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'We didn't cover that at school': education *against* pleasure or education *for* pleasure?

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This paper considers the common criteria by which school-based sex and relationship programmes are evaluated, and argues that the domination of public health outcomes serves to make invisible other aspects of courses that warrant attention. In particular, the role of pleasure in sexual development and relations is normally not acknowledged. While it may be unacceptable in most cultures to suggest that teaching young people how to achieve sexual pleasure is valuable, there are increasing indications—from developing as well as developed countries—that public health outcomes may benefit from a greater acceptance of positive sexual experiences. It is suggested that greater comfort with one's own body will enable greater ability to communicate wishes to others, and to be less 'pressured' into unwanted sexual relationships.

Introduction

This paper examines some issues regarding how to evaluate 'sex and relationships education' (SRE) that have not hitherto received substantial attention. Although most existing research has focused on school-based contexts, we should not underestimate the range of other sources through which young people acquire and make sense of knowledge, understandings, values, and so on, about bodies and sexuality. Drawing on findings from research into aspects of young people and sexual activity, as well as close involvement with policy-makers, both in Europe and in some of the poorer countries of the world, this paper examines whether 'pleasure' could and should feature more prominently in discussions about sexual activity. Although many of the examples used and policies referred to are drawn from developed countries, the issues at hand are globally relevant; more and more countries are facing up to the need to introduce SRE in some form or another as the threat of HIV and other sexually transmitted infections increases.

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Criteria for 'success' of SRE programmes

A great deal has been written in recent years about 'what works' in relation to SRE[1] programmes. Most of this work is motivated by the perceived need to encourage greater adoption of safer sexual activities, either through abstaining altogether from sex or through increased use of barrier methods to prevent unplanned conceptions and the transmission of sexually transmitted infections (STIs), including HIV.

A particularly long-standing aspect of this endeavour, albeit one that has increased in prominence within recent years, is whether sex education should be covered within schools at all; the 'abstinence movement' in the USA is particularly vocal in this regard, claiming, among other things, that covering such topics encourages early sexual activity. Similar suspicion of SRE is expressed in many other countries across the world under different guises and for a range of reasons—for example, the 'need to protect traditional values' is a particularly common justification. This paper does not deal with the issue of whether it should be covered at all, although this debate cannot be ignored; there are substantial reviews available that deal with these wider issues (for example, Grunseit & Kippax, 1993; Grunseit, 1997; Kirby, 2001).

But even in contexts where it is accepted that some level of SRE is to be welcomed,[2] the answers to questions regarding quite how it is to be delivered, by whom, at what stage in the curriculum, what should be covered, and so on, are not universally agreed upon. To this end, many studies have been undertaken in recent years to try to address some of these issues.

The 'gold-standard' approach to addressing these issues is the randomised controlled trial. By randomly allocating pupils, classes or schools to an intervention arm or a control arm, the impact, if any, of a particular approach can be assessed. According to this methodological philosophy, all other aspects that might conceivably affect outcomes are held constant. In itself, this is a highly controversial approach, smacking as it does of a purely medical discourse based on an 'injection' approach to education—'inject' knowledge and/or skills, and behaviour will change accordingly.

But even if we accept that this approach has some merits,[3] and even within its own terms, to design a study that would address all the different dimensions along which SRE programmes can vary would be an impossible task. Thus, for example, there has been interest in whether teacher-led or peer-led programmes are more effective, but to do this properly according to scientific principles of control would require many potentially confounding factors to be taken into account. These include class size, age of delivery, content, style of delivery, supporting material, mixed-sex versus single-sex delivery, ethnicity, level of parental involvement, use of outside speakers, length of course, and so on. Once the appropriate power calculations have been carried out to ensure adequate sample sizes within the cells required to control for so many variables, the scope of such a study would exhaust the school-aged population of a large country—most probably in more ways than one.

Despite these rather obvious criticisms of this approach, some such studies have been conducted. Of relevance in this context is what measures were used to assess whether they 'worked' or not; in other words, were they effective. Most such studies

use one or more of a limited number of measures, including age at first intercourse (or sexual début), condom use on the occasion of first and subsequent intercourse episodes (usually assessed through a binary yes–no question that disregards issues of correct use in relation to timing, etc.), levels of knowledge of STI transmission, symptoms and effects, levels of knowledge of pregnancy risk, knowledge of local services, and so on. Clearly, these outcomes are related primarily to the public health interest in the area and generally funded through this route. A few studies extend the outcomes to include more 'psychological' aspects, such as levels of regret after first intercourse and reported reasons for the activity; these are related both to public health issues as well as to more dynamic processes such as monitoring levels of coercion, assessing empowerment skills among women, and others. Data on reported reasons for first sex may involve an implicit assumption that some reasons are rather better than others; for example, many would argue that love is more justifiable than curiosity, experimentation or just plain lust.

Examples of this kind of work include three recent studies carried out in the United Kingdom, which are regarded by some as prime examples of their genre. These are the SHARE, RIPPLE and APAUSE projects. Each will be briefly considered in turn with a focus on outcomes rather than processes, although quite a lot of detail is available regarding the latter.

The SHARE project was conducted in Scotland and involved a multidisciplinary team with a social sciences base, albeit based at and funded by the UK Medical Research Council (Wight *et al.*, 2002). The programme was devised on the basis of the supposed best theoretical models, involved quite intensive training for staff in the intervention schools, and was initially intended to have 20 sessions of input including role-plays and other interactive activities. The control schools carried on with their normal programmes. The study was designed according to the best principles of random control trials, and the sample size power calculations were made on the basis of a 10% increase in condom use at first intercourse. The study was funded to the level of over one million pounds and ran for five years.

No changes in age at first intercourse or condom use on this occasion were found. This obviously poses a dilemma, and the results have been the basis of an intense debate within Scotland at the time that their draft sexual health policy was being debated. It is interesting to note that one significant difference was obtained concerning reported regret, with those women in the experimental schools reporting lower levels than those in the control schools. While this may regarded as a positive outcome, possibly indicating lower levels of coercion, for example, it is hardly a result that will help to persuade vocal opponents that SRE has positive and direct health benefits.

The RIPPLE project was established in order to assess the impact of peer-led sex education approaches in East and South East England (Stephenson *et al.*, 2004). Again, the principles of good randomised controlled trial design were adopted, and the study was to some extent described as providing the opportunity to directly compare the impact of teacher-led and peer-led approaches. Peer educators were 16–17 year olds and they worked for three sessions with 13-year-old to 14-year-old pupils.

By age 16 years, fewer women in the intervention arm reported having had intercourse (38–43%, although this was not an original outcome intention for the study) but there was no difference in the proportion of men or women who reported unprotected intercourse (the initial outcome intention). Pupils reported having been more satisfied with the peer-led sessions than they were with the teacher-led sessions. Other differences between the arms were small.

The APAUSE programme uses a mix of one or more of peer-led and teacher-led delivery, drama sessions and outside speakers (Department of Child Health, Exeter, 2002; Kay *et al.*, 2002). The programme was developed from knowledge of best practice gleaned from studies in the USA and is marketed to English local education authorities as a package that includes training, materials, support, evaluation and other activities. Some debate regarding its effectiveness has been ongoing for some years, and so the government Teenage Pregnancy Unit in England commissioned an independent evaluation by the National Foundation for Educational Research. As well as conducting their own questionnaire-based and qualitative research, the National Foundation for Educational Research also re-analysed the data already collected by the APAUSE team on which the earlier claims for success had been based (Blenkinsop *et al.*, 2004).

In summary, students exposed to the APAUSE programme tended to have more responsible (and less immature) attitudes to sex, higher knowledge and more positive attitudes towards sex education. No differences were found between groups on reported use of contraception, rates of intercourse and unprotected sex, or expressed regret. Apart from some practical problems in running the programme—such as peer educators or even health services staff not turning up when expected and some serious issues concerned with the level of training received by the peer educators—many of the staff involved in schools were positive about the programme. Many did, however, question whether it was sustainable when the current local education authority funding expired. A further controversy concerned the extent to which the programme was overly scripted; that is, it was seen by some to be relatively inflexible in terms of responding to the pupils' own needs and priorities.

What characterises each of these three well-funded programmes is the assumption that effectiveness should be measured in terms of reduction in risk behaviour and an increase in knowledge and/or skills—normally referred to as assertiveness or negotiation skills, and often felt to be more needed by young women than young men, who are often assumed to have too much of them already.[4]

In the USA, similar studies have been carried out for many years. Kirby (2001, 2002) has regularly prepared summaries of effectiveness, with most studies adopting similar measures as those used in the UK studies. Few of these studies use direct measures of physical sexual health.[5] Although it would clearly be beneficial to do so, the incidence of early conception and STIs is such that sample sizes and associated costs would need to be substantially increased to obtain sufficient data.[6] One study that does have relevant data with biological markers is not an assessment of school-based programmes but an assessment of the associations between young people's

sexual activity and risk and whether or not they had signed a virginity pledge (promising, normally in public, to maintain their virginity until marriage). Since the young people involved had not been randomly allocated to 'pledgers' and 'non-pledgers', no causal inferences can be made nor, indeed, are claimed by the authors (Bearman & Brückner, 2001, 2004). The data were drawn from successive waves of the large Adolescent Health surveys in the USA, in which around 12,000 young people have been followed through from age 12–18 to 18–24 years of age. The relevance to school-based SRE is that the aims of the organisations that encourage pledge signing are highly compatible with the aims of the abstinence-only education that is being strongly backed by the US Government for use both in the USA and in developing countries; indeed, many such organisations work through schools.

In brief, those who signed a pledge were found to have had their sexual début some 18 months or so after the non-pledgers (although it is of interest to note that when compared age for age, the pledgers were later in developing biologically, so this delay may be driven partly by hormones rather than solely by self-control). However, 88% of the pledgers did indeed have sex prior to marriage, and many did so with partners other than their eventual spouse. What marks this study out as particularly relevant, however, is that biological markers were used to assess STI rates. Interestingly, these were as high amongst the pledgers as amongst the non-pledgers and, in communities where pledging rates were over 20% of the appropriate population, rates were twice as high as in communities where pledging rates were lower (Brückner & Bearman, 2005). The authors point out that a public statement of intent to abstain until marriage is not compatible with the use of sexual health services for testing and/or contraception provision, and, indeed, they report data to support each of these claims.[7]

Are these criteria sufficient and what is omitted?

The outcomes relating to sexual ill-health as defined in these illustrative studies are, of course, laudable and justifiable aims, and I would not want to question their use. Two issues are, however, questionable: first, and briefly, the effect of defining success and failure in these terms and the impact this has on the design of SRE programmes; second, and relatedly, what they leave out.

First, let us look briefly at the content of the programmes and curricula themselves. Although the evaluations already outlined were large scale and directly affected relatively few schools in the United Kingdom, there are many local examples of smaller-scale evaluations carried out. Additionally, the arguments and policies that support and justify SRE inclusion are normally based on their probable or potential impact on sexual health outcomes, often being couched in pragmatic terms as means of reducing some negative outcomes, normally teenage conceptions and STIs including HIV. In other words, the intended outcomes drive the content and, within a model of health promotion that regards knowledge and skills as being paramount, then these tend, not surprisingly, to be emphasised. Issues are included only as far as they are regarded as being directly relevant by those designing the

course, individual teachers, parents (where they have any say in the matter), and others.

What these forms of evaluation, and through them the criteria adopted for the design of curricula, often fail to take into account are the many and varied reasons why young people engage in sexual activity. Certain reasons may be highlighted as being more acceptable than others; for example, 'love' is generally discussed as being a more legitimate reason than, say, curiosity or experimentation. Other more social reasons, such as the wish to acquire a reputation or to feel 'grown up', are normally discussed in derogatory ways as being trivial—or in some way less defensible, acceptable or mature reasons. Recent work has illustrated how some young men wish to have (hetero)sex early in order to prove to their friends that they are not gay (Frosh *et al.*, 2002; Phoenix *et al.*, 2003), and yet such a response option is not included in any evaluation study of the impact of an SRE programme.

As pointed out some years ago by Fine (1988), one of the key areas omitted is anything to do with desire. Although her emphasis was on the lack of recognition of female desire in much writing on sexuality issues and education, a case can be made for extending the scope of Fine's critique. Thus, for example, the issue of male desire is relatively ignored; it appears to be taken for granted as a constant threat to women, and one that they must develop the skills to resist. Outcome evaluation studies that include questions about subsequent regret concerning first intercourse generally do so as a means of assessing the level of coercion and/or of the level of 'maturity'. Qualitative work in the area reveals (for example, Ingham *et al.*, 1991; Holland *et al.*, 1992, 1998) that the regret is in many cases linked to a perceived failure, normally on the woman's part, to 'save' the event for the 'right person' and the 'right time'. In other words, regret is judged against some ideal discourse of romantic love, or what Hollway (1984) termed the 'have–hold' discourse. In this sense, the regrets were concerned with dis-empowerment or loss of control over their bodies, although 'loss of control' here is not meant in the positive sense of ecstasy, peak experience, flow or similar experience. The very few men who report regrets tend to do so in terms of perceived shortcomings in their own physical performance.

In relation to positive reactions in themselves, some young people—more men than women—referred to feelings of having 'crossed a hurdle', 'become a real man' or whatever. Women, when they were not expressing regret, tended to refer to more relational aspects—feeling close, cementing a relationship and similar responses. As with all such qualitative research, however, it is hard to be sure if what is presented is some version of the 'truth' or whether it is merely a socially accepted and acceptable narrative of events. But this is a rather larger dilemma than can be considered in this current context.

What young people tell us as researchers or evaluators may be filtered according to what they feel we want to hear, or may well reflect what they do genuinely believe to be the case. We all tend to construct narratives to try to make our lives consistent and meaningful. We all—some to a greater extent than others—want to fit in to discursive frameworks that enable communication and belongingness, and a sense of

social cohesion. And the reasons we provide for engaging in activities—like sex, for example—need to be justified for others as well as for ourselves.

What is the role of pleasure?

What characterises the examples of programmes and evaluations already summarised is the emphasis on the negative—avoid STIs, avoid unplanned conceptions, avoid being coerced into sex, avoid being pressured by peers, avoid 'doing it' out of curiosity, and so on. Positive reasons for engaging in sex in most countries are couched within the context of stable relationships including marriage and reproduction. There is, however, an acknowledgement among the moralists that sex is indeed unique and spiritual (and, by implication, positive), but this is used as an argument for saving it for that special someone with whom one has chosen to devote the rest of one's life, rather than as something that can be enjoyed for its own sake.

Furthermore, in many parts of the world, and within some religious faiths, the *only* legitimate reason for engaging in sex, at least for women, is to reproduce in a dutiful manner and at a dutiful time. Among men, learning what is involved is, in some countries, a task for sex workers, and it is not unusual for young men to have this aspect of their socialisation to be encouraged and paid for by their older relatives as a rite of passage (Tarr & Aggleton, 1999; Van Landingham & Trujillo, 2002). In yet other parts of the world, premarital sexual activity can serve as a means of demonstrating fertility, possibly so that potential future partners can be reassured that a marriage will produce children (see, for example, Sobo, 1996).

Pleasure is simply not acknowledged in most countries and, consequently, does not feature in SRE programmes or their evaluations. One can see how this situation has arisen within the contexts of research traditions that have been concerned with public health—fertility and its control, and more recently the prevention of STI transmission. Sexual activity is an act to be regulated and controlled. Furthermore, within religious and cultural contexts where sex has limited and specifically defined functions, then a discourse of sheer enjoyment is unlikely to feature prominently as a part of the process. Although much has been written on the transformation of intimacy that new contraceptive technologies have enabled (Giddens, 1993), and there has been increasing globalisation of sexual imagery and pressures (Altman, 2001), discussion of the implications of these changes for public health and educational efforts has not kept pace.

There are a number of implications of this failure to keep pace with these developments. Some of these involve pleasure as a component of sexual activity involving two (or more) people, while others bring into consideration issues relating to solo sex.

In relation to the former, there has been some limited work on the benefits of mutual masturbation as a form of safer sex. This was not mentioned in any of the evaluations of the programmes described earlier—for example, whether any unsafe intercourse had been avoided or averted through non-penetrative activities—either by hand or by mouth. Despite the priority given to vaginal penetration, it would surely be a

legitimate measure of the 'effectiveness' of sex education to assess the extent to which young people feel confident to persuade partners that alternatives can be almost or equally (or more) pleasurable and, conversely, that the partners accept that this is the case? Through the relative silencing of alternative ways of giving and receiving pleasure through the emphasis on the avoidance of negative outcomes, the reproductive and hence heterosexual priority of sexual activity is reinforced.

In relation to solo sex, relatively much less has been researched and reported despite a long history of marginal academic interest (see, for example, Finger, 1947). Certainly, there have been books written about the various taboos on the activity as regarded by different faiths and the terrible consequences for those who engage in the habit (see, for example, Sokolow, 1983); the biblical line (for men at least) regarding it not being acceptable to 'spill seed on stony ground' has had profound implications for many people.

Among men, quite apart from the perceived sinful nature of the activity in itself, there are strong taboos in some parts of the world that are supported by cultural myths regarding health outcomes. Thus, for example, in many parts of Asia and sub-Saharan Africa, semen loss, whether through masturbation or wet dreams, is thought to lead to loss of strength, reduction of physical and spiritual potency, and other similar outcomes (Pelto [2002] presents a fascinating summary of these concerns). That some of the reported negative health outcomes might be produced by guilt and anxiety at breaking these cultural taboos is rarely considered.

In western countries, male masturbation still tends to have a negative image even if these specific cultural taboos are not as strong. A common form of insult among some groups of aggressively-inclined young men in the United Kingdom is to accuse another of being a 'wanker' or 'tosser', and the appropriate hand signals are seen at many a football game when the opposition fans or players get too close. Presumably, the discourse underlying this form of abuse is that the opponents are not man enough to be able to satisfy their sexual urges in the 'normal' manner; that is, with a (presumably female) partner. The role that guilt and hypocrisy play in the whole area is nicely encapsulated by an alleged statement of St Augustine (who was apparently a compulsive masturbator): 'Give me chastity and continency—but not yet!' (*Oxford Dictionary of Quotations*, 1979). Among the many others who are reported to have been public in their condemnation of the practice are Joseph Kellogg, a Seventh Day Adventist—who apparently thought that a daily intake of breakfast cereal would help; he also proposed 30 additional techniques for preventing the practice among boys and men (Kellogg, 1892)—and Baden Powell, founder of the Boy Scout movement.

In relation to women masturbating, there is even greater silence (although Kellogg [1892] did suggest that applying carbolic acid to the clitoris would help prevent it). If it is mentioned at all, it fits into the same category or semantic space as desire. As has been well argued by writers such as Tolman (for example, 1994; see also Kitzinger, 1995), this is highly dangerous territory for many women, with close links to forms of abuse such as 'slag', 'slut' and similar derogatory terms. That these insults are as likely—if not *more* likely—to be uttered by other women as they are by men indicates the extent to which gendered sexual socialisation has taken hold even among those with most to lose by it.

Hogarth (2005) has recently conducted a review of citations of Fine's (1988) original paper on 'the missing discourse of desire'. In it, a number of interesting issues arose. First, of the 127 citations (up to April 2004), 52 simply referred to the paper as an example of feminist and/or qualitative research. In the others, desire was associated—to varying degrees—with victimisation, violence and self-control. Notably absent was mention of *masturbation* as a reflection of, or outlet for, desire. Most references were concerned with assertiveness in relationships, and how empowering women to say what they do and do not like is generally a 'Good Thing' even though it may expose them to danger in some contexts. It seems that writers and researchers are equally complicit in the silence that surrounds the topic of masturbation.

Some years ago, Ingham and van Zessen (1998) completed some research that compared young people's accounts of their early sexual development and activities in the United Kingdom and The Netherlands (see also Ingham, 2004). The key pattern of results—that more openness in schools and in the home was protective—was very helpful in developing policy in the United Kingdom and elsewhere, and in persuading those in positions of influence that they need not fear greater discussion of sexual issues (Social Exclusion Unit, 1999). What we have not yet systematically analysed are the reports provided by our participants on solo sex. Interestingly, it was our (more open) Dutch colleagues who insisted on including a fairly lengthy section on this in the interviews. But on reading through a sample of the UK transcripts it is possible to notice a couple of trends; these will be more formally analysed and compared with the Dutch material in due course.

First, there was a fairly high number of women who reported not having experienced an orgasm (if indeed they had at all) until they were fairly old in relative terms; they spoke in hushed and embarrassed tones about masturbation and the difficulties they had in relaxing and feeling guilt-free about it. Orgasms were sometimes spoken of as something that a man 'gave' them, rather than as something they could give themselves or teach their partners how to help out. Second, the ways in which men (and women, for that matter) talked about the use of pornography demonstrated similar ambivalence and uncertainties. In informal discussions with our Dutch colleagues it would appear that reactions to these areas differ between the two countries. It seems to be more accepted and acceptable to acknowledge and act upon sexual desires and wishes in the Dutch context than in the United Kingdom.

In other words, the attainment of bodily pleasure among the UK sample was frequently associated with guilt, shame and other negative emotions. One can assume, fairly safely I feel, that these associations are not unique to young people in the United Kingdom.

Why and how should pleasure be given more priority?

There are a number of compelling arguments as to why pleasure should be afforded greater priority in public health domains,[8] although the lack of recognition of the potential importance of the issue, and the accompanying lack of research, means that

some of these arguments are speculative. Just two examples will be provided here: one from some important south Asian work on semen loss, and the other from the work on comfort with bodies as revealed in the research on solo sex outlined earlier.

In brief, Indian work has revealed that semen loss, through masturbation or wet dreams, was associated with a range of negative outcomes; together, these inhibited young men from seeking pleasure for themselves. In further exploration of the impact of this phenomenon, the researchers found a number of reactions. First, some young men did indeed masturbate but experienced real guilt and fear for the impact that this would have on them and their futures. Second, and more directly relevant to public health concerns, was that as a 'solution' to the 'problem', some young men reported visiting sex-workers or engaging in penetrative male-to-male sex as a means of allowing semen release (Deepak Charitable Trust, 2002). These activities may, of course, place them at higher risk of STIs, including HIV. There are also some indications that perceived sexual health problems also manifest themselves in a higher incidence of violence towards spouses among married men (Verma, 2002).

The second example is more speculative, and concerns the possible effect of the guilt and shame experienced by many young women regarding masturbation; it was speculated that this is more prevalent in the United Kingdom than in The Netherlands. The extent to which this is a factor in the later start to sexual activities, at least as assessed by age at first intercourse, and the lower conception rates in The Netherlands needs to be ascertained; as does whether or not there are individual—as well as cultural—effects. But it certainly would appear to be a plausible area to explore. If young people are more able to create pleasure for themselves, then they may be less dependent on others to produce it for them.

So, there are—albeit limited—justifications for including discussions of pleasure into public health debates and practices. But there is a great deal that we simply do not know about, given the paucity of the research background in this and related areas. Among the issues that need to be explored are:

- What are the mechanisms through which masturbation is associated with guilt, shame, secrecy, mystery, embarrassment, feelings of inadequacy and other negative associations?
- What communication patterns between young children and their parents encourage these negativities (e.g. how do parents respond when their child first starts to play with themselves, or asks about why it feels nice)?
- Where did terms like 'self-abuse', 'abasement' and similar originate, and why and how do they persist?
- To what extent are these feelings directly transferred into the sex-with-another arena?
- How important is the close proximal association between parts of the body associated with elimination (and dirtiness) and those associated with pleasure?
- What impact does the way that the onset of menstruation is treated in families and societies have on feelings of relaxation about, and comfort with, bodies?

- To what extent could we contemplate exploring—and challenging—the attitudes and discourses that lead to the perpetuation of these views, and who then should be the target of our educational aspirations?

It is possible to extend elements of this discussion into the general area of attitudes towards nudity. If we continue to treat bits of bodies as things to be hidden, then it is not altogether surprising that young people grow up thinking/feeling/knowing that they are shameful and naughty. In a similar vein, how do parents respond when they are asked—as they inevitably are—'where do I come from?', and what impact do their answers have on their children's understanding of sex, the relation between function and pleasure, embarrassment, whether sex is generally a pleasant or unpleasant experience, and so on. Many years ago, Fisher *et al.* (1988) drew attention to the importance of erotophobia as a negative correlate of safer sexual activity; we do not appear to have learned much from this work.

What we perhaps need to do is to encourage a greater separation between, on the one hand, bodies and what we may or may not choose to do with them for ourselves, and, on the other hand, with whom we choose to share them and why. If young people are enabled to feel more relaxed about their own bodies, and about bodily pleasures, then they may be less affected by the pressures to engage in sexual activity against their wishes or in ways that they do not feel comfortable about (and this applies to men as well as women). Diorio and Munro (2003) have presented a thoughtful analysis of the way in which puberty is presented to school pupils and how this tends to perpetuate the centrality of reproductive maturation. Alternative meanings that may be experienced by young people are marginalised; although their analysis emphasises the impact this has on heterosexist assumptions, one could use the same argument to illustrate how new possibilities of bodily fulfilments tend to be minimalised or ignored.

What would the barriers be and how might they be overcome?

The implications for SRE of an approach that gave more prominence to pleasure, as such, will need thinking through and articulating clearly, and it is, of course, likely to meet with immense opposition for a wide variety of reasons. Although research has shown that parents (even in the USA) are, on the whole, in favour of earlier and fuller SRE in schools (Kaiser Foundation/ABC Television, 1998; Stone *et al.*, 1998), there must be limits to their liberalism (although such views may not always reflect liberalism—some will undoubtedly just be wishing to avoid having to deal with the issues themselves, due to their own perceived ignorance, shame, embarrassment, uncomfortable sexual histories, and so on). Teachers will object on the grounds of embarrassment, religious leaders will object on one or other faith grounds, and some or many politicians and other adults in general will object on the grounds of the threat of destroying childhood innocence.

But this is where the creative placing of topics and delivery can be useful. Media studies and literature as school subjects are hardly likely to lead to an outcry from the

far right, but much can be done in terms of challenging gender stereotypes and of questioning received wisdom in many other respects as well —such as power, values, respect, pleasure.

In school settings, delivery through small group discussion has many potential advantages. Small groups allow more focused and deeper discussion of issues than could be possible in larger classes. A further advantage is the way that the perennial problem of differentiation can be tackled; given the range of backgrounds and experiences that young people of the same age bring to the classroom, it is virtually impossible to design a SRE course that will not be too late for some, too early for others, irrelevant for yet others, and so on. Added to this is the fact that schools are the very sites where much of the (within and between) gender power battles are played out.

Arranging small group discussions with friendship groups as a basis would potentially enable deeper and more personally relevant issues to be explored and discussed; not only are such groups more likely to be at similar stages of sexual experience and development, they should be more comfortable in talking about issues with each other. Many young people welcome the opportunity to discuss concerns about sexual development and relationships in safe environments, and one small-scale study has shown that about one-half of a sample of 200 young women would even be willing to stay on after school to do so (Edmonds, 1994). In parts of the world where school attendance is not universal, then alternative fora will need to be considered; for example, the media, the youth service, workplaces and leisure sites.

This paper commenced by pointing out that most evaluations of SRE programmes attempt to measure change in pupils' knowledge, skills and/or attitudes. This approach, in many ways, does not concern itself with how and why the young people being exposed to the SRE have the views and attitudes that they have at the start of the course—just with the impact of the course itself. But what the recipients bring to the course, and the wider contexts in which the course is delivered, may be crucial to any potential impact.

Notes

1. SRE is used as a generic term to include any school-based intervention that covers sex education and related issues.
2. The term 'welcomed' in this context is used in a loose sense. Many developments in the field are probably better regarded as being 'tolerated' within a public health agenda when faced with the threats that poor sexual health poses.
3. Merits, either from a scientific point of view, or a purely pragmatic point of view, in that medical and health research money is more likely to be forthcoming if this design is adopted.
4. Curiously, much SRE in the United Kingdom at least is regarded as being 'successful' to the extent that it encourages women to say 'no' or to 'wait' when faced with the predatory males, thereby reinforcing the very discourse that some would argue we should be challenging.
5. Relying on self-report of sexual activities raises its own issues; these are not discussed in this paper.
6. The SHARE project does plan to include medium-term follow up of their cohorts to enable comparison of abortion rates among the intervention and control samples.
7. This study is unique in that the results provide both some solace and some challenges to both sides of the debate on sex education. Delayed sexual debut is welcomed by the moralists, but

the data on the failure to wait until marriage and those on STI rates provide support for the critics of such an approach.

8. There are also strong arguments as to why pleasure should be given more priority as an end in itself, but these are subservient in the present context to those of the public health imperatives for purely pragmatic reasons.

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