book for the second year (VO2: 13–14-year-olds) has a special chapter devoted to 'Human reproduction'. This includes information about sexual intercourse, fertilisation, pregnancy, abortion, contraception and STIs, with a focus on risk-prevention for which contraception is seen as the main vehicle. It is the first time in this secondary school that pupils will come across the biology of human reproduction, although they may have had some sex education as part of PSHE in the first year (VO1: 12–13 year olds). The teacher noted that there was a significant difference between the different levels of secondary education. Whereas VWO-pupils (the stream most similar to the UK's old grammar school) were largely 'immature' and had little or no sexual experience, the MAVO-pupils (a lower-level comprehensive stream) were far more experienced in sexual matters, and the teacher was fairly convinced that quite a few of the 13- and 14-year-olds were sexually active. When asked to reflect on the wider social and cultural transformations, she turned out to be quite despondent. She lamented a general breakdown in morality in Dutch society, but especially amongst young teenagers. She thought that there might be two main contributors to these shifts: an increase in families where both parents worked and the spread of an increasingly immoral culture particularly promoted by the mass media and the internet.

Secondary School 2: Protestant comprehensive, semi-urban area.

Two teachers were interviewed at this school, the PSHE teacher and the biology teacher. This was the only school where the PSHE teacher was the first nominated member of staff to be interviewed (it was also the only school where the referral was given by an administrator rather than the head of school). She indicated that most of the curriculum was derived from the biology classes of VO2 (equivalent of Year 8 in the UK). However, in VO1 (Year 7), representatives from Proctor and Gamble would visit the school to hand out an information pack (differentiated between boys and girls) containing, among other things, a booklet about adolescence, menstruation, (some) contraception, STIs and acne. For girls, it contained a packet of sanitary pads and a packet of tampons; for boys, there was a small bottle of Clearasil. The representatives would hold an hour-long session with the pupils to explaining them about various issues regarding adolescence and puberty, including sex, and answering questions. Needless to say, there is a commercial objective here as well, as Proctor and Gamble is one of the world's largest producers of hygiene- and health-related products. This was the only example of an 'outsider' (it is debatable whether a public relations worker from Proctor and Gamble counts as a 'sexual health expert') coming into the school for the provision of 'sex education', and this constituted only a very small part of the curriculum.[27]

The teacher stressed that she was open about everything and prided herself on her taboo-breaking approach. However, although the teacher advocated the philosophy that children should know everything and that everything should be discussed without fear of

recrimination, she also emphasised that her educational role was to develop an awareness of sexual risks and to dispel myths about what her pupils believed to be (in her own words) 'normal (and acceptable) sexual behaviour'. She said that she did not believe that anal sex and orgies should be considered as 'normal'. Referring to specific questions raised by teenagers in the last two years, she feared that teenagers increasingly view anal sex and orgies as part of a normal, healthy sex life, and are subsequently more likely to engage in sexual activity. She blamed the mass media and the internet for spreading misinformation about sex, which led young people to have an inadequate conception of it.

At the same school, we also interviewed the biology teacher who had worked at the school for more than 30 years. During those years he had witnessed a dramatic transformation, mainly due to radical educational reforms in the late 1980s. This had transformed the school from a highly successful traditional grammar school into a mediocre comprehensive. The teacher pointed out that during those changes there had been a steady decline, not only in the academic achievements of the pupils, but also in their social skills. He particularly mentioned a lack of respect for authority and a lack of commitment to learning. However, equally telling was the fact that, for him, the basic structure and curriculum of sex education, as far as it was being taught within biology, had not changed much since the 1970s. Apart from a few additional STIs and the inclusion of more graphic illustrations regarding genitalia, the content of sex education was still quite similar. He stressed that, at this school, the sole focus was on the cognitive rather than the socio-emotional development of pupils. In contrast to the PSHE teacher who favoured the more outspoken and experienced 'lower achievement streams' (many of whom she thought were sexually active at the age of 14), he preferred to teach the higher VWO stream because they were more receptive to more complex and advanced biological theory.

Secondary School 3: Urban, Catholic Comprehensive

Compared to the other two comprehensives, this school has a slightly higher intake from the 'lower socio-economic strata', due to its location in a largely working-class area of the city of Dordrecht. As a result, the school also had a higher intake of ethnic minority students. Similar to the aforementioned Protestant school, religious affiliation mattered very little in the daily affairs of pedagogy and didactics. The biology teacher we interviewed was himself not a Catholic, although he generally supported the ethos of the school. Most sex education at this school was covered within the biology curriculum, which, like the other schools in our sample, followed the *Biologie Voor Jou* method, and thus included a focus on developing sexual risk-awareness, which is mainly used to promote contraception. For him, too, not much in the sex education curriculum had actually changed over the years, although he also noticed that pupil behaviour and attitudes had. Whereas 15 years ago many of the VO2 students (13–14-year-olds) would not have been able to reflect on actual sexual experiences, he felt that many of them now were. He believed that part of this was because pupils are more sexually active, but also because they had come across a vastly increased volume of information about, and representations of, sex through the mass media and the internet. Like the other teachers we interviewed, he was quite negative about this and stressed that this made his job more difficult. This was not due to the fact that pupils today ask more direct questions about 'deviant' sexual practices in attempts to shock him, but to the fact that they seem to attach very little relevance to any moral embedding of sexual practices. However, very similar to the male biology teacher in the Protestant comprehensive, he felt that his job was to focus solely on cognitive development and information provision. He did not see himself as equipped to give pastoral care or moral guidance, even when he felt that was required.

Secondary School 4: Vocational, Semi-Urban, Protestant

Compared to the three comprehensives, this was a very different school. As a preparatory vocational school (VMBO) it mainly recruits pupils who will continue a vocational education. Such qualifications have relatively low status compared to other more academic degrees. Without exception, pupils drawn to this type of education are from the lower socio-economic strata of Dutch society (including many from ethnic minorities, which constitute almost half of the school population). Although the government has also set learning outcomes and targets for this school type, in practice pupils are not expected to meet them. Instead, the main aim is to try to keep the pupils in education until their sixteenth birthday in the hope that they may learn something as well. Yet, whilst this may present a rather bleak outlook on the educational experience, the teacher we interviewed at this school was much less despondent than the others we had spoken to. He was responsible for both biology and PSHE lessons. Because of the vocational character and the persistence of stereotypical sex-roles, boys and girls usually end up in segregated streams with boys being mainly in technical classes and girls in those focused on care and administration. This has enabled him to obtain a unique perspective on the different processes of maturation between the two gender groups. As with all the other schools, girls were seen as maturing earlier and being more responsible than boys. As a result, they were more receptive to sex education, and usually also had earlier experiences of sex. He reported that he believed that virtually none of the 14-year-old girls were virgins, whilst more of the boys were. When the girls reach 15 and 16 they will often have longer-term relationships with much older boys who have cars. This leaves 15–17-year-old boys in a strange vacuum as girls of their age won't have sex with them. This may explain why they seem to be more interested in 13- and 14-year-old girls.

Given their low average standards of educational achievement, the pupils were only expected to understand the basic biological principles of sexual reproduction and risks. Considerably more attention was being paid to the social dimensions of sex. The teacher noted that although most pupils were well informed about contraception, they were not always using it properly. He had witnessed a steady flow of abortions with the VO3 and VO4 (14–16-year-old) girls. However, he was not that concerned about possible increases in conception and STI rates. He stated that the recent social and cultural changes have had much less impact on these pupils because they were already sexually more active and more prone to taking sexual risks.

Reflection on Secondary Schools:

Compared with the UK, where PSHE has a more prominent role (Winn *et al.,* 1995), sex education in the Netherlands is characterised by the centrality of biology. Indeed, the distinction between *voorlichting* (information provision) and *vorming* (socialisation) that was made by the primary school teachers is institutionally anchored within the Dutch secondary education system, in which biology provides the first function and the Dutch equivalent of PSHE (called *verzorging*) the second. Because it resembles a traditional subject area, with clear learning outcomes and an established repertoire of assessment and testing, biology has a higher status and is often given more prominence in the establishment of Dutch sex education curricula. Given the unambiguous national guidelines on learning outcomes, which include the topic of human reproduction, very few secondary schools in the Netherlands will have opted out of sex education altogether even before 1993, when the government recommended that schools should ensure that the subject was adequately covered.

The vast majority of secondary schools, however, will have maintained a strong biological component to the programme because, as has been shown earlier in this chapter, the learning outcomes are much more detailed and unambiguous for biology than for v*erzorging*. This was reflected by our selection of schools for which the only fixed curriculum for sex education was developed within the field of biology. When questioned, those teachers who were working in secondary education well before 1993 (the biology teachers of schools 2 and 3, both male) said that the changes of 1993 regarding sex education did not have nearly as much impact as the more general educational reforms that were introduced at the same time. However, both did state that they believed that, since then, discussing issues regarding sexuality in the classroom has become more difficult due to a gradual increase in 'inappropriate' sexual awareness (which they mostly related to increased exposure to products of the sex-industry) amongst their pupils, which led them, in turn, to focus more on sexual risks.

This is in sharp contradistinction to claims made by authors such as Clark and Searle (1994), who assert that biology has a less prominent position in Dutch sex education than in Britain. As they neither disclose their data nor their methodology, it is difficult to explain why they have come to such a conclusion, which seems to have no corresponding reality. It also undermines the argument that the high teenage conception rates in the UK are due to a neglect of the social and emotional aspects of sex. The case studies suggest that these aspects get very little attention in the Dutch curriculum because the emphasis is strongly on knowledge and risk-perception.[28] The issue of risk had emerged mainly as a result of growing fears of an emergent HIV/AIDS pandemic. For all teachers, the risk discourse was a primary motivator behind their commitment to sex education, with STIs having become almost as prominent as pregnancy. This is also reflected in the written curriculum where the issue of STI-risks features prominently in most sections on human reproduction. This is used mainly to advocate the use of condoms *alongside* the pill (the so-called 'double-Dutch method'). Whilst this means that there is an explicit recognition of the risk of contraceptive failure, this does not feature – strangely enough – as an issue as such, and is not explicitly discussed as a potential problem.[29]

The importance of biology in sex education reflects a significant division of allocated primary responsibilities between schools and parents (regarding *voorlichting* and *vorming*) and fits quite well with the general image of Dutch culture as being 'pragmatic', 'direct' and 'no-nonsense'. Schools rely on parents for the normative socialisation of their children regarding issues of sexuality. There is probably a gender difference as well in terms of teachers' attitudes. Male teachers may be less willing to include 'socio-emotional' aspects into their sex education curriculum. They refer to the subject of *verzorging* as the appropriate area for these issues (which is by and large taught by women). We can assume that the dominance of biology-oriented sex education will be particularly the case in the 'higher-achievement streams' of comprehensive schools, which have a stronger academic focus on the development of cognitive skills. According to two of the female teachers, children in the high-achievement stream are also less 'sexually aware'. This suggests that, as in the UK, prevalence of teenage sexual behaviour is related to socio-economic factors, including those of career prospects, which manifest themselves culturally in terms of attitudes, morals and practices.

Although, in contradistinction to primary schools, the curriculum and approach of teachers in these secondary schools seem much more homogenous, there are noticeable differences in terms of inclusion of student experiences and 'openness'. The two male biology teachers in the comprehensives deliberately excluded most of the student experiences. Their openness was also limited, as suggested by the phrase that 'everything should in principle be addressable, but this does not mean that everything must be addressed'. For example, if a pupil were to raise the subject of anal sex, they

both said would respond to it by sticking to the biological fact that the anus is not naturally designed for such activities, but they were strongly resistant to the idea of bringing it up themselves.

Despite their confessed 'openness' to student questions, they both insisted that they were firmly in control of the curriculum and did not allow any diversions from what they had set out as the main targets. The teacher at the Protestant comprehensive was even more restrictive than the one at the Catholic school. Whereas the female teachers (at the secular and Protestant comprehensives) and the male teacher at the vocational school were more open to the inclusion of student experiences, they did so in different ways. In the secular comprehensive, they followed a specific pedagogical method (Dalton) in which pupils set out their own programme of study and work, independently or in groups, on specific projects. Because there was very little collective work, openness usually involved small-group discussions, or individual one-to-one sessions. Student input was not seen as vital to the programme, but as a possible ingredient of the project the students were engaged in. In the comprehensive Protestant school, openness and student experience were essential parts of the PSHE curriculum, but here the teacher used these as a means to address 'myths'; that is, her main interest in students' opinions and views was to be able to debunk myths. This is also why she preferred lower achievement stream groups, because they had more experiences to share, whereas the high-achievement stream were mainly interested in absorbing information to get a higher grade at the next test. Very few of them had any significant sexual experiences. For the male biology/PSHE teacher at the vocational school, openness and student-experience were vital instruments in making the classes more interesting (and relevant) to the pupils, who were more at risk of dropping out. He did not believe that what he does will have any influence on the behaviour of most of them.

4.2 Overview of Data from Primary and Secondary Schools

Table 4.1 indicates that there are some similarities and many differences between Dutch schools in their provision of sex education. The main similarities are in the timing of sex education provision, the type of materials used, the absence of sexual health experts and the support of parents; the main differences occur in the pedagogical ethos, didactics and reported problems regarding teenage sexuality in and around the school.

Given these differences in approach to pedagogy and didactics, it is difficult to see which specific curriculum or climate of sex education reduces teenage sexual risk behaviour. Both of our non-random samples of primary and secondary schools show a wide variety in methods and approaches. If the hypothesis that 'good' sex education contributes to lower teenage conception and STI rates is valid, then there are quite a number of 'good practices' to choose from, varying in terms of openness and attention given to the 'socio-emotional' aspects of sexuality (*vorming*). Only the written curriculum of biology in secondary education was fairly homogenous, and the way this material is used, and the emphasis it receives, still varies greatly between schools.

However, if we look further at differences between Dutch schools, then it is immediately clear that some schools have more problems than others.[30] The most problematic schools (according to the teachers themselves) are those whose intake of pupils is from the lower socio-economic strata. These are also the schools that are most 'open' and 'explicit' in their sex education provision, and pay most attention to the *vorming* of their pupils, primarily in response to what they perceive to be a lack of parental involvement. They are also the ones that have the most 'student-led' types of sex education,

Table 4.1 Overview of main findings in case studies

	Primary School 1	Primary School 2	Primary School 3	Primary School 4
Denomination	Secular	Protestant	Protestant	Catholic
Location	Rural	Urban	Suburban	Suburban
SES of school population	Mixed	Working class	Middle class	Middle class
Ethnic composition of school population	White	50% non-white	Mainly white	Mainly white
Gender of teacher(s) interviewed	Male	Female (2)	Male and Female	Female
Year when S.E. is mainly taught (UK equiv.)	Year 7	Year 7	Year 7	Year 7
Nature of pedagogic ethos of sex education	Restricted, mainly *voorlichting* (biology)	Open, mainly *vorming*	Restricted, mainly *voorlichting*	Open, both *voorlichting* and *vorming*
Didactics	Teacher-led	Pupil-led	Teacher-led	Pupil-led
Leading subject	n.a.	n.a.	n.a.	n.a.
Curriculum material	Teacher-developed	Teacher-developed	Teacher-developed	Teacher-developed
Audio-visual material used	A video and some slides (not explicit)	Video, examples of contraception	Video, slides, images from books (not explicit)	Videos, slides, magazines and tapes (not explicit)
External sexual health expertise involved	Never	Never	Never	Never
Problems reported with teenage pregnancy in or around the school	No	Yes, outside the school	No	No
Involvement of parents	Supportive	Supportive	Supportive	Supportive

	Secondary School 1	**Secondary School 2**	**Secondary School 3**	**Secondary School 4**
Denomination	Secular	Protestant	Catholic	Protestant
Location	Suburban	Suburban	Urban	Suburban
SES of school population	Middle class	Middle class	Mixed	Working class
Ethnic composition of school population	White	Mainly white	30% non-white	50% non-white
Gender of teacher(s) interviewed	Female	Male and Female	Male	Male
Year when S.E. is mainly taught (UK equiv.)	Year 9	Year 9	Year 9	Year 9
Nature of pedagogic ethos of sex education	Relatively restricted, mainly biology	Biology – restricted; PSHE – relatively open	Restricted, mainly biology	Open, *vorming*-led (PSHE and biology)
Didactics	Pupil-led (Dalton)	Teacher-led	Teacher-led	Pupil-led
Leading subject	Biology	Biology	Biology	PSHE
Curriculum material	*Biologie voor jou*	*Biologie voor jou*	*Biologie voor jou*	*Biologie voor jou*
Audio-visual material used	Images from books (not explicit)	Images from books (not explicit)	Images from books (not explicit	Images from books (not explicit
External sexual health expertise involved	Never	One session in Year 8 (by Proctor & Gamble)	Never	Never
Problems reported with teenage pregnancy in or around the school	No	No	No	Yes, both inside and outside the school
Involvement of parents	Supportive	Supportive	Supportive	Supportive

where the approach strongly relies on the 'street-wisdom' that children bring to school. Although the emphasis is still on de-bunking myths and replacing street-knowledge with more scientifically accurate knowledge, teachers admit that they find it difficult to get their message across.

Although it is noticeable that the schools in relation to which teachers indicate that actual teenage sexual risk behaviour (of pupils or former pupils) might be a problem (Primary School 2, Secondary School 4) are also the ones with the most open and student-led sex education curriculum, we would be wrong to conclude, on the basis of this small sample of case studies, that the one causes the other. These schools differ greatly from the others in terms of school culture and student intake. In both cases, socio-economic and cultural factors seem to have a much greater effect on teenage sexual practices than curriculum, pedagogy or didactics. Sex education at these schools is – according to the teachers – developed as a *response* to perceived problems that the pupils bring to the school; their *rationale* is thus formed on an *ad hoc* basis.

4.3 Differences Between Dutch and British Sex Education

To our knowledge, no large scale systematic comparative research of British and Dutch sex education has ever been conducted. However, our initial observations are that – as far as the official curriculum is concerned – the differences are not as large as have sometimes been suggested. It is perhaps true that Dutch schools have a slightly more biological and cognitive focus and that Dutch PSHE has an even lower status than in the UK. Inside Dutch schools, debate plays only a subsidiary role; the main emphasis is on factual knowledge. Dutch secondary schools start providing sex education slightly later than most British schools (whereas in the UK it is Year 7, in the Netherlands it is Year 9 [see endnote 25]). In primary schools, nothing is offered until children are at least 10; more commonly when they are 11 or 12 (Year 7). When sex education is offered in British primary schools, it mainly targets 10 and 11 year olds (Year 6).

This places a question-mark over the hypothesis that earlier sex education will help to prevent sexual risk behaviour among teenagers, as is claimed by Anne Weyman, chief executive of the Family Planning Association (cited in Hill, D., 2000). The pedagogical climate, to which Ingham (2000) and UNICEF (2001) refer, is also a spurious category, as differences between schools *within* the Netherlands are evidently larger than the alleged average differences *between* the Netherlands and the UK.

Indeed, if anything is different in the Netherlands, it is the way in which issues of teenage sexuality are raised within families. According to Schalet (2000), Dutch parents are much more involved in the sex education of their children and less anxious about their teenage children's sexual maturation than (in her example) American ones (who are often assumed to be much closer to British parents, e.g. UNICEF, 2001). She stresses that this involvement includes a clear moral dimension that sexuality is necessarily embedded in the context of enduring relationships based on love (Schalet, 2000: 85). Whereas such generalisations must be approached with great caution, as they obviously ignore possibly extensive variations in terms of region, religion, age, ethnicity and class, they reflect the teachers' own observations that most teenagers do communicate with their parents about issues of sexuality, and that for them parents are the best suited to deliver the development of 'socio-emotional' aspects of sex education. As a result, not only are there possibly higher levels of trust between parents and children, but also between teachers and parents in the Netherlands. Dutch schools feel less urgency to compensate for the 'failure' of the parents to inform their children about the facts of life. Those schools that have taken on the role of 'compensators' are also the ones facing the greatest problems in

terms of teenage sexual behaviour. This is also stressed in the aforementioned UNICEF report (2001: 21).

This corresponds with observations and comments from teachers that the Dutch education system is increasingly encountering a discrepancy between what is being taught and what children are doing outside the classroom. This is quite strongly reflected by the teachers' almost despondent outcry over the current state of sexual culture, which is immersed in commodified and instrumental sex (discussed in the Dutch curriculum as *lustbeleving*) at the expense of meaningful and moral relationships. This strongly resonates with recent research in France in which a government-sponsored survey suggests that the views on sex espoused by French teenagers are heavily influenced by highly explicit sexual imagery. French public health officials relate this to significant shifts in teenage sexual attitudes and behaviour, which are reconfigured through an increasingly commodified process of sexualisation (Henley, 2002). That is to say, the sexualisation of society affects a whole plethora of cultural products that range from advertisements of cars and ice cream to adult entertainment. Whereas UNICEF (2001) seems to suggest that this is an autonomous process that happens as a side-effect of modernisation and individualisation (or 'progress'), it is far more logical to argue that it is an effect of cultural industries, for whom the use of sexual imagery is a means of increasing profits. The sexualisation of society is simply a process of sexual commodification, turning 'sex' into a service or object, made available on markets for consumption.

Indeed, the Dutch teachers of our sample admit that sex education is a very poor antidote against the onslaught of the sexualisation of culture. As a result, while teaching young people about contraception may (or may not) make them use it more, this in itself does not help to reduce the conception rates or the spread of STIs. Instead of taking the pedagogical climate or information provided as central variables to determine how sex education relates to teenage sexual behaviour, our research suggests that there is a strong indication that what happens inside the classroom often reflects the immediate context in which schools operate (rather than the other way round).

Chapter 5

Explanations of Differences in Pregnancy Rates between the Netherlands and the UK

5.1 Sex Education

The research that forms the basis of this report is not all of a quantitative nature and cannot therefore produce conclusive evidence on the direct and indirect effects of sex education on sexual risk behaviour among teenagers. However, its partly qualitative character also has a number of advantages that large-scale surveys do not have. We were able to investigate in some detail the pedagogical culture of particular schools and what their respective sex education programmes actually entail. This also includes the extent to which these programmes reflect on cognitive and socio-emotional aspects (for example, understanding aspects of human reproduction as having biological, social and psychological implications and consequences) as well as 'moral knowledge' (for example, how one 'should' behave towards other people and the extent to which sexuality implies issues of right and wrong) regarding issues of sexuality.

The case-studies described in the previous chapter suggest that the excessive claims made with regard to the education system as a means of resolving the problems of teenage sexuality are unjustified and based on misguided assumptions. The Dutch teachers in our case studies are all well aware of the limitations of sex education. As a result, they do not try to engineer teenage sexuality, but simply respond to the pressures they face. As many teachers have said, they do not wish to impose any restrictions on what is being said, but increasingly find themselves acting against norms and expectations generated from teenage exposure to commodified sexual imagery (that is, sex for the sake of increasing an appeal) that are infiltrating mainstream popular culture in the Netherlands (as in many other countries). They find this frustrating and are deeply concerned. Moreover, the pedagogical climate generated in the classroom is usually related to the general climate and culture of the school, which in turn cannot but be a response to the social and cultural environment in which the school operates.

The schools that face the largest problems, and where teachers have reported most direct experience of problems with teenage sexuality, are those located in the more socio-economically deprived areas. Teachers at these schools unequivocally suggest that these problems are most prevalent in cases where family structures are inadequate to guide teenagers through the minefield of the rather volatile sexual culture of Western (Dutch) society. However, they also realise that there is little they can do to compensate for such failures. It is therefore no coincidence that these schools also have the most liberal and unstructured 'open' sex education curriculum. As the schools struggle to make sex education relevant to the children and teenagers, many of whom are already quite 'streetwise' about sex, they can neither simply impose a fact-based approach, nor rely on existing social, personal and emotional development. These schools face many children who are quite well informed about what sex is, but lack the emotional, social, personal and cultural stability, maturity and above all moral knowledge or competency to handle this information adequately.

Other schools with a more liberal and open approach, who teach children from a predominantly white and middle-class area, do not necessarily encounter a dysfunctional sexual culture, but do report problems due to an increasing gap between the norms and

values espoused by sex education and those produced by the commodified sexuality of the mass media. As a result, they face pressures to 'open up' the sex education curriculum further, to include an increasing amount of sexually explicit material focusing on the relationship between sexuality and immediate gratification of primordial desires (*lustbeleving*). Whilst some may call this 'progress', none of the teachers we interviewed was happy with the situation.

What is most striking in these cases is the difficulty of addressing moral questions regarding sexual issues, because the liberal ethos within which sex education is being delivered erodes the ability of teachers to provide a consistent and non-ambivalent normative framework within which they could be handled. In the absence of the ability to guide moral judgements, teachers and pupils were caught in a trap of relativism, in which each opinion is as good as any other. The only exception here is the realm of interpersonal ethics, where the principle of not harming others provides at least a basic moral principle for informing young people about sexuality. Needless to say, this in itself opens a whole new problem of identifying consensus and limits.[31] In the absence of adults taking responsibility for the moral development of young people, the pressures and risks are shifted downwards to individuals, who at the same time are not equipped with the necessary tools to make proper judgements. This process of individualisation and its association with risk has been widely recognised in the sociological literature (Bauman, 2001; Adam, Beck and van Loon, 2000; Beck and Beck-Gernsheim, 2002; Davis, 1999; van Loon, 2002).

In other words, those schools where teenage sexuality is less of a problem, and where teachers are best able and most confident to deal with the moral issues of sexuality, are not schools with a more 'open' approach to sex education, but schools that strongly rely on the primacy of the moral responsibility of parents. Teachers in such schools see their task as simply tying up the loose ends, but still within an implicit moral framework. This also problematises the suggestion that liberal sex education simply encourages young people to have sex at an early age (also see Visser and van Bilsen, 1994). It is not as simple as that. What happens inside the classroom is related to the school climate, and the school climate is related to the cultural and social context in which it operates. The role of the parents is the crucial lynch pin in this complex system of interactions. This is also widely acknowledged in the literature (Blake *et al*., 2001; Schalet, 2000; Visser and van Bilsen, 1994).

Finally, the schools with restricted programmes function as falsifications of the claims of Visser and van Bilsen (1994) and Ingham (2000) that effective sex education takes place in an open atmosphere focused on socio-emotional development. It is quite the opposite. Schools with restrictive sex education programmes do not operate in environments with high levels of teenage pregnancy, yet their sex education is primarily focused on providing information and facts, specifically about the risks of sex (following the government's own guidelines regarding learning objectives). Again, such schools rely on good parenting for their sex education to be effective.

To conclude then, the first hypothesis, that good sex education – focusing on personal, social and emotional development offered to young people at an early age and independent of moral issues – results in low conception rates, is not supported by our findings nor by most other studies. First of all, the schools in our study whose curriculum resembled these characteristics most were also those with the most noticeable problems regarding teenage sexual risk behaviour. Secondly, as we have seen in Chapter 2, Dutch sexual health experts have criticised schools in general for lacking such qualities in sex education, pointing towards the persistence of traditionalism in school curricula and parenting. Parents, especially, are accused of imposing an old-fashioned moral agenda

onto sexual health. Thirdly, and perhaps most telling, is the statistical evidence reported in Chapter 3, which suggests that the official introduction of sex education into the primary and secondary school curricula, especially after the launching of the HIV/AIDS awareness campaigns in 1987/1988, has not corresponded with further reductions in teenage conception rates, abortions or incidence of STIs; and that – instead – these have all slowly but steadily increased, especially since 1995.

Whilst the second hypothesis, that the 'culture of openness' that prevails in Dutch society contributes to lower teenage sexual risk behaviour, has not been falsified, it has still generated some ambiguity. 'Openness' only seems to be contributing to a reduction in attitudes conducive to sexual risk behaviour if this is firmly embedded in family-based interactions between teenagers and parents. If these are absent, then school-based sex education is hardly effective, and may be even counter-productive (also see DiCenso *et al.,* 2002). Schools cannot compensate for dysfunctional families. In addition, this openness still has to be placed in a moral framework of love and mutual- and self-respect that is not restricted to a reliance on interpersonal consensus to determine when 'one is ready'.

The third stalking-horse usually invoked when debating the reduction of teenage conception rates refers to contraception. In their conclusion, Ketting and Visser (1994) make the 'obvious' policy recommendations that can be found in many official documents (e.g. Kane and Wellings, 1999; UNICEF, 2001). First they state that contraception must be promoted to prevent abortions, which should remain a last resort only. However, they state that abortion services should be made more available because:

> abortion completes the range of options for controlling fertility, and the ultimate availability of this method increases acceptance and trust in the entire system of family planning education and services (1994: 170).

There is no evidence supporting any of this, as it is a matter of opinion whether the availability of abortion increases trust in family planning systems. Moreover, it contradicts their earlier suggestion that the Dutch, including young women, are quite ambivalent towards having abortions themselves (which led them to embrace contraception so heavily). One might as well argue the opposite: that pushing abortions may lead to a general distrust of family planning services, as they do not seem to believe what they promote: that their advocated contraceptive methods are safe.

Other recommendations refer to the promotion of contraception in sex education and via the mass media. This, they argue, requires a 'positive approach' instead of emphasising:

> negative aspects, that often deter people, instead of attracting their attention. After all, sexuality can and should be pleasurable in the first place and prevention of risks only follows after that (*ibid*).

Again, without having provided any evidence of this, they present an essentially ideological position under the guise of scientific fact. This also applies to their emphasis on the socio-emotional aspects of sexuality in sex education and low-threshold access-provision to family planning services. Then, suddenly, and quite unexpectedly, the text takes a strange turn. The authors ask:

> How is it possible that, in spite of the tremendous increase in effectiveness of contraceptive use in the Netherlands, the abortion rate remained more or less stable during the past two decades? Why did the need for abortion not decrease at the same pace as contraceptive effectiveness increased? (*ibid*).

However, instead of drawing the logical conclusion that this may have something to do with the increased frequency of sex, they point again towards 'trust', in this case in contraceptive technology. They admit that, because of the spreading of what amounts to a contraceptive mentality (see section 5.3), unplanned pregnancy is increasingly seen as a

problem for which there is a simple, amoral, technological solution (van Loon, 2002). In other words, there is a logical as well as statistical connection between contraceptive use and abortion. To rest our case, we simply let Ketting and Visser speak for themselves here: 'Therefore, in an almost perfect contraceptive population like the Dutch one, safe and legal abortion services are as badly needed as in any other population' (*ibid*). The widely held assumption that making contraception more widely available and easily accessible automatically implies 'safer sex' becomes problematic in the face of this.

Statistics clearly show that the assumption that lowering the threshold of access to contraception leads to a reduction in either teenage pregnancies or STIs is false (see Chapter 3). At least since 1990, unobstructed availability of and access to contraceptives, especially the pill, does not correlate with reductions in conception rates among teenagers in the Netherlands (see Tables 3.1 and 3.5). Moreover, although condom use is now widely practised (by about 85 per cent of those having sex, compared to only 17 per cent in 1981, Ketting and Visser, 1994) as a prevention against HIV and other STIs, the overall rate of STI-incidence has steadily increased since 1990, especially chlamydia, which affects young people disproportionately (see table 3.6).[32]

The simple explanations of the low teenage conception rate in Dutch society that attribute it to a combination of sex education, an 'open culture' and widespread contraceptive use simply do not stand up to the evidence. Instead, we have to consider a more complex set of factors as alternatives. These are divided into two categories: socio-economic (especially poverty) and cultural (sexual morality and the role of the family).

5.2 Poverty[33]

Socio-economic factors could have a major influence on teenage sexuality. Two totally different theoretical perspectives would suggest this to be the case. On the one hand, there is the perspective offered by rational choice theory which suggests (Oettinger, 1999; Paton, 2002) that teenage sexual behaviour involves a rational calculation of perceived benefits (e.g. sexual gratification, belonging to a peer group etc.) and costs (STIs, pregnancy, abortion) and can as such be predicted if these estimations made by teenagers are known (Paton, 2002). The perspective assumes that many of these costs and benefits can be expressed in an economic model. That is to say, even those aspects that have no direct financial implications (for example social stigmatisation as a result of teenage pregnancy) can still be translated into costs (a reduction of 'social capital'). It is obvious that having a baby costs money, but also entails other opportunity costs, for example, in terms of future life chances (educational career) and social stigmatisation (and isolation). However, if the present financial situation of the teenagers in question is already poor, than the 'loss' in socio-economic position as a result of a pregnancy is also less.

Moreover, if this loss is further compensated by social welfare benefits, for example in terms of income support or housing (in the UK), then the cost of having a baby may not be very high. Furthermore, if the teenagers in question do not perceive their education as worthwhile, for example because of a lack of career prospects, and if the estimated degree of social isolation and stigmatisation is also low, perhaps because there are many other teenage mothers in the neighbourhood, then the opportunity costs are also low. In short, those at the lower end of the socio-economic scale have less to lose from teenage pregnancy than the middle classes.

A second, completely different, theoretical perspective that would explain a correlation between socio-economic deprivation and higher teenage conception rates comes from what can be loosely labelled 'cultural Marxism'. As a perspective originally developed by left-wing criminologists and researchers into youth sub-cultures (Hall and

Jefferson, 1993), it suggests that particular cultural and ideological formations are generated by different social classes to explain and cope with their relatively marginal social position. An important aspect of this response is the rejection of mainstream cultural values and morality, which could thus include issues of sexual morality. Young people living in socio-economically deprived areas simply have less affinity with the cultural codes of mainstream middle-class culture, which dominate the mass media and the school curriculum. A lack of career prospects and a sense of socio-economic enclosure related to the knowledge that one simply cannot obtain the necessary cultural and social capital required to increase one's life chances make a radical break from mainstream culture more likely. Cultures of resistance may find expressions in 'deviant' sexual behaviour (Willis, 1977; Wilson, 1993).[34]

This is not the place to test which perspective is more credible. What matters here is that to some extent they add up to the same hypothesis: a higher degree of socio-economic deprivation is associated with a higher frequency of teenage sexual activity and associated risk behaviour. It is therefore important to consider the socio-economic differences between the UK and the Netherlands. This is not easy, as we need to compare two different societies, with different standards and notions of poverty. Moreover, what really counts is *relative deprivation*, as costs and benefits are always measured against norms that operate within a similar set of parameters. What we can analyse, however, is the development of levels of deprivation over time within both countries, as well as regional differences. In this report, we shall only consider the situation in the Netherlands. This is because in much of the official literature on its low teenage conception rates, references are made to the inclusive nature of the socio-economic structures of Dutch society.

Poverty in the Netherlands has dropped considerably since the 1960s, but especially in the 1990s when the Netherlands recovered from a lengthy recession that stifled the economy in the 1980s. In 1999, 13.2 per cent, i.e. just over one in eight households, were considered 'poor', that is, in need of income support (Thijssen, 2001). Based on statistical averages, one third of these households are expected to escape poverty within the next three years, indicating a reasonably high level of social mobility. Only six per cent of households in poverty are expected to suffer enduring poverty (Erwich and Uunk, 2001). Single-parent families are over-represented amongst the poor in the Netherlands. Almost half (47 per cent) of all single-parent families live in poverty, compared with the national average of 13.2 per cent. Immigrant groups are also over-represented, with 40 per cent of immigrant households suffering poverty, often of an enduring nature (Thijssen, 2001). A considerable part of this poverty, especially among immigrant groups, is urban.

The position of young people, who are also statistically over-represented among the poor, is also of interest, especially those experiencing long-term poverty. Under-18-year-olds are often trapped in enduring poverty (Erwich and Uunk, 2001). Poverty among young people is directly related to the regulations about income support for under-18s. In the Netherlands, in general, they are not entitled to receive much income support. On the website of the Jongeren Informatie Punt (JIP), a local government-sponsored youth-work organisation, it is explicitly stated that: 'If you are a teenage mother and younger than 18 and living at home, you will not qualify for benefits' (*http://www.jip.org/denhaag/tienermoeders/index.htm*).

However, all children, including those of teenage mothers, are entitled to child support. In 2002, this amounted to 56.29 euros (£37.52) per month per child (under five years old). Another crucial legal matter is that babies born to teenage mothers will be assigned a legal guardian (usually a parent of the mother) to whom the child benefit is to be paid. There is also limited statutory income support for 18–21 year olds of 390 euros

(£260) per month, although municipal governments can use some discretion in allowing a top-up to a monthly maximum of 953.63 euros (£618). Only in rare cases will under-18 mothers qualify for housing benefits, namely if they live in registered assisted housing schemes. They can then receive up to 172.54 euros per month (£112). In other words, mothers under 18 years of age are expected to continue to live with their parents.

The city councils of larger urban areas, however, are now considering increasing their support to teenage parents, because of perceived levels of poverty and deprivation. Local governments do have some discretion to support teenage mothers financially. In 2002, for example, the local authority of The Hague initiated a 'baby benefit' of 213 euros per month (£142) especially for teenage mothers under the age of 18. This means that teenage mothers who are under 18 can receive up to 300 euros per month in financial support (£200). Without housing benefits, this effectively means that, under the age of 18, teenage mothers are unable to live on their own. Moreover, not all local authorities in the Netherlands support their teenage mothers in this way. The nearby municipality of Zoetermeer, for example, does not provide any baby benefit for teenage mothers. As has been mentioned in Chapter 3, according to the same Jongeren Informatie Punt (2002) the municipality of The Hague has also faced a dramatic increase (22.1%) in teenage pregnancies over the last five years.[35]

In the main cities, there is a fear of a growing underclass in which teenage parenthood plays a pivotal role in creating cycles of dependency. In Rotterdam, a new Income Support Bill was passed in 1996 that obliged single parents (of 18 years and older) receiving income support to start a job search. The local education authority introduced an education scheme, similar to those in the UK such as 'baby, think it over', targeting children aged 12 and upwards with the message that being a teenage (single) parent is a tough job that is to be avoided at all costs (Smits, 2001).

This immediately highlights a possibly significant difference between the UK and the Netherlands. In the UK teenage parents are entitled to income support and housing benefits, which to some extent alleviate the 'costs' of pregnancy and increase the benefits. As teenagers in the Netherlands get little or nothing, their risk of downward mobility following pregnancy is far greater, even for socio-economically deprived groups, as their own parents have to bear most of the costs.

This might indeed indicate that teenagers make rational choices regarding sexuality (rather than the Marxist thesis of 'cultures of resistance'). Continuing a pregnancy is simply too costly. This is further underlined by the relatively high abortion ratios among Dutch teenagers (62.7% in 2000; see section 3.2) compared with the very low abortion ratios among Dutch women in general (13.6% in 2000). Abortions typically involve highly charged moments of decision-making in which pregnant women are actively encouraged to make rational choices based on cost/benefit analyses. A prospect of living in poverty might indeed deter young women from having a baby.

Research has shown that poverty is related to teenage sexual risk behaviour (Billy, Brewster and Grady, 1994; Bloor, 1995). However, socio-economic status alone cannot explain sexual risk behaviour by teenagers. The role of cultural and contextual factors is equally important. Decisions on whether to continue or terminate a pregnancy, for example, are not solely based on cost/benefit analyses in economic terms, but also involve social, emotional and moral dimensions. Cultures of poverty are much less prevalent in the Netherlands than in Britain, with the exception of some deprived areas in the large cities where the situation more closely resembles that of the UK. The fact that poverty is not widespread in Dutch society can certainly not be ruled out as having a major impact on the relatively low conception rates. However, in a US-based study, Garis (1998) argued that, once family breakdown is controlled for (when one of the partners is

no longer involved in the life of the child), poverty ceases to contribute to sexual risk behaviour. Rather than poverty, he argues, family breakdown is the key factor. However, as there is a direct relationship between family breakdown and poverty (as most mothers will experience a decline in income), it is difficult to argue, logically, that socio-economic factors are irrelevant.

The differences between teenage sexual risk behaviour in the UK and the Netherlands cannot be solely explained on the basis of economic factors, but there remains a strong case for considering the importance of socio-economic deprivation both directly, as having an impact on the assessment of costs associated with pregnancy, and indirectly, as part of a wider cultural formation of poverty associated with a lack of career-aspirations. However, not all teenagers living in socio-economically deprived areas have turned *en masse* to taking sexual risks. Garis' research points towards a crucial mediating factor of divorce. Hence, we need to look more closely at a completely different dimension of the social order: that of morality and the role of the family.

5.3 Sexual Morality

To explain the discrepancy between the UK and the Netherlands in terms of teenage sexual risk behaviour, we thus also need to include some understanding of differences in 'moral culture'. A first realm of comparison that could give an indication of different moral standards is law. The Dutch penal law relating to underage sexuality is relatively straightforward. Similar to the UK, the age of consent is 16 (article 245 of the Penal Code Book 2, title 14 – *Misdrijven tegen de Zeden*), but there are extra-harsh punishments for those engaged in sex with under-12s (article 244), and those who support or encourage prostitution with under-18s (article 248b). No distinction is made between hetero- and homosexuality, and it may come as a surprise that the current penal law regarding child abuse is quite strict compared with other aspects of law (e.g. cannabis, prostitution, pornography). Mandatory punishments are higher, for example, for paedophilia (up to 12 years' imprisonment) than for many aspects of organised crime and compare only with murder. Legally speaking, the Netherlands is not more liberal than its British counterpart.

Both the UK and the Netherlands are marked by what could be called a 'contraceptive mentality'. That is to say, the notion that sexual reproduction can be technologically controlled (in particular, but not exclusively, in terms of preventing conception), has become hegemonic in both societies. This can be seen, for example, in the fact that contraceptives are widely promoted, both in schools and via the mass media, as *the* best way to prevent pregnancy and the spread of HIV, rather than abstinence and sexual fidelity within marriage. To a large extent, the latter have been ruled out as alternatives through the simple assertion that they have become 'unrealistic'.[36]

The contraceptive mentality has become so hegemonic that interpreters of statistics still deploy it even if its falsification stares them right in the face. For example, we have already seen that Ketting and Visser (1994) have noted a correlation between an increase in the use of the contraceptive pill and a continuation of abortion (albeit at modest levels compared with the UK). This was confirmed by more recent statistics referring to the 1990s (see Tables 3.1 and 3.5). Similarly, in Table 3.6 we have seen that STIs have *not* decreased (and chlamydia has increased) among teenagers, alongside an increase in the use of condoms and other contraceptives. Yet, they simply fail to suggest that this correlation is based on a shared causality. Both increases are the effect of increased sexual activity! With an increase in sexual activity, given a fixed probability of failure, one automatically gets an increase in unwanted outcomes. Yet, the contraceptive mentality

has become so hegemonic that only a small minority (dubbed 'right-wing moralists') draws the logical conclusion that a far more effective way to reduce teenage pregnancies and STIs is to find ways of discouraging teenagers from having sex in the first place.

A second dimension of sexual morality, alongside the contraceptive mentality, is promiscuity. In what UNICEF (2001: 11) referred to as 'the sexualised society', a culture of promiscuity becomes prevalent in which sex is disconnected from both reproduction and love. It no longer operates in a framework of married relationships, and can be exchanged for goods, services or financial rewards. The decoupling of sexuality and morality has at least two major negative consequences. The first is a shifting of the burden of anxiety and responsibility to ever-younger teenagers, who are forced to take potentially life-altering decisions without possessing either the skills or the knowledge to understand their implications. The second is that it turns sex into something casual and insignificant. Casual sex is easily commodified. Indeed, promiscuity becomes a marketing tool. Using sexually explicit imagery as well as innuendo is a tried and tested strategy to sell products; but the sexualisation of culture has spread to all aspects of the mass media. Sex has become an industry itself, and is not merely confined to pornography or prostitution. Sexualisation entails the promotion of promiscuity and hedonism, and these in turn enable the transformation of sexuality into a market for the buying and selling of services and commodities. Ketting and Visser (1994) stress the importance of linking sex and pleasure in sex education, rather than sex and risk. There is a clear danger here in that it is widely known that risk and pleasure are themselves also linked (Lupton, 1999; Lupton and Tulloch, 1998). Risk behaviour can generate pleasures of transgression and violation.

However, empirical research on attitudes towards sexual permissiveness and promiscuity in the Netherlands (Kraaykamp, 2002) suggests that whereas attitudes towards pre-marital sex have become substantially more liberal since 1965, the same cannot be said for extra-marital sex, for which prevailing attitudes initially liberalised until the mid-1970s, but then reversed to more traditional values. Kraaykamp notes that attitudes towards permissiveness tend to be more conservative among Dutch women (although differences with men are decreasing), elderly people, married couples and those practising religion.

From our initial research into Dutch sex education it became obvious that openness and promiscuity were strongly separated. The latter was universally condemned. Hence, implicit moral frameworks underscored even the most liberal curriculum. Advocates of liberal and open sex education will not be able to tell young people why having sex might have moral implications. Ultimately, the message that young people must be set free to explore their own sexuality is an extreme form of relativism.

Regardless of nationality, teachers (especially those who have children of their own) who work with young people on a daily basis know that moral relativism is detrimental to education. This is why most of them will not refrain from imposing a (limited) moral framework onto their sex education curriculum starting with the suggestion that – in case of doubt – it is better to postpone engagement of sexual relations. In other words, they should only 'do it' if they are absolutely sure that they are 'ready'.[37] However, there is no official discourse on the sanctity of marriage within Dutch sex education and there is no abstinence education in the mainstream Dutch curriculum. In both the UK and the Netherlands, the official line from sexual health experts suggests that teaching young people about the virtues of abstinence is wrong and dangerous; they prefer to place the moral responsibility (and burden, including those of risk, guilt and blame) of knowing when one is 'ready' to the youngsters themselves.[38]

Sexual health expertise in the Netherlands closely resembles that of the UK. It emerged from the same cultural roots of the 1960s and had similar associations with the promotion of women's rights, including abortion rights, and homosexual rights. Its normative basis is equally derived from liberal individualism, and throughout the 1960s and 1970s (and well into the age of AIDS) it has sought to reform sexual culture to embrace a more hedonistic ethos of sexual liberation and experimentation. If there is a difference with the UK, however, it is the relationship between sexual health expertise and the British schooling system. Lewis and Knijn (2002) have argued that because sex education has been a contentious political issue in the UK, teachers in British schools are much less confident in addressing issues related to sexuality. In contrast, the lack of political debate over teenage sexuality in the Netherlands has enabled teachers to engage with the sensitive material with far greater confidence. Our research shows that teachers are rarely asked to explain themselves to their boards of governors, let alone politicians, and have on the whole a good working relationship with most parents. However, Lewis and Knijn are wrong to suggest that, as a result, Dutch schools are much more willing to embrace sexual health expertise than their UK counterparts. In our sample (which was larger than theirs), none of the schools ever sought the advice of official sexual health experts; the only experts invited (and to one school only) were from a company specialising in sanitary products. It is far more logical to argue that because teachers are much more confident in addressing these issues, they *do not need sexual health experts*. This has resulted in recent complaints by sexual health experts of persistent traditionalism in the Dutch education system (Paans, 2002: 25).

A closely related aspect that may explain differences between Dutch and British sex education is that, in Britain, moral development may be more difficult to integrate into the curriculum on a practical basis because of its higher degree of organisational centralisation. In the UK, parents do not always participate effectively in the development of school policies and curricula, and may feel less involved in their children's education. Few people would deny that the role of the parents is crucial, especially in the socio-emotional and moral development of children, and that this has a direct impact on their involvement in sexual risk behaviour (Garis, 1998). Because, as we have seen, most official sex education curricula in schools do not offer much direct moral guidance to children, it is of paramount importance that parents do so if they want their children to be able to act as moral agents. Schools in the Netherlands expect parents to take care of the socio-emotional and moral aspects of sex education. Because of the importance placed on the freedom of education and the strong parental role therein, most primary schools, for example, are not willing to lower the age at which children are exposed to sex education for the first time.

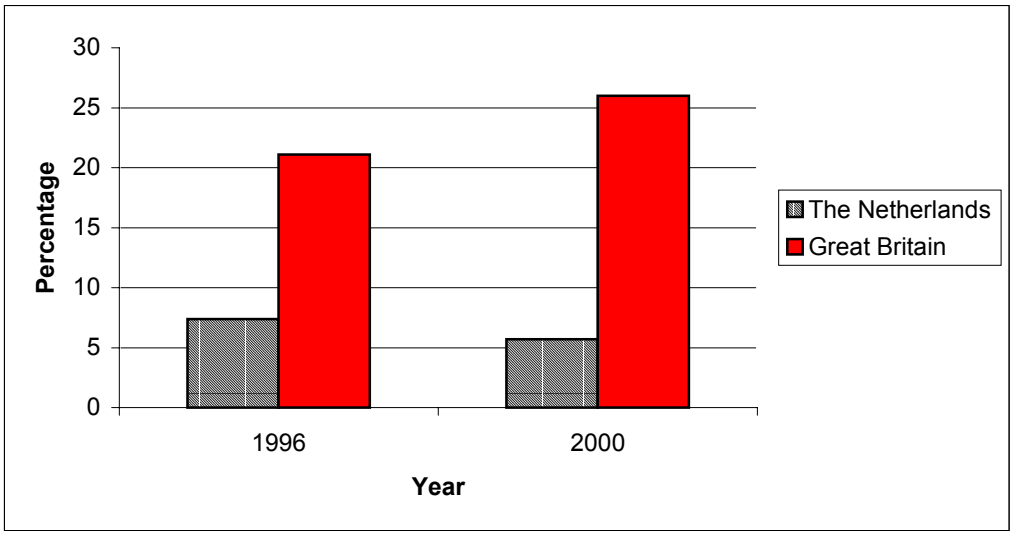
This is not to say that such proposals are not made. As in the UK, family planning ideology is widespread in the Netherlands and entrenched in many public and private bodies that are considered to hold 'sexual health expertise'.[39] Alongside long-standing trench warfare between educational reformers and traditionalists about the proper role of religion in the organisation of the education system, they have made considerable inroads into the autonomy of schools and parents to develop strategies for the socialisation of their children through collaboration and consensus. The dual system of subsidiarity and sovereignty in one's own circle that has traditionally provided an effective infrastructure for social organisation, especially education, is still at risk of being pushed aside by forces both of centralisation and individualisation. This is further reinforced by the ongoing process of secularisation (SCP, 2000).

5.4 The Social Organisation and Embedding of the Family

The key question is whether parenting and the role of the family is different in the Netherlands from in the UK. Although a lot more research is needed in this area, some preliminary observations can be made.

Figure 4 suggests that in 1996 lone-parent families in the Netherlands represented 7.4 per cent of all households with children, compared with 21 per cent in Great Britain. Indeed, the data from the European Community Household Panel (ECHP) upon which this table is based suggest that the UK has by far the highest percentage of single-parent families in Europe (SCP, 2001: 175). More recent figures indicate that in Great Britain, the number of lone-parent families has since then increased even further. The 2000/2001 General Household Survey conducted by the Office for National Statistics, suggests that, in Great Britain, single-parent families made up 26% of all families with children in 2000 (ONS, 2001: 10–11, 18). In contrast, the figure dropped to 5.7% in the Netherlands.

Figure 4: Lone-parent families as a percentage of all families with children, the Netherlands and Great Britain, 1996 and 2000



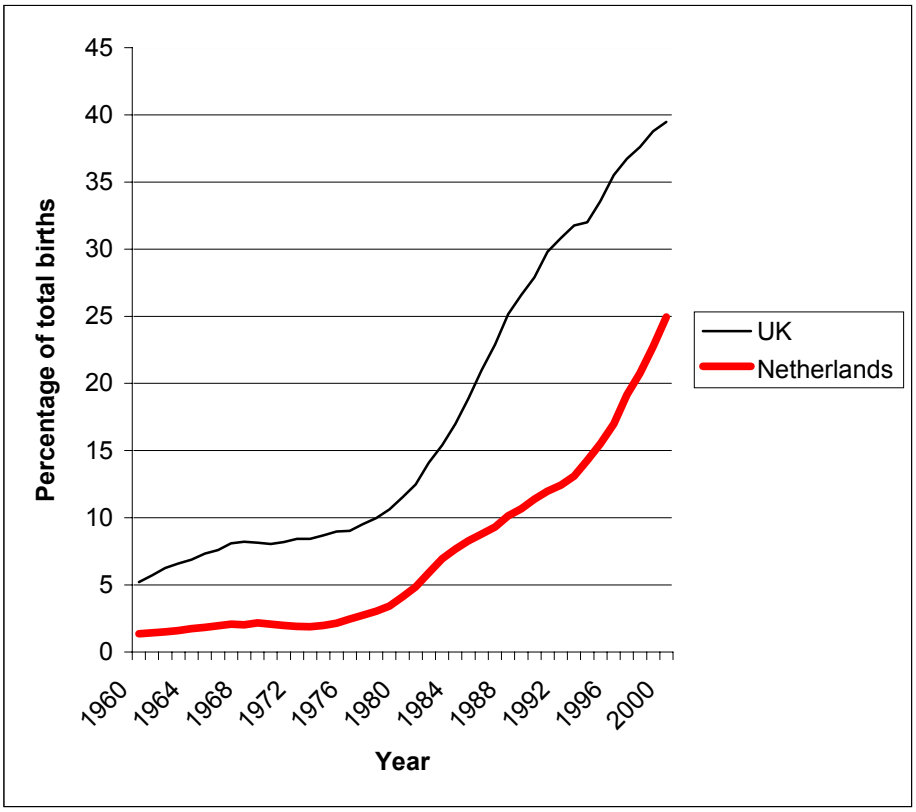
Source: ECHP, 1996; cited in CBS, 2001: 175; http://statline.cbs.nl and ONS, 2001: 10–11, 18.

The Central Bureau of Statistics uses this data as evidence that the Netherlands is in many ways a traditional society. While Dutch family law is noted for its liberal character, the relatively low prevalence of single-parent households suggests that patterns of family life in the Netherlands have generally remained more traditional than in many other Northern and Western European countries. This may be due, in part, to a legacy from the pillarisation of Dutch society, whereby people from different religious and cultural traditions have been prepared to tolerate a large degree of liberty within the law for others, whilst pursuing a more traditional way of life for themselves.

For example, since January 1998, Dutch law has permitted registered partnerships as an alternative to marriage, but the take-up has been relatively small, with the overwhelming majority of couples preferring the lifelong commitment signified by marriage. While cohabitation before marriage has become more common, births outside

marriage have not increased at the same rate. Kiernan (2000) notes that, in most European countries, levels of cohabitation and out-of-wedlock births tend to go hand in hand. However, she records that the United Kingdom has a higher rate of births outside marriage than estimates of cohabitation would predict, while in the Netherlands the out-of-wedlock birth rate is lower than might be anticipated from cohabitation levels. Figure 5 shows that while 40 per cent of births in the UK now take place outside marriage, three-quarters of births in the Netherlands are to married couples.

Figure 5: Percentage of live births outside marriage for the Netherlands and the UK, 1960–2000



Source: Eurostat

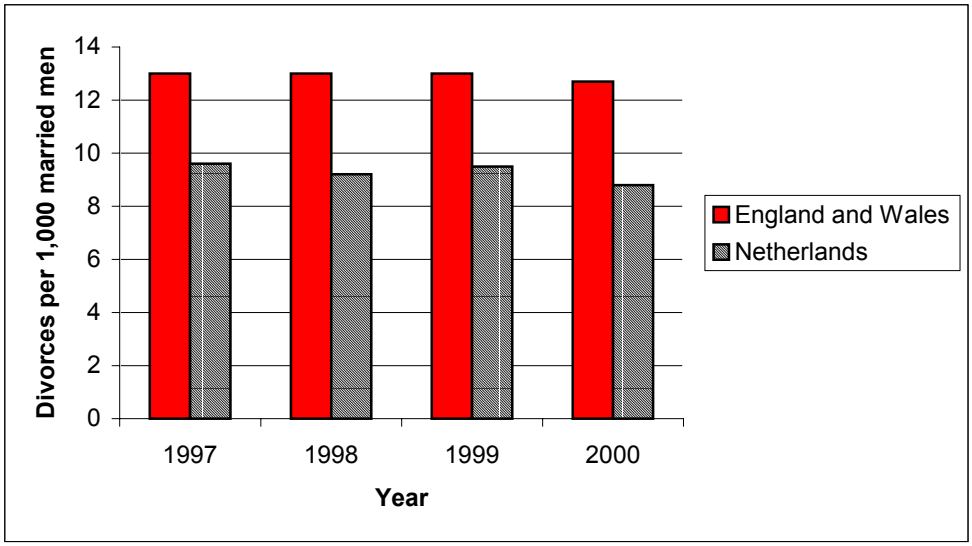
A more traditional attitude to marriage in the Netherlands is also reflected in the divorce statistics. A comparison of the annual divorce rates in the UK shows that, in 2000, 12.7 per 1,000 married men obtained a divorce in England and Wales, as opposed to 8.8 per 1,000 in the Netherlands (Figure 6).

Demo and Acock's review of research into the effects of divorce on children noted that: 'findings consistently demonstrate that males and females not living with both biological parents initiate coitus earlier than their counterparts in intact families' (Demo and Acock, 1988). Whitbeck *et al* noted that:

> Young people who live in single-parent households engage in sexual activity at younger ages and more frequently than those from intact two-parent families… The effects of

parental marital status are persistent even when other important factors such as race, religiosity, age and social class are controlled. (Whitbeck *et al.,* 1994)

Figure 6: Divorce rates per 1,000 married men in England and Wales and the Netherlands, 1997–2000



Sources: CBS (2002) and ONS (2002a)

A study of over 2,000 young people in England aged 13–15 found that, in families headed by a married couple, only 13 per cent of the children were sexually active. The percentage doubled (26 per cent) for young people living in one-parent families. The figure was 24 per cent for the children of cohabiting couples, 26 per cent where the parents were separated, 23 per cent where children divided their time between two parents living apart, 24 per cent where the parents were divorced, and 35 per cent where children did not live with either parent (Hill, C., 2000: 58).

5.5 Women's Participation in the Labour Market

It has been suggested that, in the Netherlands, traditional views of family life persisted much longer than elsewhere in Northern and Western Europe, but the shift to modern liberal ideals of individualisation and women's emancipation was very sudden and radical, especially over the last ten years (van Praag in SCP, 2001: 174). This is reflected in the sudden increase in labour market participation of married women and mothers, whilst childcare facilities were slow to develop.

In 1998, 47 per cent of all women between 15 and 65 were involved in paid labour and more than half (52 per cent) of all mothers with children under four years of age (SCP, 1998). However, some of these figures are misleading, as women's labour market participation is greatly determined by their educational status. More than two-thirds (70 per cent) of all highly educated women, but less than a third (27 per cent) of women with only lower educational credentials, were involved in paid labour. However, most of these women were still performing the majority of household duties, which again signals that the costs and benefits of individualisation are not equally shared.

Labour market participation of women in the Netherlands has dramatically increased to levels close to the UK and now ranks among the highest in Europe (from having been one of the lowest). However, the major part of this participation is based on part-time work (12–20 hours per week). Sixty-seven per cent of all working women work less than 35 hours a week (SCP, 2000). As in the UK, Dutch women are often employed in jobs at a lower level than their educational qualifications would predict. Many have little prospect of promotion. Marloes van Engen, who recently obtained a PhD for her research into women as managers, condemns the Netherlands as an unemancipated society: 'Nowhere else is childcare so poorly arranged. A real "motherhood ideology" still prevails'.[40] This was condemned by the Dutch secretary of state (equivalent to a minister in the UK) for emancipation, Mrs Verstand. According to an editorial in *De Volkskrant* (a Dutch national broadsheet):

> Although the policy of the secretary of state for emancipation prescribes that every woman must be able to provide for herself and thus requires a (nearly) full-time job, the Dutch mother rarely chooses this. Couples stick to the more traditional division of tasks, in which he takes care of the largest part of the family income and she takes the lion's share of the responsibility for caring tasks. The policy of Verstand should take that reality into account.[41]

Schulze (1999) reports that in the Netherlands just five per cent of all women with children are in full-time employment and only 29 per cent believe that women should contribute to the family income, compared with 75 per cent Europe-wide. The majority of women leave full-time paid employment when they have their first child, and fewer still continue to work full-time after the birth of a second child. In comparison with the Netherlands, a far higher proportion of mothers in the United Kingdom are in full-time work during their children's school careers. In 2001, 18.3 per cent of mothers with a child under the age of five were employed full-time, rising to 31.9 per cent for mothers with children aged between five and 18.[42]

Another indicator of traditional family structures is the low percentage of children in some form of daycare or out-of-school care in the Netherlands. In 2000, less than five per cent of all children were in full-time daycare (SCP, 2001: 213). The Social and Cultural Planning Office (SCP) also notes that, in 1998, 16 per cent of 0–3 year olds and 2 per cent of 4–12 year olds were in some form of daycare, compared with 6 per cent and 0.2 per cent respectively in 1990 (SCP, 2000). This suggests that Dutch mothers are more closely involved in the day-to-day care of their children than their British counterparts. In view of the higher rate of full-time labour force participation by mothers in the United Kingdom, it is not surprising to find a higher rate of childcare usage. In 1999, around 35 per cent of mothers of pre-school children in the United Kingdom used some form of daycare, and around 27 per cent of mothers of children aged between five and 12 used some form of out-of-school care (Paull, Taylor and Duncan, 2002: 89, 107). Clearly, children who are supervised more closely by their parents will have fewer *opportunities* to engage in sexual experimentation. The comparatively high level of *part-time* labour market participation of Dutch mothers may be an indicator that they are at home more than their UK counterparts.

However, it must be stressed that there is no evidence of a link between labour market participation of women and a loosening of sexual morality. On the contrary, Kraaykamp (2002: 235) found that, among Dutch women between 1965 and 1995, 'the increased economic independence of women resulted in a more conservative moral *(sic)* on sexuality'. We do not suggest that women's labour market participation contributes to higher rates of teenage sexual risk behaviour because of more permissive attitudes on the part of the mothers, but because of the opportunities offered to youngsters by virtue of absence of direct supervision. Ingham's (1998) findings that British teenagers report

opportunity far more often as a reason for having had their first intercourse than their Dutch counterparts are revealing in this respect.

In the previous chapter, we have seen that teachers believe that most Dutch parents talk to their children about sex before they receive sex education in schools. This is confirmed by most research (e.g. Ingham, 1998; Lewis and Knijn, 2002; Schalet, 2000). Indeed, this again confirms that Dutch society seems to have maintained a stronger family-oriented culture, which has prevailed despite a rapid process of individualisation and a widespread and hegemonic ideology of liberal pluralism.[43]

In the Netherlands, many family lives are still organised around shared meals, and most parents are quite well informed about the whereabouts of their children (SCP, 1997). The Social Cultural Planning Bureau suggests that Dutch parents pay a lot of attention to the moral development of their children, but this is associated with the development of individual autonomy and social empathy. Most parents seek to attain a balance between support and control, with the emphasis shifting from the latter to the former as the child gets older (SCP, 1997: 193). The SCP report further suggests that parents and children often discuss and negotiate decisions (also see Schalet, 2000). Children, in turn, state that whereas they have considerable autonomy in decision-making, they generally pay attention to their parents' wishes. This suggests that, in the average Dutch family, there is not a high degree of inter-generational conflict and alienation, and the conditions are conducive to mutual respect, dialogue and consensus building. This is strongly supported by research on solidarity in Dutch families by Komter and Vollebergh (2002: 171–188), who argue that familial solidarity, particularly in the form of care and assistance, still prevails over non-familial solidarity.

However, whereas in most families the moral nature of parent/child relationships remains strong, the situation is less clear with regard to the teacher/pupil relationship in schools. Although teachers were reluctant to include strong moral guidelines in their teaching, when confronted with specifics they were all very eager to intervene, to stop – for example – sexually motivated bullying, celebrations of casual sex or lowering the age of sexual activity. Homosexuality is for many primary schools still somewhat problematic. Even if individual teachers thought it should be discussed at some stage in sex education, they felt it was inappropriate to freely introduce it to 11–12-year-olds. Instead, they preferred to respond to specific questions. This also applies to most schools with regard to the question of how to use contraception; this is not something deemed appropriate for most 11–12-year-olds.

Conclusions

The assumption that sex education contributes to lower teenage conception rates is problematic. Our research has shown that whereas Dutch birth and abortion rates are indeed much lower than in the UK, these differences cannot plausibly be attributed to sex education. The decline in teenage conception rates started before the introduction of sex education. Later extensions of sex education provision, especially with the Education Act of 1993, have not resulted in lower conception rates. Most significantly, perhaps, our research has shown that there are large differences in sex education practices between Dutch schools which do not immediately correspond with any variation in teenage conception rates.

Instead of a simplistic mechanical model where teenage conceptions are the direct outcome of specific deficiencies in sex education, contextual factors have a far more important role to play. The relationship between school climate and environmental culture seems essential. Both poverty (when it correlates with family breakdown) and deficient sexual morality contribute to increases in teenage sexual activity at a younger age, and – as a consequence – increases in teenage conceptions and abortions.

The highly restricted income support system for teenage parents in the Netherlands could be a major factor in deterring them from having children (but not necessarily from having sex, as abortions could in theory be used as an escape route). Pockets of poverty and poverty culture exist in the Netherlands. There is a strong ethnic component, and usually in areas where teenage conception rates, STI incidence and sexual violence are most prevalent. Although we do not have any accurate breakdown of figures by region or area, there are strong suggestions that the problems are worse in cities (Garssen and Sprangers, 1999; 2000; Jongeren Informatie Punt, 2002; Smits, 2001). Moreover, our research suggests it is here that schools could face most difficulties in providing sex education.[44]

Sexual morality is perhaps an even more important factor. The most crucial element here is the role of the family. Marriage and two-parent families are still the norm in the Netherlands. Parents are still the main providers of sex education to their children, placing sexuality within the context of the family. Although some teachers did state that connecting love and sex was part of their teaching, this was still predominantly seen as the work of parents. The prevailing ideology of motherhood has furthermore enabled mothers to remain strongly involved in the lives of their teenage children. Whilst having increased their labour-market participation, Dutch mothers have often opted for part-time work.

Finally, there are indications that the situation in the Netherlands regarding teenage pregnancy and sexual morality is changing. We have seen that teenage pregnancy rates have increased since 1995, and in some cities teenage parenthood is considered to be a growing social problem. Whilst, elsewhere, increasing teenage pregnancy rates are largely being obscured by increasing abortion rates, the noticeable increase in STI incidence, reported by the National Health Inspection, strongly suggests that Dutch teenagers are increasingly engaged in sexual risk behaviour. This will undoubtedly result in calls for more expansive sex education and more easily available contraception and abortion; however, our data supports research that suggests that sexual risk behaviour often involves the use of contraceptives; it is the increase in sexual activity that produces the problems.

Still, by and large, the Netherlands is not a promiscuous society and not an ideal society for sexual liberationists. The typically Dutch attitude of: ‘I would not want to be part of this but if others do, that's fine by me’, applies to an increasing number of issues, but

particularly those associated with lifestyle choices and values. What typifies Dutch liberalism is not a desire for hedonism, but a public indifference. However, this is not limitless. There are residual pockets of resistance against both drug and sex cultures, opposing the policy of 'tolerance' (or benign neglect), especially outside the four main cities. Whilst not always motivated by religion, and crossing a wide political spectrum (the far-Left are as much part of this opposition as the far-Right), there are those calling for tougher policing, a clampdown on hooliganism, vandalism and street violence, a more expedient and effective judicial system, and limits to be set on the availability of sexually explicit imagery and drugs.

Just as in the UK, the vocal minority advocating a less liberal moral political agenda is often ridiculed by the popular media and politicians. The virtual absence of organised opposition to legal abortion is a sign of the clear hegemony of the liberal consensus. However, the near-landslide victory of the Christian Democrats in the 2002 national elections, and the expected continuation of electoral support in the next elections of 2003, suggest that the tide may be turning. Growing concerns over an erosion of moral and social integration in Dutch society, associated with a range of issues but significantly including sexuality, are indications that, even in the Netherlands, dogmatic liberal indifference may be approaching its own limits.

Bibliography

Adam, B., Beck, U. and van Loon, J. (eds.) (2000) *The Risk Society and Beyond. Critical Issues for Social Theory*. London: Sage.

Bauman, Z. (2001) *The Indivdualized Society*. Cambridge: Polity Press.

Beck, U. and Beck-Gernsheim E. (2002) *Individualization: Institutionalized Individualism and its Social and Political Consequences*. London: Sage.

Billy, J.O.G., Brewster, K.L., and Grady, W.G. (1994), 'Contextual Effects on the Sexual Behaviour of Adolescent Women', *Journal of Marriage and the Family* 56 (2): 387–404.

Blake, S.M., Simkin, L., Ledsky, R., Perkins. C., Calabrese, J.M. (2001) 'Effects of a Parent-Child Communications Intervention on Young Adolescents' Risk for Early Onset of Sexual Intercourse'. *Family Planning Perspectives* vol. 33 (2): 52–61.

Bloor, M. (1995) *The Sociology of HIV Transmission*. London: Sage.

Bosely, S. (1999) 'Contraception fails to prevent pregnancies', *The Guardian* (13 October).

Bright, M., (1999) 'UK eyes Dutch sex lessons', *The Observer*, 21 February.

CBS (2000) 'Abortus' ['Abortion'] *CBS Index* (2): 14.

CBS (2001) *Samenleven: Nieuwe Feiten over Relaties en Gezinnen*.[Living Together: New Facts about Relationships and Families'] Voorburg: Centraal Bureau voor de Statistiek.

CBS (2002) *Statistical Yearbook of the Netherlands 2001*. Voorburg: Centraal Bureau voor de Statistiek.

Clark, A. and Searle, S. (1994) 'Flying Dutch visit: lessons for the UK on sex education and abortion'. *British Journal of Sexual Medicine* (January/February): 4–5.

Craven, B. Dixon, P., Stewart, G. and Tooley, J. (2001) HIV and AIDS in Schools. *The Political Economy of Pressure Groups and Miseducation*. London: The Institute of Economic Affairs.

Davis, N. (1999) *Youth Crisis: Growing Up in the High-Risk Society*. Westport: Praeger.

Demo, D. and Acock, A. (1988) 'The Impact of Divorce on Children'. *Journal of Marriage and the Family* 50 (August): 619–648

DiCenso, A., Guyatt, G. and Griffith, W.L. (2002) 'Interventions to reduce unintended pregnancies among adolescents: systematic review of randomised controlled trials'. *British Medical Journal* vol 324 (15 June): 1426–1434.

Erwich, B. and Uunk, W.J.G. (2001) 'Dynamiek van armoede: Één op de drie armen is na en jaar niet arm meer' ['Dynamics of poverty: One in three of the poor is no longer poor within a year']. *CBS Index* (10): 2–4

Fenton, K., Korovessis, Chr., Johnson, A.M., McCadden, A., McManus, S., Wellings, K., Mercer, C., Carder, C., Copas, C., Nanchahal, K., Macdowall, W., Ridgway, G., Field, J. and Erens, B. (2001) 'Sexual behaviour in Britain: sexually transmitted infections and prevalent genital chlamydia trachomatis infection'. *The Lancet* vol. 358 (1 December): 1851–1854.

Foucault, M. (1982) 'The Subject and Power' in Dreyfus, H. and Rabinow, P. *Michel Foucault: Beyond Structuralism and Hermeneutics.* Brighton: Harvester Press.

Garis, D. (1998) 'Poverty, Single-Parent Households, and Youth-At-Risk Behaviour: An Empirical Study. *Journal of Economic Issues*. Vol 32 (4): 1079–1105.

Garssen, J. and Sprangers, A. (1999) 'Tienermoeders' [Teenage mothers]. *CBS Webmagazine* (April 2001) Voorburg: Centraal Bureau voor de Statistiek [www.cbs.nl].

Garssen M.J. and Sprangers, A.H. (2000) 'Aantal tienernoeders toch weer iets gestegen' ['Number of teenage mothers rise a little yet again'] Maandstatistiek van de Bevolking (January): 23–25.

Haks, K, and van der Laar, M.J.W. (2001) 'Stijging soa niet beperkt tot risicogroepen' [Rise in STI not limited to high risk groups]. *Infectieziekten Bulle*tin 12 (11): 412–415

Hall, S. and Jefferson, T. (ed.) (1993), *Resistance through Rituals: Youth cultures in post-war Britain*. London: Routledge.

Henley, J. (2002) 'Pornography forms French children's views on sex'. *The Guardian* (25 May 2002): 16

Hill, C. (2000) *Sex Under Sixteen?* London: Family Education Trust

Hill, D. (2000) 'Sex Games', *The Guardian Education Supplement* (7 November).

Ingham, R. (1998) 'Exploring interactional competence: comparative data from the United Kingdom and the Netherlands on young people's sexual development.' Paper presented at the 24th meeting of the International Academy of Sex Research, Sirmione Italy.

Ingham, R. (2000) 'Doctors Should advise adolescents to abstain from sex: against'. *British Medical Journal* vol. 321 (16 December): 1521–22.

Ingham, R. and Kirkland, D. (1997). Discourses and sexual health; providing for young people. In Yardley, L. (Eds.), *Material Discourses of Health and Illness*. London: Routledge.

Inspectie van de Gezondheidszorg (2000) *Jaarrapport IGZ*. The Hague: IGZ.

Johnson, A. M., Mercer, C.A., Erens, B., Copas, A.J., McManus, S., Wellings, K., Fenton, K.A., Korovessis, Chr., Macdowall, W., Nanchahal, K., Purdon, S. and Field, J. (2001) 'Sexual behaviour in Britain: partnerships, practices and HIV risk behaviours'. *The Lancet* vol. 358 (1 December): 1835–1842.

Jones, E.F., Forest, J.D., Goldman, N., Henshaw, S., Lincoln, R., Rosoff, J., Westhoff, C. and Wulf, D., (1986) *Teenage Pregnancy in Industrialized Countries*. New Haven: Yale University Press.

Jongeren Informatie Punt (2002) 'Persbericht, conclusies en aanbevelingen t.a.v. het Jonge moeder onderzoek door ES&E in opdracht van het JIP in Den Haag' ['Press release, conclusions and recommendations related to the research on young mothers by ES&E commissioned by JIP in The Hague'. http://www.jip.org/denhaag/tienermoeders/voorkan.htm.

Kane, R. and Wellings, K. (1999) *Reducing the rate of teenage conceptions. An international review of the evidence: data from Europe*. London: Health Education Authority.

Ketting, E. and Visser, A.P. (1994) 'Contraception in the Netherlands: the low abortion rate explained'. *Patient Education and Counselling* vol 23: 161–171

Kiernan, K. (2000) 'Cohabitation in Western Europe: trends, issues and implications'. A paper given at the Family Issues Symposium 2000, Population Research Institute, Pennsylvania State University. http://www.pop.psu.edu/events/kiernanpaper.pdf

Kirby, D. (1997) *No easy Answers*, Washington DC: National Campaign to Prevent Teen Pregnancy.

Kirby, D., Short, L., Collins, J., Rugg, D., Kolbe, K., Howard, M., Miller, B., Sonenstein, F. and Zabin, L.S. (1994) 'School-based programs to reduce sexual risk behaviors. A review of effectiveness. *Public Health Reports 109* (3): 339–360.

Komter, A.E. and Vollebergh, W.A.M. (2002) 'Solidarity in Dutch Families: Family Ties Under Strain?' Journal of Family Issues. Vol. 23 (2): 171–188.

Kraaykamp, G. (2002) 'Trends and Countertrends in Sexual Permissiveness: Three Decades of Attitude Change in the Netherlands 1965–1995. *Journal of Marriage and Family* 64 (February 2002): 225–239.

Lewis, J. and Knijn, T. (2002) 'The Politics of Sex Education Policy in England and Wales and the Netherlands since the 1980s'. *Journal of Social Policy*. Vol 31 (4): 669–694.

Lijphart, A. (1974) *The Politics of Accommodation: Pluralism and Democracy in the Netherlands.* Berkeley: University of California Press.

Lupton, D. (1999) *Risk*. London: Routledge.

Lupton, D. and Tulloch, J. (1998) 'The Adolescent "Unfinished Body", Reflexivity and HIV/AIDS Risks'. *Body & Society* vol. 4 (2): 19–34

Ministerie van Buitenlandse Zaken [Department of Foreign Affairs] (2001) 'Abortus in Nederland' [Abortion in the Netherlands]. http://www.minbuza.nl.

Monk, D. (1998) 'Sex education and the problematisation of teenage pregnancy: a genealogy of law and governance', *Social and Legal Studies, An International Journal* Vol. 7. 239–260.

Moore, S. and Rosenthal, D. (1993*) Sexuality in Adolescence*. London: Routledge.

Nicoll, A., Catchpole, M., Cliffe, S., Hughes, G., Simms, I., Thomas, D. (1999) 'Sexual health of teenagers in England and Wales: analysis of national data'. *British Medical Journa*l vol 318 (15 May): 1321–22.

Oettinger, G.S. (1999), 'The Effects of Sex Education on Teen Sexual Activity and Teen Pregnancy', *Journal of Political Economy*, 107 (3): 606–44.

ONS (2001) *Living in Britain. General Household Survey 2000/01*. London: Office for National Statistics.

ONS (2002) *Population Trends 109*, Autumn 2002. London: Office for National Statistics.

ONS (2002a) *Marriage, divorce and adoption statistics*, Series FM2 no. 28. London: Office for National Statistics

ONS (2002b) *Birth Statistics*, Series FM1 no. 30. London: Office for National Statistics.

Paans, A. (2002) 'Seks Nog Taboe in Opvoeding' ['Sex Still Taboo in Parenting'] *Algemeen Dagblad* (15 February 2002): 25, 27.

Paton D. (2002), 'The Economics of Family Planning and Underage Conceptions'*, Journal of Health Economics*, 21, 2 (March), 27–45.

Paull, G., Taylor, J. and Duncan, A. (2002), *Mothers' employment and childcare use in Britain*, London: The Institute for Fiscal Studies.

Pearson, V.A.H., Owen, M.T., Phillips, D.R., Pereira Gray, D.J, and Marshall, M.N. (1995), 'Family Planning Services in Devon UK: awareness, experience and attitudes of pregnant teenagers', *British Journal of Family Planning*, 21, 45–9.

Public Health Laboratory Service (2001) *Sexually Transmitted Infections in the UK (1995–2000)*. London: PHLS.

Rademakers, J. (2002) *Abortus in Nederland. Jaarverslag van de landelijke abortusregistratie*. [Abortion in the Netherlands. Annual report of nation wide abortion registration]. Heemstede: STISAN.

Ranjit, N., Bankole, A., Darroch, J.E., Singh, S. (2001), 'Contraceptive Failure in the First Two Years of Use: differences across socioeconomic subgroups'. *Family Planning Perspectives 33* (1): 19–27.

Schalet, A. (2000) 'Raging hormones, regulated love: adolescent sexuality and the constitution of the modern individual in the United States and the Netherlands'. *Body and Society* 6 (1): 75–105.

SCP (1997) *Het Gezinsrapport* [Report on the Family]. The Hague: Sociaal Cultreel Planbureau.

SCP (1998) *Sociaal en Cultureel Rapport 1998* [Social and Cultural Report 1998]. The Hague: Sociaal Cultureel Planbureau.

SCP (2000) *Sociale Culturele Verkenningen 2000* [Social and Cultural Explorations 2000]. The Hague: Sociaal Cultureel Planbureau.

SCP (2001) *Sociale Culturele Verkenningen 2001* [Social and Cultural Explorations 2001]. The Hague: Sociaal Cultureel Planbureau.

Schulze, H-J. (1999) 'The Netherlands: A Land of Two Faces'. *Family Observer*, European Commission.

Singh, S. and Darroch, J.E., (2000) 'Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries', *Family Planning Perspectives* 32 (1): 14–23.

Smits, G. and Waas, B. (1999) *Biologie Voor Jou: 2vmbo, 3vmbo deel 1, vwob1*. Den Bosch: Malmberg.

Smits, H. (2001) 'Waar is mijn geld?' [Where is my money?]. *NRC Handelsblad,* February 12.

Social Exclusion Unit (1999), *Teenage Pregnancies*, London: HMSO CM434.

Thijssen, J. (2001) 'Armoedetrends: Steeds minder armoede' [Poverty trends: Less and less poverty']. *CBS Index* (10): 8–9.

Thompson, R. and Holland, J. (1998) 'Sexual relationships, negotiation and decision making' in Coleman, J. and Roker, D. *Teenage sexuality: Health, risk and education*, Reading: Harwood Academic Publishers.

Tincknell, E., Chambers, D. and van Loon (2003) Begging for It: 'New Femininities', Social Agency and Moral Discourse in Contemporary Teenage and Mens' Magazines. *Feminist Media Studies*. forthcoming

UNICEF (2001) A League Table of Teenage Births in Rich Nations. Florence: UNICEF Innocenti Research Centre

van der Laar, M.J.W., Haks, K., Coenen A.J.J. and van der Meijden, W.I. (2001). 'Halfjaarrapportage soa-registratie 2001: Stijging soa zet door in 2001'. [Bi-annual report STI-registration 2001: Rise in STI continues in 2001]. *Infectieziekten Bulletin* 12 (12): 457–460.

van der Laar, M. J.W. and Haks, K., Coenen, T. (2002) 'Sterke stijging SOA in 2001' [Strong increase of STIs in 2001]. *Infectieziekten Bulletin* 13 (8): 293–296.

van Kemenade, J.A., Lagerwij, N.A.J., Leune, J.M.G., Ritzen, J.M.M. (eds.) (1986), *Onderwijs Bestel and Beleid 2. Onderwijs en Samenleving*. Groningen: Wolters-Noordhoff.

van Loon, J. (2002) *Risk and Technological Culture. Towards a Sociology of Virulence*. London: Routledge.

van Lunsen, R.H.W., Arnolds, H.T., van Maris, M.G.M. (1994) 'Choices and changes in contraceptive behaviour; the role of information sources'. *Patient Education and Counselling* vol 23: 197–202.

Visser, A.P. and van Bilsen, P. (1994) 'Effectiveness of Sex Education Provided to Adolescents'. *Patient Education and Counselling* vol 23: 147–160.

Walker, D. (2002) 'Sex talk "reduces teen pregnancy rate"'. *The Guardian* (4 January): 6.

Wellings, K., Nanchahal, K., Macdowall, W., McManus, S., Erens, B., Mercer, C.H., Johnson, A.M., Copas, A.J., Korovessis, C., Fenton, K. and Field, J. (2001) 'Sexual behaviour in Britain: early heterosexual experience'. *The Lancet* vol 358 (December 1): 1843–1850.

Whitbeck, L.B., Simons, R.L., Kao, M. (1994) 'The effects of divorced mothers' dating behaviours, and sexual attitudes on the attitudes and behaviours of their adolescent children'. *Journal of Marriage and the Family* 56 (August): 615–621.

Wight, D. (1997) 'Does sex education make a difference?' *Health Education*, (2): 52–56.

Willis, P. (1977) *Learning to Labour. How working class kids get working class jobs*. Farnborough Hants: Saxon House.

Wilson, W.J. (1993) (ed.) *The Ghetto Underclass. Social Science Perspectives.* London: Sage.

Winn, S., Coleman, J and Roker, D. (1995) 'Knowledge about puberty and sexual development in 11–16 year olds: implications for health and sex education in schools'. *Educational Studies*, vol. 21 (2): 187–201.

Endnotes

1. Jones, D., 'Time after time British liberals claim Holland's low rate of teenage pregnancy is due to its permissive sex education. But the real reason is that it's a society which still understands the true meaning of shame', *Daily Mail*, 23 January 1999.

2. This is by no means to suggest that these are the only factors that matter. For example, social factors such as poverty and cultural factors such as notions of masculinity ('laddishness'), promiscuity and contraceptive mentality could be of considerable importance and are addressed in this report. However, due to a lack of quantifiable statistical material, the relative influence of these factors is very difficult to assess.

3. What such glowing references to the Dutch situation systematically overlook, however, is the fallacy of cultural generalisation. If a culture of openness contributes to lower degrees of sexual risk behaviour, then surely such differences must apply within the Netherlands as well. That is to say, there must be considerable regional variation in teenage pregnancies and STI-rates, with the more 'open' and 'liberal' regions having lower rates, and more traditional regions with higher rates. However, there is little evidence that this is the case. Instead, the adverse effects of teenage sexual risk behaviour are mostly felt in the least traditional geographical locations: the western urban enclave of the 'Randstad'. Rather, socio-economic inequality seems to be a stronger determinant.

4. The statistics will be dealt with in Chapter 3.

5. Their interpretation of their own data is, however, questionable. Having translated statistics from the Council of Europe (1997) into a graph and marking this with significant events, they show that after 1972, which is marked as the year in which abortion became available and media campaigns started to promote contraception, teenage conception rates dropped most significantly, having risen slightly from 1960 onwards, yet they conclude that 'the decline in the teenage birth rate was already well-established before abortion became available in 1972' (Kane and Wellings, 1999: 48).

6. It may be a sign of the times that nowadays parenting has to be reinvented as an extension of schooling, rather than the reverse. Indeed, many advocates of sex education no longer conceptualise parenting as primary socialisation. No longer is the advocacy of sex education described in terms of a necessity because of the failings of parenting; parenting is becoming an addendum to the societal regulation of sexuality.

7. There is an issue here as to what is defined as being 'contraception'. This is subject to a highly technical and intense debate, for which we have no space here. However, for the purpose of clarity, we use the term for all those appliances and techniques that aim to prevent conception. Whilst acknowledging that the contraceptive pill may also have an abortive function, we follow convention and group it with contraception. This is in contrast to appliances and techniques whose main aim is to remove the fruit of conception *post hoc*, which thus includes the morning-after pill, menstrual extraction (which is a political term for very early abortions, up to 14 days after conception) and induced abortions. The texts we refer to may differ in their use of the term contraception and its relationship with technologies of abortion.

8. Hypothesis (d) has been dismissed by the Social Exclusion Unit (1999) and ignored by the rest. Hypothesis (e) has been mentioned by Ingham (1998), but has no wider statistical back up. Hypothesis (f) is a reinterpretation of Schalet's and Lewis and Knijn's arguments by stressing that 'openness' can also be a form of supervision and discipline rather than permissiveness. Hypothesis (g) is acknowledged by both the Social Exclusion Unit (1999) and Kane and Wellings (1999), but strongly downplayed by both in favour of the sex-education and contraception hypotheses.

9. As no attempt at generalisation has been made, the choice of schools and their geographical location is largely irrelevant. The only aim was to get a sufficient spread in terms of denomination and social class. For both sets of schools, we relied heavily on existing networks and contacts to obtain access. So, when we generalise, it is not an empirical generalisation but a logical, theoretical one. The main aim was to see to what extent different schools provide different kinds of sex education. The more variation, the more difficult it is to sustain that sex education contributes to reducing teenage pregnancy rates. Our data show that there are vast differences between schools, which suggest correspondence not so much with religious denomination as with the socio-economic environment of the schools, which in turn correspond with different types of parental involvement and teenage sexual behaviour.

10. Lewis and Knijn do not provide any operational definition of the concept of 'openness' in relation to interactions between teachers, parents and teenagers about issues related to sexuality, let alone empirical evidence of its relevance.

11. Ministerie van Onderwijs, Cultuur en Wetenschappen, Kerndoelen Verzorging domein A no. 11; http://monocw.nl/basisvorming/kerndoelen/209p.html. Author's translation.

12. Interview with Prof. J.M.G. Leune, former chairperson of the Education Council of the Netherlands.

13. Ministerie van Onderwijs, Cultuur en Wetenschappen, Kerndoelen Biologie domein B no. 5; http://monocw.nl/basisvorming/kerndoelen/211p.html. Author's translation.

14. This is further supported by other statistics that suggest that Dutch families are still fairly traditional. This will be further discussed in Section 5.4.

15. Figures for the Netherlands of 1980, 1985, 1990 and 2000 have been derived from Rademakers (2002: 34), whose birth rates are the same as those of the Dutch Office of National Statistics (CBS, 2001), but whose abortion statistics are more accurate than those of the CBS, because they have been provided by the abortion providers themselves. The Dutch 1995 birth rate is derived from CBS (2001: 47); the 1995 abortion rate was based on data from the National Health Inspection, published by the Dutch Ministry of Foreign Affairs (2001). The 1975 abortion rate has been derived from Ketting and Visser (1994: 167). There are no 1970 abortion figures for the Netherlands as it was still not legal at that time. The 1970 and 1975 birth rates have been obtained from Darroch and Singh (2000); however, these figures are relatively high compared with the graph presented by Kane and Wellings which suggest conception rates around 16 and 10 respectively (1999: 48), and our own estimates based on CBS data (which are 16.6 for 1970 and 9.4 for 1975).

16. Garssen, J. and Sprangers, A. (2000) 'Lichte toename aantal tienermoeders: Allochtonen over-vertegenwoordigd' [Small increase in numbers of teenage mothers: Ethnic minorities overrepresented]. *CBS Index* (February): 26-18. Also see CBS (2002: table 48 p.62).

17. UNICEF's 'A League Table of Teenage Births in Rich Nations' *Innocenti Report Card* 3 (2001), uses 'pregnancy rates' and 'birth rates' interchangeably. The Dutch Office of National Statistics (CBS) consistently uses the term 'birth rates'. In the UK, the terms 'conception rates' and 'pregnancy rates' are used as equivalents and include pregnancies that end in abortions.

18. In their Annual Report of 2000, the Dutch Health Inspection (Inspectie van de Gezondheidszorg, 2000: 101) states that 14.3 per cent of all abortions in 1999 were performed on women aged 19 and younger, a figure that has increased by 1.6 per cent from 1998 (menstrual extraction increased by 1.3 per cent. The figures used by Rademakers (2002: 13), however, are lower (12.3 per cent).

19. STISAN is the National Association of Cooperating Abortion Clinics in the Netherlands.

20. This has also been found in the UK. Wellings *et al.* (2001) note that, whereas contraceptive use has increased, conception rates have also increased; also see Paton (2002).

21. These figures are not age-specific. However, as Ranjit *et al.* (2001) have suggested, contraceptive failure is higher among inexperienced users, particularly teenagers. We have no reason to suspect that these figures will present a more positive picture for 15–19 year olds.

22. Although rates would have been more useful for comparative purposes, there are no figures available for these.

23. With the exception of chlamydia, the absolute numbers of cases of STIs in teenagers in the Netherlands, are too low, according to this rather limited list, to make any useful assessments about relative increase or decrease.

24. The primary schools were in the municipalities of Schouwen Duivenland, Breukelen and Rotterdam. The secondary schools were in Barendrecht, Dordrecht and Zwijndrecht (all three are part of an urban area referred to as Drechtsteden).

25. Because children start schooling at the age of four, there is no reception year for five year-olds, but instead this is called 'year one'. The Dutch year eight is thus the same as the British Year seven. Because Dutch children leave primary school at the age of 12 (year 7), the fact that in the Netherlands sex education is given at primary schools is not evidence that children get it at a younger age than in the UK, where year seven (11–12 year olds) is placed in secondary education.

26. At this school, as in two of the three others (Secondary School 4 is an exception), PSHE has very little input in the sex education curriculum. It is only focusing on issues of personal hygiene and sexual health. This is why, at this school, we decided not to interview the PSHE teacher. However, we did check at two other schools, 2 and 4, to see whether it was indeed true that PSHE had little input. In one school (School 2) this was the case, but in the other (school 4), there was more overlap between PSHE and biology, mainly because it was taught by the same person.

27. One of the reasons why Lewis and Knijn may have overestimated the influence of sexual health experts in the Netherlands is that much of their data on the Netherlands is obtained via the Netherlands Institute for Sexological Research (NISSO), which represents those in the field of sexual health expertise.

28. Of course our sample is very small, but quite representative of the 'Drechtsteden' region in the Netherlands. We have no reason to believe that the situation in this region is vastly different from that of the Netherlands as a whole,

as in secondary education centrally issued learning outcomes are much more influential in school curricula than in primary schools. Drechtsteden is part of the Randstad, and although the region has its own traditions and lore, it is increasingly dominated by the urban culture of Rotterdam, the largest urban agglomerate in the Netherlands.

29. In terms of risk-management strategy, the logic behind the double-Dutch method is that whereas condoms will inhibit large scale transmission of most, but not all, STIs and thereby reduce their presence amongst the population, individual failure still contains a high risk of pregnancy, for which the contraceptive pill functions as a back-up as the chances of both failing at the same time are, even by conservative estimates, very small. However, this all depends on the assumption that the rate of teenage sexual activity remains constant. If this is not the case, then we can expect an increased STI-rate simply due to condom failure, as, unlike pregnancy-prevention, STI-risk management has no back-up plan.

30. There are no data available on regional differences of teenage conception rates in the Netherlands. We simply rely on reported problems by teachers themselves during our interviews. There is no reason to believe, however, that their knowledge of pupils' sexual behaviour is completely inadequate. For secondary schools, in particular, pregnancies and abortions are likely to be discussed at staff meetings as they impact on individual students' attendance and performance. Teachers will also be able to gauge, from both questions and responses of their pupils, the levels of their knowledge and awareness, in particular related to risks. Of course, the status of this evidence remains anecdotal and illustrative, which makes comparisons more difficult.

31. It is noteworthy that sexual reforms, such as those espoused by associates of the Netherlands Institute for Sexological Research (NISSO), always encounter the dual problem of sexual liberation and sexual harassment. The whole problem of sexual harassment is turned into an interpersonal dynamic because of the dogmatic inability of liberal relativism to engage in a discussion of the possibility of absolute and universally applicable moral criteria regarding sex. As always, it is then up to individual women to decide where the limits are and to communicate these to their male counterparts, who are simultaneously taught by sexualised Western culture that 'no' does not necessarily mean 'no'. Davis (1999: 22), for example, reports that, in the USA, 60 per cent of girls who have had their first sexual experience before the age of 13 have experienced involuntary sex.

32. The UNICEF report wrongly claims that in the Netherlands STI rates have fallen. The reasons for this are that the statistics it refers to relate to the early 1990s and were based on a very narrow selection of diseases that did not include chlamydia, for example.

33. The term poverty is used rather than social exclusion to highlight the importance of a lack of material (i.e. financial) resources. Social exclusion is a rather vague term, which includes factors such as 'access' to governmental services such as health provision, and education, which are often implicitly used to increase the involvement of governmental agencies in local settings and communities.

34. It is clear that both perspectives could thus also explain the relationship between socio-economic deprivation and prostitution. Rationally speaking, prostitution makes more economic sense for those who have less income and/or chances of upward social mobility; but may equally involve a radical rejection of both traditional notions of chastity as well as liberal notions of self-respect.

35. It would be useful if the government of the Netherlands would monitor regional and local differences in teenage pregnancy rates over the next decade to see to what extent local differences in benefit systems affect teenage pregnancy rates.

36. This is the backbone of the argument used by Roger Ingham in a recent debate with Trevor Stammers, published in the *British Medical Journal* (16 December 2000). He rhetorically asks, 'what rights have professionals to deny young people the opportunity to form relationships and to express their feelings safely in ways that they choose to?' He then proceeds to assure the reader that: 'A policy of advising teenagers simply not to have sex runs the risk that they will become even more alienated from adults and that they will be less likely to use the services available, leading to greater rather than lower risks' (2000: 321). Ingham, suggesting that he speaks on the basis of fact and not opinion, thus states that moral socialisation is both wrong and dangerous. It is equally telling that in his discourse against professional advice to abstain he never mentions the role of parents or the importance of love.

37. This is very similar to advice given by most sexual health experts. It can also be found in most teenage magazines aimed at girls. Those aimed at boys, such as *FHM* and *Loaded*, seem to suggest that boys are always ready (Tincknell *et al.,* in press).

38. The problem always comes after this initial imposition. Having stated that abstinence is best, sex educators then tell children that if they think they are ready, they should take contraceptive precautions. This suggests that having sex is inevitable and that young people are expected to engage in it at some stage. The moral nature of sexuality as it pertains to fidelity and love is replaced by a much more detached, indifferent and cold analysis of artefacts and techniques. The tiny bits of moral knowledge left relate to 'being ready' and 'only doing what feels right'. Needless to say, these latter expressions are so vague that they cannot possibly be communicated within an institutional setting. If the parents are not taking on his role then it will be inevitably up to the individual to find out what these mean. For

girls, the consequences are often far more serious and irreversible than for boys. The absence of strong moral socialisation thus enables boys to ignore the interpersonal aspects and engage in a more direct and indifferent pursuit of hedonistic pleasures (Thompson and Holland, 1998).

39. Monk (1998) provides a critical analysis of the functions of sexual health expertise and describes how they contribute to an expansion of state-control and regulation of the lives of individuals.

40. *Algemeen Dagblad*, 24 December 2001, p. 29

41. *De Volkskrant* 27 October 2001; http://www.volkskrant.nl

42. UK figures taken from: ONS (2001) Labour *Market Trends*, Vol 109, No 11, November 2001. London: Office for National Statistics.

43. This is furthermore corroborated by evidence presented by the SCP that whereas institutional religion has declined in the Netherlands, religious views and beliefs have increased. The SCP argues that this increase is also associated with an intensification of moral strictness in the 1990s, which particularly turned against justifications of abortion and tax fraud. The 37 per cent of Dutch people who still consider themselves as members of a church (of whom only 23 per cent can be considered 'practising faithful') are seen as 'extremely morally conservative'.

44. This is not to say that ethnic groups are more to blame for the social problems of poverty, but simply that housing allocation and socio-economic constraints (some of which may have an origin in 'institutionally racist practices') have resulted in a higher concentration of ethnic groups in socio-economically deprived areas.