

RESTRICTED  
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Sexuality Education  
in New Zealand

A Critical Review

By Miriam Grossman, MD  
*with Christopher White*



Report to Family First  
New Zealand June 2013



# Author

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

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

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

Dr Grossman visited New Zealand in 2012.

*For more information, see [www.MiriamGrossmanMD.com](http://www.MiriamGrossmanMD.com)*

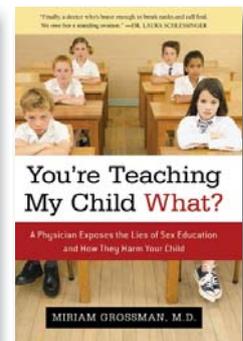
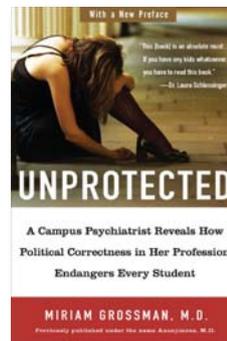


## Portions of this report were previously published in:

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

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

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



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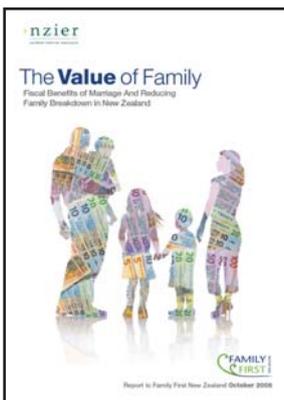
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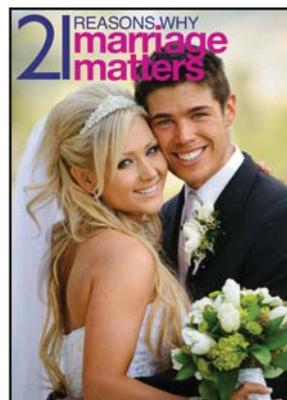
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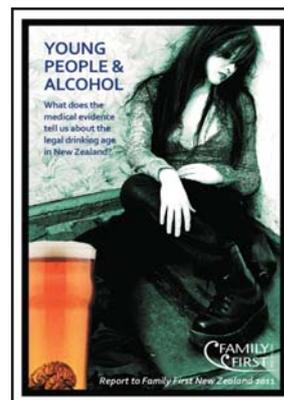
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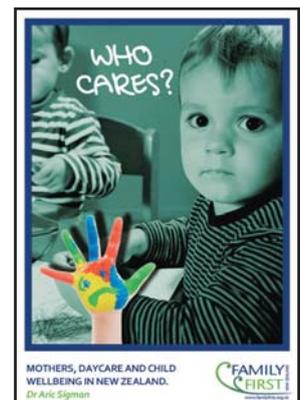
2008



2009



2011



2012

# Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Delaying sexual activity until adulthood is not presented as a viable alternative with considerable rewards.*

*Neuropsychology says teens are not ready for sexual relationships. Sex education must say the same thing.*

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

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

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

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

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

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

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

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

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

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

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

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

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