

**DOMESTIC ABSTINENCE-ONLY PROGRAMS:
ASSESSING THE EVIDENCE**

HEARING

BEFORE THE

**COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM**

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

APRIL 23, 2008

Serial No. 110-115

Printed for the use of the Committee on Oversight and Government Reform



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U.S. GOVERNMENT PRINTING OFFICE

46-712 PDF

WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
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CONTENTS

	Page
Hearing held on April 23, 2008	1
Statement of:	
Capps, Hon. Lois, a Representative in Congress from the State of California; and Hon. Sam Brownback, a U.S. Senator from the State of Kansas	15
Brownback, Hon. Sam	25
Capps, Hon. Lois	15
Keckler, Charles, Acting Deputy Assistant Secretary for Policy, Administration for Children and Families, U.S. Department of Health and Human Services; and Marcia Crosse, Ph.D., Director, Healthcare, U.S. Government Accountability Office	296
Crosse, Marcia	312
Keckler, Charles	296
Santelli, John, Department Chair, professor of clinical population and family health, Mailman School of Public Health, and professor of clinical pediatrics, College of Physicians and Surgeons, Columbia University; Georges Benjamin, executive director, American Public Health Association; Margaret J. Blythe, M.D., Chair of American Academy of Pediatrics' Committee on Adolescence; Stanley Weed, Ph.D., director, Institute for Research and Evaluation; Harvey Fineberg, M.D., Ph.D., president, Institute of Medicine of the National Academies; Max Siegel, policy associate, AIDS Alliance for Children, Youth and Families; and Shelby Knox, youth speaker	84
Benjamin, Georges	153
Blythe, Margaret J.	162
Fineberg, Harvey	191
Knox, Shelby	217
Santelli, John	84
Siegel, Max	202
Weed, Stanley	171
Letters, statements, etc., submitted for the record by:	
Benjamin, Georges, executive director, American Public Health Association, prepared statement of	155
Blythe, Margaret J., M.D., Chair of American Academy of Pediatrics' Committee on Adolescence, prepared statement of	164
Brownback, Hon. Sam, a U.S. Senator from the State of Kansas, prepared statement of	27
Capps, Hon. Lois, a Representative in Congress from the State of California, prepared statement of	19
Crosse, Marcia, Ph.D., Director, Healthcare, U.S. Government Accountability Office, prepared statement of	314
Davis, Hon. Tom, a Representative in Congress from the State of Virginia, prepared statement of	13
Fineberg, Harvey, M.D., Ph.D., president, Institute of Medicine of the National Academies, prepared statement of	193
Jordan, Hon. Jim, a Representative in Congress from the State of Ohio, prepared statement of	257
Keckler, Charles, Acting Deputy Assistant Secretary for Policy, Administration for Children and Families, U.S. Department of Health and Human Services, prepared statement of	298
Knox, Shelby, youth speaker, prepared statement of	219
Sali, Hon. Bill, a Representative in Congress from the State of Idaho: Heritage Foundation study	229
Prepared statement of	226

IV

	Page
Letters, statements, etc., submitted for the record by—Continued	
Santelli, John, Department Chair, professor of clinical population and family health, Mailman School of Public Health, and professor of clinical pediatrics, College of Physicians and Surgeons, Columbia University, prepared statement of	87
Siegel, Max, policy associate, AIDS Alliance for Children, Youth and Families, prepared statement of	204
Souder, Hon. Mark E., a Representative in Congress from the State of Indiana, staff report	37
Waxman, Chairman Henry A., a Representative in Congress from the State of California, prepared statement of	5
Weed, Stanley, Ph.D., director, Institute for Research and Evaluation, prepared statement of	173

DOMESTIC ABSTINENCE-ONLY PROGRAMS: ASSESSING THE EVIDENCE

WEDNESDAY, APRIL 23, 2008

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m. in room 2154, Rayburn House Office Building, Hon. Henry A. Waxman (chairman of the committee) presiding.

Present: Representatives Waxman, Cummings, Kucinich, Watson, Yarmuth, Norton, McCollum, Hodes, Sarbanes, Welch, Davis of Virginia, Burton, Shays, Souder, Duncan, Issa, Foxx, Sali, and Jordan.

Staff present: Phil Barnett, staff director and chief counsel; Kristin Amerling, general counsel; Karen Nelson, health policy director; Karen Lightfoot, communications director and senior policy advisor; Naomi Seiler, counsel; Earley Green, chief clerk; Teresa Coufal, deputy clerk; Jesseca Boyer, investigator; Caren Auchman and Ella Hoffman, press assistants; Zhongrui "JR" Deng, chief information officer; Leneal Scott, information systems manager; Kerry Gutknecht, William Ragland, and Miriam Edelman, staff assistants; Larry Halloran, minority staff director; Jennifer Safavian, minority chief counsel for oversight and investigations; Keith Ausbrook, minority general counsel; Ashley Callen, minority counsel; Jill Schmaltz and Benjamin Chance, minority professional staff members; Brian McNicoll, minority communications director; and Ali Ahmad, minority deputy press secretary.

Chairman WAXMAN. The meeting of the committee will come to order.

We are all here today because we are concerned about the well-being of America's youth. We may not see eye-to-eye about policy, but we share the common goal of improving adolescents' health.

The statistics are shocking. A few weeks ago the Centers for Disease Control released data showing that one in four teenage girls in the United States has a sexually transmitted infection. Of all American girls, 30 percent become pregnant before the age of 20. For African American and Latino girls, the rate is 50 percent. And thousands of teenagers and young adults in the United States become infected with HIV each year.

If we are serious about responding to these challenges, we must base our policy on the best available science and evidence, not ideology.

We are here today to discuss evidence on the effectiveness of abstinence-only programs. There is a broad consensus that the bene-

fits of abstinence should be taught as part of any sex education effort. But abstinence-only programs teach only abstinence. In federally funded abstinence-only programs, teenagers cannot receive information on other methods of disease prevention and contraception, other than failure rates.

To date these programs have gotten over \$1.3 billion of Federal taxpayer money, along with hundreds of millions of dollars in State funds, to conduct programs in schools and communities throughout the country. Meanwhile, we have no dedicated source of Federal funding specifically for comprehensive classroom sex education.

The purpose of this hearing is to examine whether the evidence on abstinence-only programs justifies this expenditure of \$1.3 billion in taxpayer funds.

I respect the commitment and intentions of people who run abstinence-only programs. They are doing it because they care about young people and want to counter the sexual messages that are all too pervasive. Young people who work in these programs demonstrate to their peers that not all teens are having sex, which is an important message. But we will hear today from multiple experts that, after more than a decade of huge Government spending, the weight of the evidence doesn't demonstrate abstinence-only programs to be effective. In fact, the Government's own study showed no effect for abstinence-only programs.

In 2007, the Bush administration released the result of a longitudinal, randomized, controlled study of four federally funded programs. The investigators found that, compared to the control group, the abstinence-only programs had no impact on whether or not participants abstained from sex. They had no impact on the age when teens started having sex. They had no impact on the number of partners. And they had no impact on rates of pregnancy or sexually transmitted diseases.

There is a lot of talk about the failure rates of condoms. It is time we face the facts about the failure rate of abstinence-only programs.

There are also serious concerns about the content of some of these programs. A report I released in 2004 found false or misleading medical information in the majority of the abstinence-only curricula most frequently used by Federal grantees.

While some of these errors have been corrected, recent reviews have continued to find misinformation. Some programs are still teaching stereotypes about gender, like the idea that men judge themselves based on their accomplishments and women judge themselves based on their relationships. And the exclusive focus on abstinence until marriage ignores the needs, and sometimes even the existence, of gay and lesbian youth.

Meanwhile, more and more research shows that many well-designed, comprehensive programs that teach about abstinence and contraception are effective. Comprehensive, age-appropriate programs have yielded results including increasing contraceptive use, delaying sex, and reducing the number of sexual partners. In other words, the evidence demonstrates that, not only do good comprehensive programs not encourage teen sexual activity, they actually decrease it.

This shouldn't be too surprising, because in effective comprehensive programs, young people are taught that abstinence is the safest choice, the healthiest choice, the choice that they should never feel pressured to abandon.

Americans want taxpayers' dollars to be watched for carefully by the Congress. They want us to fund programs that produce results. Yet we are showering funds on abstinence-only programs that don't appear to work, while ignoring proven, comprehensive sex education programs that can delay sex, protect teens from disease, and result in fewer teen pregnancies.

This triumph of ideology over science is bad economics and even worse health policy.

Today we are going to hear from experts at the American Public Health Association and the American Academy of Pediatrics. They will tell us that, based on their professional assessments, the weight of the evidence does not support the continuation of current abstinence-only policy. Instead, both organizations support comprehensive education that includes both abstinence and information on contraception.

The Society for Adolescent Medicine has submitted a statement that says, "Efforts to promote abstinence should be provided within health education programs that provide adolescents with complete and accurate information about sexual health."

The American College of Obstetricians and Gynecologists have a similar view. They submitted a statement that states, "Careful and objective scholarly research during the last two decades has shown that sexuality education does not increase rates of sexual activity among teenagers; rather, sexuality education increases knowledge about sexual behavior and its consequences and increases prevention behaviors among those who are sexually active."

The American Psychological Association submitted a statement recommending that, "[p]ublic funding for the implementation of comprehensive sexuality education programs be given priority over public funding for the implementation of abstinence-only and abstinence-until-marriage programs until such programs are proven to be effective."

And the American Medical Association has an official policy stating that it "supports Federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections and also teach about contraceptive choices and safer sex."

All of these professional societies have reached the conclusion that abstinence-only programs are not supported by the weight of the evidence and that the Government should support more comprehensive programs for youth.

States are also reaching that conclusion. Today 17 States, including California and Virginia, decline to accept these abstinence-only funds. Many of these States cite the lack of evidence supporting abstinence-only programs and the restrictive program guidelines as a basis for their decisions.

We will hear testimony from witnesses who believe that abstinence-only education does have positive effects. I respect the depth of their commitment, but ultimately we need to focus on the full

body of evidence on what works to achieve our shared goals of keeping teenagers safe and reducing teen pregnancies.

We have already spent over \$1.3 billion on abstinence-only programs. The question we must ask today is whether we can justify pouring millions more into these programs when the weight of the evidence points elsewhere.

I look forward to our witnesses' testimony today.

[The prepared statement of Chairman Henry A. Waxman follows:]

HAW Statement for April 23, 2008**“Domestic Abstinence-Only Programs: Assessing the Evidence”**

We are all here today because we are concerned about the wellbeing of America’s youth. We may not see eye to eye about policy. But we share the common goal of improving adolescents’ health.

The statistics are shocking. A few weeks ago, the CDC released data showing that one in four teenage girls in the U.S. has a sexually transmitted infection. Thirty percent of all American girls become pregnant before the age of twenty; for African-American and Latina girls, the rate is 50%. And thousands of teenagers and young adults in the United States become infected with HIV each year.

If we’re serious about responding to these challenges, we must base our policy on the best available science and evidence, not ideology.

We’re here today to discuss evidence on the effectiveness of abstinence-only programs. There is a broad consensus that the benefits of abstinence should be taught as part of any sex education effort. But abstinence-only programs teach only abstinence. In federally funded abstinence-only programs, teenagers cannot receive information on other methods of disease prevention and contraception, other than failure rates.

To date these programs have gotten over \$1.3 billion dollars of federal taxpayer money, along with hundreds of millions of dollars in state funds, to

conduct programs in schools and communities across the United States. Meanwhile, we have no dedicated source of federal funding specifically for comprehensive classroom sex education.

The purpose of this hearing is to examine whether the evidence on abstinence-only programs justifies this expenditure of \$1.3 billion in taxpayer funds.

I respect the commitment and intentions of people who run abstinence-only programs. They are doing it because they care about youth and want to counter the sexual messages that are all too pervasive in popular culture. Young people who work in these programs demonstrate to their peers that not all teens are having sex, which is an important message.

But we will hear today from multiple experts that after more than a decade of huge government spending, the weight of the evidence doesn't demonstrate abstinence-only programs to be effective.

In fact, the government's own study showed no effect for abstinence-only programs. In 2007, the Bush Administration released the results of a longitudinal, randomized, controlled study of four federally funded programs. The investigators found that compared to the control group, the abstinence-only programs had *no impact* on whether or not participants abstained from sex. They had *no impact* on the age when teens started having sex. They had *no impact* on the number of partners. And they had *no impact* on rates of pregnancy or sexually transmitted disease.

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There are also serious concerns about the content of some of these programs. A report I released in 2004 found false or misleading medical information in the majority of the abstinence-only curricula most frequently used by federal grantees. While some of these errors have been corrected, recent reviews have continued to find misinformation. Some programs are still teaching stereotypes about gender, like the idea that men judge themselves based on their accomplishments and women judge themselves based on their relationships. And the exclusive focus on abstinence until marriage ignores the needs – and sometimes even the existence – of gay and lesbian youth.

Meanwhile, more and more research shows that many well-designed comprehensive programs that teach about abstinence and contraception *are* effective. Comprehensive, age-appropriate programs have yielded results including increasing contraceptive use, delaying sex, and reducing the number of sexual partners.

In other words, the evidence demonstrates that not only do good comprehensive programs not encourage teen sexual activity, they actually decrease it. This shouldn't be too surprising, because in effective comprehensive programs, young people are taught that abstinence is the safest choice, the healthiest choice, and a choice that they should never feel pressured to abandon.

Americans want Congress to be good stewards of their tax dollars. They want us to fund programs that produce results. Yet we are showering funds on abstinence-only programs that don't appear to work, while ignoring proven comprehensive sex education programs that can delay sex, protect teens from disease, and result in fewer teen pregnancies. This triumph of ideology over science is bad economics and even worse health policy.

Today, we are going to hear today from experts at the American Public Health Association, the American Academy of Pediatrics. They will tell us that based on their professional assessments; the weight of the evidence does not support the continuation of current abstinence-only policy. Instead, both organizations support comprehensive education that includes both abstinence and information on contraception.

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All of these professional societies have reached the conclusion that abstinence-only programs are not supported by the weight of the evidence – and that the government should support more comprehensive programs for youth.

States are also reaching the conclusion that abstinence-only programs aren’t working. Today, 17 states – including California and Virginia – decline to accept these abstinence-only funds. Many of these states cite the lack of evidence supporting abstinence-only programs and the restrictive program guidelines as the basis for their decisions.

We will also hear testimony from witnesses who believe that abstinence-only education does have positive effects. I respect the depth of their commitment. But ultimately, we need to focus on the full body of evidence on what works to achieve our shared goals of keeping teenagers safe and reducing teen pregnancies.

We've already spent over \$1.3 billion on abstinence-only programs. The question we must ask today is whether we can justify pouring millions more into these programs when the weight of the evidence points elsewhere.

I look forward to our witnesses' testimony today.

Chairman WAXMAN. I want to recognize our ranking member, Mr. Davis, for his opening statement.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Chairman.

I know I have to go to the floor to manage our side of some of the committee's bills, so I will not be here for the full hearing, but I want to thank you for convening this hearing to review the performance of federally funded education programs on sexual abstinence.

Not surprisingly, we can expect strong feelings and views to be expressed on all sides today, because we are talking about an issue of fundamental importance to public health and to the healthy development and well-being of our children. But disagreements need not turn disagreeable. To be constructive, mutual respect and understanding of divergent perspectives should drive our discussion.

We proceed from the premise that everyone here today speaks and acts only out of a sincere and well-informed interest in a healthy future for young people throughout our Nation. Despite differences over how to best reach it, the goal of delaying sexual activity among teenagers is widely—almost universally—shared. The benefits of abstinence are as absolute and obvious as they are difficult to convey through the inconsistent surge of teenage hormones, cultural stereotypes, and peer pressure.

In the public health realm, scientific certainties are rare, but we know without question not having sex absolutely protects young people from the physical and emotional perils that can and do befall those who engage in high-risk and age-inappropriate behaviors. High school is a difficult enough time without the added pressures of complex sexual relationships that too often result in pregnancy, sexually transmitted diseases, and emotional trauma.

Young people should be spending that time of their lives focusing on school, extra-curricular activities, friends, and their futures, not succumbing to the risks of early age sex. And those risks are substantial. A third of American young people will become pregnant before the age of 20. A third of those between the ages of 15 and 17 reportedly already feel pressure to have sex. One in four teenage girls is infected with STDs. And, tragically, STDs are found at almost twice that rate in African American young women. And half of all new HIV infections occur in people under the age of 25.

As dire as these numbers may seem, progress has been made since the early 1990's. Between 1990 and 2004, the teen pregnancy rate fell 38 percent. The percentage of high school students who have had sexual intercourse also declined over the same decade. Today it is estimated less than half of American high school students have ever had sex.

Despite these important gains, the United States compares unfavorably in these measures with other developed nations. Particularly among racial minorities, troubling disparities persist.

So we appropriately ask today how well Federal programs support abstinence education. It is a fair question, but it is not the only question that bears on how to protect public health and the welfare of precious young lives.

In this discussion we should abstain from an urge to take an all-or-nothing approach or make false choices between abstinence-only programs and more clinical—some might say permissive—sex edu-

cation. Particularly today, against cultural trends that glamorize the immediate gratification of physical and material wants while minimizing personal responsibility, we need to use every means available to reach young people to help them make responsible decisions.

Focusing only on the performance of abstinence-only programs also risks leaving the impression the Federal Government funds only those courses, or that just those efforts need oversight. In fact, the Federal Government funds the full spectrum of sex education, as it must under our Constitutional system. Decisions about the nature and content of sex education in schools are made at the State and local district levels, with strong input from parents. Different communities have different mores and traditions. What works in Utah may not be what is needed or wanted in rural Mississippi or inner city Los Angeles.

The Federal Government's role is to empower States and localities to make those choices, not supplant the judgment of parents, teachers, and school boards. So we permit States, school districts, and community organizations to seek Federal funds for the types of sex education they judge best to meet the needs of their students. We should not deny them the option of abstinence education programs because some perform better than others. Each life saved is of immeasurable value.

Data on the impact of abstinence education programs may be difficult to capture or slow to be recognized, but problems with how abstinence is taught cannot be allowed to undermine its indispensability as a core element of what is taught. It is inaccurate and unfair to claim all abstinence education programs are the same or that all such programs fail, therefore none should be funded.

To bring a more nuanced view to the evaluation, we asked that Dr. Stan Weed be invited to testify. His work in this field should shed a needed light on the elements of an effective abstinence education program. I thank Chairman Waxman to agreeing to our request for this witness. Identifying what works and what doesn't can help focus Federal funding on the best practices and the most efficient programs.

We welcome all of our witnesses this morning and look forward to a constructive conversation on how to fund the very best abstinence education programs.

[The prepared statement of Hon. Tom Davis follows:]

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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Statement of Rep. Tom Davis
Ranking Republican
Committee on Oversight and Government Reform
“Domestic Abstinence-Only Programs: Assessing the Evidence”
April 23, 2008

Thank you, Mr. Chairman, for convening this hearing to review the performance of federally funded education programs on sexual abstinence. Not surprisingly, we can expect strong feelings and views to be expressed on all sides today because we’re talking about an issue of fundamental importance to public health and to the healthy development and well-being of our children. But disagreements need not turn disagreeable. To be constructive, mutual respect and understanding of divergent perspectives should drive our discussion. We proceed from the premise everyone here today speaks and acts only out of a sincere and well-informed interest in a healthy future for young people throughout our nation.

Despite differences over how best to reach it, the goal of delaying sexual activity among teenagers is widely - almost universally - shared. The benefits of abstinence are as absolute and obvious as they are difficult to convey through the insistent surge of teenage hormones, cultural stereotypes and peer pressure. In the public health realm, scientific certainties are rare. But we know without question not having sex absolutely protects young people from the physical and emotional perils that can, and do, befall those who engage in high-risk and age-inappropriate behaviors.

High school is a difficult enough time without the added pressures of complex sexual relationships that too often result in pregnancy, sexually transmitted diseases, and emotional trauma. Young people should be spending that time of their lives focusing on school, extracurricular activities, friends, and their futures, not succumbing to the risks of early-age sex.

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*Statement of Rep. Tom Davis
April 23, 2008
Page 2 of 2*

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We welcome all our witnesses this morning and look forward to a constructive conversation on how to fund the very best abstinence education programs.

Chairman WAXMAN. Thank you very much, Mr. Davis.

First of all, by unanimous consent, without objection, all Members will be permitted to enter opening statements in the record.

We are pleased to have two of our colleagues with us today to present their position on this issue. We have Congresswoman Lois Capps, representing the 23rd District of California, where she serves on the Energy and Commerce Committee. She is the founder and co-chair of the House Nursing Caucus and is the Democratic Chair of the Congressional Caucus for Women's Issues.

We are pleased to have you with us.

Senator Sam Brownback is the senior Senator for Kansas. He serves on the Appropriations, Judiciary, and Joint Economic Committees and is the ranking member on the Joint Economic Committee.

We are pleased to have you here, as well.

I guess before we do that, I should inform you and all the witnesses that it is the practice of this committee that everyone who testifies before us testifies under oath, so even though you are Members of Congress I think we ought to apply the same rules to you, as well.

[Witnesses sworn.]

Chairman WAXMAN. The record will indicate that the witnesses answered in the affirmative.

Ms. Capps, why don't we start with you. Your prepared statements will be in the record in full. We would like to ask, if you would, to keep your oral presentation to around 5 minutes.

STATEMENTS OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; AND HON. SAM BROWNBACK, A U.S. SENATOR FROM THE STATE OF KANSAS

STATEMENT OF HON. LOIS CAPPS

Ms. CAPPS. Thank you, Chairman Waxman, for inviting me to participate today. It is an honor for me to appear with my esteemed colleague from the Senate.

I sit before you today both as a colleague in the House and as a registered nurse. Long before I entered the halls of Congress I worked as a school nurse and health educator for the Santa Barbara Public School Districts. My responsibilities then were to make decisions that best meet the needs of my students and school district, much as they are now to make decisions that best represent the needs of my constituents and the American people.

As a public health nurse, it was natural for me to reinforce that prevention is a most important component of health education. Teaching young people about healthy behaviors, including the risks associated with unprotected sex and teen pregnancy, are important messages that need to be conveyed, always in alliance with the parents involved.

I know from my first-hand experience what does and doesn't work with youth. That is why I promoted comprehensive health education for all students, including age-appropriate information about reproduction and decisionmaking associated with sex, always with the parents' permission.

Knowing about mitigating the risk of sexually transmitted disease and ways to prevent pregnancy are important life skills needed in today's world. Withholding this information from teens does a great and perhaps dangerous disservice to them, and one that runs contrary to my training and education as a public health nurse.

In my work as a school nurse I have been part of many curriculum review panels regarding sex education at both the school site and the local school district level. These panels are always centered around parents and include teachers, administrators, board members, and often community health professionals such as pediatricians.

As a school nurse I also had the privilege of directing a program for pregnant and parenting teens, which allowed them to stay in regular high school with their peers. Part of this program was, of course, to provide care for their children while they were studying and in class, but, more importantly, this teen parenting program provided education on life skills with an emphasis on parenting, as well as an education on how to prevent or delay further teen pregnancies. After all, teen parents are all too likely to have a second birth relatively soon. About one-fourth of teenage mothers have a second child within 24 months of that first early birth.

Mr. Chairman, according to a 2005 CDC study, 46.8 percent of all high school students reported having had sexual intercourse. For high school seniors, this figure reaches 63.1 percent. The bottom line is, as much as parents and teachers and all of us alike stress abstinence among teens, sexual activity is a reality for many young people. So what can we do to confront that reality?

Some say that abstinence-only education is the answer, but claiming that the only proper information with teens, even teens who are already parents, is abstinence only and nothing else means withholding scientifically based medical information. This is completely unrealistic, in my view.

Of course, abstinence is at the core of any comprehensive sexual education curriculum. Practicing 100 percent complete abstinence is 100 percent effective in preventing pregnancy, and that is a primary message. For many young people, this message reinforces positive behaviors, but it is not realistic to expect such behavior from all teens, so the best thing we can do to protect young people from the negative consequences of unsafe sex is to give them the information they need. We know this works.

A national campaign to prevent teen pregnancy study revealed that over 40 percent of the comprehensive education programs that were evaluated delayed the initiation of sex, and more than 60 percent reduced unprotected sex. Furthermore, no comprehensive program hastened the initiation of sex, according to the study, or increased the frequency of sex.

Conversely, just last year a federally funded evaluation of the Title V abstinence-only programs conducted by Mathematica Policy Research, Inc. found no evidence that these programs—that is abstinence-only—increased rates of sexual abstinence. Scientific study after scientific study has shown that these programs are ineffective and often contain false information, something that bears out in my own anecdotal survey of them.

I urge us not to add to the \$1.3 billion in Federal dollars that have been invested over the past decade in programs that are ineffective and many of them downright false.

I am proud that my own State of California has rejected these dollars from day one. In fact, California is the only State that has never applied for and never received Title V abstinence-only until-marriage funding. California would have been eligible for over \$7 million in Title V abstinence-only until-marriage funding in fiscal year 2007, but the State chose not to apply for these funds due to the extraordinary restrictions upon how the money must be spent. This was based on the State's previous experience in the 1990's with a State-funded abstinence-only education program that proved to be ineffective. Evaluation of the program proved that youth who were given abstinence-only education were not less likely than youth in the control groups to report a pregnancy or a sexually transmitted infection.

California isn't the only State to draw these conclusions. The Kansas Department of Health and Environment conducted a 2004 evaluation of abstinence-only until-marriage programs, and this evaluation found that there were no changes noted for participants' actual or intended behavior, such as whether they planned to wait until marriage to have sexual.

The evaluation also revealed negative changes in attitudes. After participating in abstinence-only until-marriage programs, students surveyed were less likely to respond that the teachers and staff cared about them, and significantly fewer students felt that they had a right to refuse to have sex with someone. Researchers therefore concluded that, rather than focusing on abstinence-only until-marriage, data suggests that including information on contraceptive use may be more effective at decreasing teen pregnancy. This evaluation is, unfortunately, all too typical of the result of the abstinence-only education programs.

Mr. Chairman, as of 2008, January, 17 States have rejected Title V abstinence-only funding based on sound public health concerns and because Governors have deemed the program to be inconsistent with their State's values or public health mandates.

I commend these States for making smart decisions regarding the health of their young people and listening to parents who want more comprehensive education for their children. Recent polling reveals that a vast majority of adults support a comprehensive approach to sexuality education. According to a study conducted by the National Campaign to Prevent Teen and Unplanned Pregnancy, 78 percent of California residents support programs that teach about abstinence as well as how to obtain and use contraceptives.

Furthermore, residents believe that the Federal Government should pay for this instruction. That is why I am proud to be a co-sponsor of legislation such as the Responsible Education About Life [REAL] Act, and the Prevention First Act. It is in the best interest, I believe, of public health of our entire society to ensure that all students are receiving scientifically and medically accurate information that will enable them to make the healthiest lifestyle decisions for them.

Furthermore, I believe that we must discontinue any funding that is Federal for abstinence-only education programs. I believe they have been a waste of taxpayer dollars and have produced no positive results. As a Member of Congress, again, as a registered nurse, this is a position I encourage my colleagues to adopt as we have a responsibility, I believe, to protect the public health. We should follow the recommendations of the Institutes of Medicine: "Congress, as well as other Federal, State, and local policymakers, eliminate the requirements that public funds be used for abstinence-only education and that States and local school districts implement and continue to support age-appropriate, comprehensive sex education and condom availability."

Thank you, again, for the opportunity to testify today.
[The prepared statement of Hon. Lois Capps follows:]

**Testimony of Representative Lois Capps Before the
Oversight and Government Reform Committee
April 23, 2008**

Thank you, Chairman Waxman, for inviting me to participate today.

I sit before you today both as a colleague in the House and a registered nurse.

Long before I entered the halls of Congress, I worked as a school nurse and health educator.

My responsibilities then were to make decisions that best met the health needs of my students and school district, much as they are now to make decisions that best represent the needs of my constituents and the American people.

As a public health nurse, it was very easy for me to reinforce that prevention is the most important component of health education.

Teaching young people about healthy behaviors, including the risks associated with unprotected sex and teen pregnancy, were important messages that needed to be conveyed.

I know from my firsthand experience what does and doesn't work with youth.

That is why I promoted comprehensive health education for students, including information about reproduction and decision making associated with sex.

Mitigating the risk of sexually transmitted disease and prevent pregnancy are important life skills teens must know.

Withholding this information from them is doing a horrible disservice and one that runs contrary to my training and education as a public health nurse, which mandate that I always act in the best interests of my patients – in this case, students.

I have been part of many curriculum review panels at both the school site and the school district level.

These panels always included parents, teachers, administrators, board members and health professionals, such as pediatricians from the community.

As a school nurse, I had the privilege of directing a program for pregnant and parenting teens which allowed them to stay in a regular high school with their peers.

Part of this program was, of course, to provide day care for the babies of these young parents so that they could attend class.

But more importantly, the teen parenting program provided education on life skills, with an emphasis on parenting, as well as education on how to prevent or delay further teen pregnancies.

After all, teen parents are all too likely to have a second birth relatively soon – about one fourth of teenage mothers have a second child within 24 months of the first birth.

Mr. Chairman, according to a 2005 CDC study, 46.8% of all high school students reported having had sexual intercourse.

For high school seniors, this figure reaches 63.1%.

The bottom line is, as much as parents and teachers alike stress abstinence among teens, sexual activity is a reality for many young people.

So what can we do to confront this reality?

Some say that abstinence-only education is the answer.

But claiming that the only proper information to share with teens, even teens who are already parents, is abstinence-only and nothing else, means withholding scientifically-based medical information.

This is completely unrealistic.

Of course abstinence should be at the core of any comprehensive sexual education curriculum – practicing 100% complete abstinence is 100% effective in preventing pregnancy.

For many young people, this message reinforces positive behaviors, but it is not realistic to expect such behavior from all teens.

So the best thing we can do to protect young people from the negative consequences of unsafe sex is to give them the information they need.

We know this works.

A National Campaign to Prevent Teen Pregnancy study revealed that over 40% of comprehensive education programs that were evaluated delayed the initiation of sex and more than 60% reduced unprotected sex.

Furthermore, no comprehensive program hastened the initiation of sex or increased the frequency of sex.

Conversely, just last year, a federally-funded evaluation of the Title V abstinence-only programs conducted by Mathematica

Policy Research Inc. found no evidence that these programs increased rates of sexual abstinence.

Scientific study after scientific study has shown that these programs are ineffective and often contain false information.

I urge us not add to the 1.3 billion in Federal dollars that have been invested over the past decade in programs that are ineffective and outright false.

I am proud that my own state of California has rejected these dollars from day one.

In fact, California is the only state that has never applied for and never received Title V abstinence-only-until-marriage funding.

California would have been eligible for over \$7 million in Title V abstinence-only-until-marriage funding in Fiscal Year 2007, but the state chose not to apply for these funds due to the extraordinary restrictions upon how the money must be spent.

This was based on the state's previous experience in the 1990's with a state-funded abstinence-only education program that proved to be ineffective.

Evaluation of the program proved that youth who were given abstinence-only education were not less likely than youths in control groups to report a pregnancy or sexually transmitted infection.

California isn't the only state to draw these conclusions.

The Kansas Department of Health and Environment conducted a 2004 evaluation of abstinence-only-until marriage programs.

The evaluation found that there were “no changes noted for participants’ actual or intended behavior; such as whether they planned to wait until marriage to have sex.”

The evaluation also revealed negative changes in attitudes.

After participating in abstinence-only-until-marriage programs, students surveyed were less likely to respond that the teachers and staff cared about them and significantly fewer students felt they “have the right to refuse to have sex with someone.”

Researchers therefore concluded that, “rather than focusing on Abstinence-Only-Until-Marriage, data suggests that including information on contraceptive use may be more effective at decreasing teen pregnancies.”

This evaluation is, unfortunately, all too typical of the result of abstinence-only education programs.

Mr. Chairman, as of January 2008, 17 states have rejected Title V abstinence-only funding based on sound public health concerns and because Governors have deemed the programs to be inconsistent with their state’s values or public health mandates.

I commend these states for making smart decisions regarding the health of their young people and listening to parents who want more comprehensive education for their children.

Recent polling reveals that a vast majority of adults support a comprehensive approach to sexuality education.

According to a study conducted by the National Campaign to Prevent Teen and Unplanned Pregnancy, 78% of California residents support programs that teach about abstinence as well as how to obtain and use contraceptives.

Furthermore, residents believe that the federal government should pay for this instruction.

That is why I am proud to be a cosponsor of legislation such as the Responsible Education About Life, or REAL Act and the Prevention First Act.

It is in the best public health interest of our entire society to ensure that students are receiving scientifically and medically accurate information that will enable them to make the healthiest lifestyle decisions.

Furthermore, I believe that we must discontinue any federal funding for abstinence-only education programs.

They have been a waste of taxpayer dollars and have produced no positive results.

As a Member of Congress and a registered nurse, this is the position that I encourage my colleagues to adopt, as we have a responsibility protect the public health.

We should follow the recommendations of the **Institute of Medicine (IOM)** that:

“Congress, as well as other federal, state, and local policymakers, eliminate the requirements that public funds be used for abstinence-only education, and that states and local school districts implement and continue to support age-appropriate comprehensive sex education and condom availability.”

Thank you again for the opportunity to testify today.

Chairman WAXMAN. Thank you very much, Ms. Capps.
Mr. Brownback.

STATEMENT OF HON. SAM BROWBACK

Senator BROWBACK. Thank you very much, Mr. Chairman. Thank you for allowing me to be here and to testify. I am glad to join Ms. Capps. I have worked with her on a number of different issues over the years, and it is always a pleasure to join her. I think we have a bit of a different opinion on this one. I look forward to the discussion on it.

I come here because I am in the U.S. Senate, but I have five children and I have a fair amount of practical experience dealing with this. Our oldest is 21, youngest two are 10. I think I identify with most parents. I want the best for my kids and there is hardly anything I wouldn't do for them to see that they do have the best.

I am like most parents in this country: I want them to abstain from sexual activity until they are married. That doesn't happen to be just in the Brownback household. There is a Zogby poll in my testimony; 8 in 10 parents want that for their children.

I think also I am like most parents in that I feel often that the current culture pushes against what we try to teach in the Brownback family, that you have respect for other people, that everybody is a dignified human, that we think this is something that should be retained for marriage, and that is the best place.

It is something that we would hope our Government would back us up on. That, I think, is at the crux of what the debate is here, and it is about desire of parents and what is best for their kids, high expectations, not low expectations, high expectations for our children and a desire to lead them toward that.

We have a crisis in the country today. It is striking—I thought stunning—when I read this number, that one in four teenager girls in the United States has a sexually transmitted disease. One in four, according to CDC. That is a truly shocking number.

Clearly, where we have put the bulk of our money in sex education, which is the comprehensive programs, have not worked. We have a culture that pushes another way that rarely shows consequences of early sexual activity but really just says let's just go ahead and do it.

The end of this debate has been the push against abstinence education, which I think probably if we surveyed most Members here toward their own children they would say no, that is what I would hope my kids would do, and that is what I encourage them to do. I would just say then why wouldn't we have the Government do similarly.

I have followed a number of the studies that have been coming out looking at this. I don't think all of them have been followed, though. The Heritage Foundation just recently released a report looking at 15 studies that have examined abstinence based programs only. They didn't do the study on the programs, they just pulled 15 programs out, and they found 11 of these programs on abstinence reported positive findings, many of them quite extraordinary positive findings.

It seems to me that the route we should do, in listening to parents and listening to our own hearts here, would be to say, OK,

what of these abstinence programs are not working, and let's not fund the areas that are not working rather than throwing the whole idea out, which is supported by most parents.

I am most familiar with one here in Washington, DC, that I have worked with over a number of years. I am the ranking member on the Appropriations Committee for D.C., have been the authorizing chairman for D.C. I have been very concerned about what is happening here in the District. The best one I am familiar with is Best Friends program in Washington, DC. They had a 2005 study evaluation of the impact of the program. They found this about their program: teenage girls in the six middle schools that participated in the program were substantially less likely to engage in sexual activity than similar teenager girls in the District who did not participate in Best Friends.

And they found collateral support, as well, or collateral positive things. Best Friends girls were also significantly less likely to use illegal drugs, smoke or drink, compared to their peers. And the program worked.

You have Dr. Stan Weed that has done a more thorough investigation on the impact of the programs. I would hope that his testimony would be seriously considered.

I think there is a way forward on this, Mr. Chairman, and I think it is to examine the abstinence programs, because not all of them are created equal. Clearly we have a huge problem. Clearly comprehensive sex education has not worked with the level of STDs that we have in this country.

I would hope what we would do is look at what in these programs and which ones and what design of it has worked, and let's replicate and let's support and let's push that. And let's be very supportive of it rather than this constant public debate of attack that I think reads out to most of the public, Well, we just don't like this approach. Then the public goes, Well, I guess you are going to attack my parental ideas again. They get very frustrated. I know I can speak as one.

I would hope we could work together on this. I don't think this needs to be a partisan divide on it. I think it is one that we can work with parents and work with these programs and help design them to work better. It would be my hope, my pledge to you and to others to work to make them work better and to use the models of the ones that do work.

Thank you for allowing me to be here, Mr. Chairman.

[The prepared statement of Senator Sam Brownback follows:]

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Testimony of Senator Sam Brownback

Presented to

**The United States House of Representatives Committee on Oversight and
Government Reform**

**The Honorable Henry A. Waxman, Chairman;
The Honorable Tom Davis, Ranking Member**

The Case for Supporting Abstinence Education

I want to thank the Chairman for the opportunity to testify at this hearing concerning federal abstinence education programs.

Teen sexual activity is a widespread problem across our nation. Each year, more than 2.5 million teenagers become sexually active—a rate of 7,000 teens per day. Among high school students, almost half report having engaged in sexual activity and one-third are currently active.

Early sexual activity is associated with an increased risk of sexually transmitted diseases (STDs), reduced psychological and emotional well-being, delinquent behavior, lower academic achievement, teen pregnancy, and out-of-wedlock childbearing. These risks can be eliminated or reduced significantly if teens choose to abstain from sexual activity.

Abstinence education “teaches abstinence from sexual activity outside marriage as the expected standard for all school age children”. Such programs stress the social, psychological, and health benefits of abstinence. Abstinence education programs also teach youth valuable life and decision-making skills that set the foundation for personal responsibility and developing healthy relationships and marriages later in life.

In my testimony today, I will seek to make four basic points.

- First, a common criticism of abstinence education is that there is no evidence demonstrating that abstinence education programs are effective. This is not true. In fact, there are a large and growing number of studies showing that youth participating in abstinence programs have lower rates of sexual activity when compared to youth who do not receive abstinence education.
- Opponents of abstinence education claim that, aside from sexually transmitted disease and unintended pregnancy, there are no harmful effects from consensual teen sexual activity. This is also not true. In reality, casual teen sex has substantial negative psychological, social and economic effects. Increased condom use will not make these effects go away.

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- Many seek to replace abstinence education with so-called comprehensive sex education. Proponents of this approach claim that comprehensive sex education programs emphasize abstinence. This is not true. Comprehensive sex education curricula place an overwhelming emphasis on promoting contraceptive use. The main message embodied in these curricula is that it is okay for teens to engage in sex as long as they use contraception; over ninety percent of parents reject this message.
- Nearly all parents approve of the themes of self-restraint conveyed by abstinence programs. By contrast, nearly all parents reject the permissive values conveyed by comprehensive sex education.

Abstinence Programs are Effective

Critics of abstinence education maintain that there is no evidence supporting the effectiveness of authentic abstinence education programs. This is not correct.

The Heritage Foundation has recently released a comprehensive review of all prior studies of the effectiveness of abstinence education programs. The review examined 21 existing studies, including 15 evaluations of specific abstinence education programs, and six studies of virginity pledges. Most of these studies appeared in peer review publications. Of the 21 studies, 16 reported significant positive behavioral changes such as reduced sexual activity. Overall, the studies reporting positive behavioral results from abstinence programs outnumbered those reporting no results by a ratio of three to one.

Looking at the review in detail, one finds that 11 of the 15 evaluations of specific abstinence programs reported positive behavioral change—such as delayed initiation of sexual activity—among youths who received abstinence training. Only a quarter of the evaluations reported no behavioral impact. Of the six studies of virginity pledges, five found substantial positive behavioral outcomes among youth who made virginity pledges compared to similar youth who did not.

Findings for specific abstinence programs include the following:

Not Me, Not Now. Not Me, Not Now, is a community-wide abstinence intervention program targeted toward youth ages 9 through 14 in Monroe County, New York, which includes the city of Rochester. The program wanted to raise awareness of the problem of teen pregnancy and increase knowledge of the negative consequences associated with teen pregnancy. The program also sought to help youth develop resistance skills to peer pressure and promote communication between parents and teens about these important topics.

Not Me, Not Now was quite successful in reaching adolescents in Monroe County. Nearly 95 percent of the target audience reported seeing a Not Me, Not Now ad. Teens in community also reported significant positive shifts in their attitudes toward abstinence. During the intervention period, the sexual activity rate of 15-year-olds dropped by a

significant amount, from nearly 47 percent to 32 percent. The pregnancy rate of 15- to 17-year-old girls in the county declined significantly as well, from 63 pregnancies per 1,000 girls ages 15 to 17 to 50 pregnancies per 1,000. In fact, the teen pregnancy rate fell more rapidly in Monroe County than in nearby similar counties as well as upstate New York in general.

Project Taking Charge. Project Taking Charge was designed to serve youths in lower-income communities with high teen pregnancy rates. The curriculum offered youth instructions on self-development, sexual biology, vocation goal-setting, and communication between family members.

When surveyed in a study, a group of adolescents in Wilmington, Delaware, and West Point, Mississippi, who participated in Project Taking Charge reported an increase in their knowledge of the problems associated with teen pregnancy and STDs. The same study also reported that among youths who participated in Project Taking Charge, only about one quarter initiated sexual activity six months later, compared to half of teens who did not participate in the program.

Heritage Keepers. Heritage Keepers is abstinence education program that serves a diverse population of middle school and high school students in South Carolina. A 2005 study examined the program's impact on the behavior of some 2,500 7th to 9th grade students in 34 schools in South Carolina. The study found that Heritage Keepers students were significantly less likely to have initiated sexual activity compared to peers in their communities who did not participate in the program one year later. Specifically, among Heritage Keepers students who were virgins prior to the study, only about 1 in 8 teens initiated any sexual activity one year later, compared to one-quarter of students who did not participate in Heritage Keepers. The study found similar positive impact on subgroups of only Caucasian students and only African-American students.

Sex Can Wait. Sex Can Wait is an abstinence program that serves upper elementary, middle school and high school students. The curriculum focuses on skills-building in the areas of youth's self-esteem, decision-making, communication, goal-setting and life planning. The curriculum also contains lessons on reproductive biology and physiology. Homework includes activities that involve students' parents.

The study compared outcomes of students who participated in Sex Can Wait to students who received the school district's standard sex education programs. Among upper elementary students, the authors of study found that, students who received abstinence education reported greater knowledge of the subjects taught, sense of hope about the future, and self-efficacy compared to students who received the district's standard sex education. Middle school students who participated in the Sex Can Wait were more likely to remain abstinent overall compared to non-participants a year and half after the programs ended. Among high school students, those who received abstinence education reported attitudes more supportive of abstinence and a stronger intention to remain abstinent. They were also more likely to remain abstinent in the short-term than peers who did not receive abstinence education.

Best Friends. The Best Friends program works with teenage girls across the country. The Best Friends curriculum covers a range of important topics, including “friendship,” “love and dating,” “self-respect,” “decision making,” “alcohol and drug abuse,” “physical fitness and nutrition,” and “AIDS and STDs.” This program also pairs teenage girls with teacher mentors, who meet with their students individually for 30 to 45 minutes each week.

The Best Friends program, founded in the District of Columbia, served adolescent girls in six of the 20 middle schools in the city. These six Best Friends middle schools tended to be located in the more disadvantaged parts of the city. Academically, these schools are comparable, if not slightly worse, than the District’s middle schools in general.

When 2005 study evaluated the impact of Best Friends, it found that teenage girls in the six middle schools that participated in the program were substantially less likely to use engage in sexual activity than similar teenage girls in the District who did not participate in Best Friends. Furthermore, Best Friends girls were also significantly less likely to use illegal drugs, smoke or drink, compared to their peers.

Teen Aid and Sex Respect. Evaluators of the Teen Aid and Sex Respect programs in Utah found particularly encouraging results among youths who appeared to hold more permissive attitudes. When surveyed, these youths were more likely to believe that “having sex should be treated as a normal and expected part of the teenage dating relationship” and “having sex with a boyfriend or girlfriend is a good way to show how much you care for them.” Among high school students who held these more permissive attitudes, the study found that teens who received abstinence education were one-third less likely to engage in sexual activity one year after the program compared to peers of similar family background, religious involvement, dating and drinking behavior but who did not receive abstinence education.

Like the most recent Heritage study on abstinence programs, Dr. Stan Weed’s study, *An abstinence Program’s Impact on Cognitive Mediators and Sexual Initiation*, researched a Northern Virginia abstinence program that also showed positive outcomes for program participants, yet again proving that abstinent programs are effective.

The study showed affirmative results for most of the 7th grade students participating in the abstinence program, but also showed extraordinary results for the African American program participants.

Although the study was small, 550 students comprising both program participants and the comparison group, Dr. Weed found that 90.8 percent of students did not engage in sexual intercourse one year after completing the program compared with 83.6 percent in the comparison group. To put a finer point on this finding, only 9.2 percent of students enrolled in the abstinence program engaged in sex while 16.4 percent who were not in the program engaged in sex. Perhaps even more exciting, the study found that of the African American 7th graders who participated in the program, only 3.2 percent who participated

in the program engaged in sex compared with 33.3 percent of the comparison group who did initiate sex.

These findings are significant and underscores the reason abstinence programs should be continued and why these programs should be supported both legislatively and financially by the federal government.

Abstinence is Good for Teens

Proponents and critics of abstinence education differ greatly in their views on the appropriateness of adolescent sexual activity. Critics of abstinence education often view teen sexual activity in a positive, non-problematic light. Many proponents argue that there is no downside to comprehensive sex education.

In contrast to abstinence opponents, American parents do not believe that adolescent sexual activity is harmless and without “adverse impact.” More than nine out of ten parents object to teaching that teen sexual activity is okay as long as teens use contraceptives. The evidence shows that American parents are right on this point and that abstinence opponents are wrong. In addition to being the best means to prevent STD’s and teen pregnancy, teen abstinence is strongly associated with positive psychological, social and economic outcomes.

- Research by Dr. Denise Hallfors of the University of North Carolina at Chapel Hill shows that sexually active teens are two and a half times more likely to be depressed and to have thoughts of suicide when compared to abstinent teens from the same socio-economic and family background. These differences in depression and suicidal thoughts occur even when the sexually active teens are not engaged in related risk behaviors such as drinking and drug use.
- Among girls, increased depression chronologically follows the initiation of sex activity. This increase in depression appears even after adjusting for initial differences in depression prior to sexual activity, a fact strongly indicating that sexual activity, in many cases, causes increased depression.
- Adolescent sexual activity is strongly associated with other risk behaviors such as drug and alcohol abuse and delinquency. The initiation of adolescent sexual activity is linked to subsequent increases in delinquent behavior. By contrast, those who remain abstinent have the lowest levels of delinquent behavior even after adjusting for differences in socio-economic and family background.
- Teen sexual abstinence is strongly linked to positive educational outcomes. Teens that remain abstinent throughout high school are almost twice as likely to attend and graduate from college as are sexually active teens from the same socio-economic, racial and family backgrounds. Because of their higher educational attainment abstinent teens, on average, will have lifetime incomes that are some

\$370,000 higher than sexually active teens from the same socio-economic background.

Comprehensive Sex Education Curricula Do Not Promote Abstinence

Some in Congress would like to end funding for abstinence education and replace it with comprehensive sex education (CSE). Proponents of comprehensive sex education claim that their programs put a primary emphasis on abstinence and discuss contraception only as a secondary backup, if the abstinence message fails. However, a detailed analysis of prominent CSE curricula by the U.S. Department of Health and Human Services and a similar analysis by The Heritage Foundation show this is not the case. In reality, comprehensive sex education curricula place an overwhelming emphasis on encouraging youth to use condoms and make only minor, often cursory, references to abstinence.

For example, the HHS review of CSE curricula found that even the most balanced CSE curriculum contained seven times more references to contraception than it did to abstinence or not having sex. The HHS report also noted the CSE curricula had a factual error rate similar to that in abstinence curricula.

A paragraph by paragraph content analysis by The Heritage Foundation of nine prominent comprehensive sex education programs found that these curricula, on average devoted only 4 percent of their content to abstinence and 27 percent to promoting contraceptive use. Moreover, this analysis found that most discussions of abstinence were simplistic, perfunctory, and in many cases almost dismissive. None of the CSE curricula contained even a single sentence urging teens to abstain from sexual activity until the teen had finished high school. In nearly 1000 pages of CSE text, less than ten sentences could be found vaguely suggesting that young people wait until they were older before commencing sex activity. In most cases, even these isolated sentences lacked force.

According to the Heritage analysis, the typical comprehensive sex education curriculum briefly mentions abstinence as the safest choice to avoid STDs or pregnancy but then will spend page after page explaining that sex with condoms is extremely safe. The implicit message for students is that abstinence is, at best, a marginal choice for students. CSE curricula almost never mention the negative psychological and social impacts on teen casual sex, nor do they mention any connection between marriage and sex or between marriage and child-bearing. This is very alarming considering that currently 38 percent of children are born outside of wedlock, which is having a devastating effect on our nation's families.

Most comprehensive sex education curricula give example after example of happy, thriving teens having trouble-free sex while using condoms. The overwhelming message is that it is both acceptable and appropriate for youth to be sexual active as long a condoms are used. This is not a message which American parents find acceptable.

Parents Overwhelmingly Support Abstinence Values and Messages

Zogby International has conducted a poll of a nationally representative sample of parents to determine their attitudes toward sex education. The poll shows that American parents overwhelmingly support the themes and messages of abstinence education programs. On many themes, parental support is nearly unanimous. For example,

- The poll shows most parents want teens taught a strong abstinence message. For example: Some 79 percent of parents want teens to be taught that they should not engage in sexual activity until they are married or at least in an adult relationship leading to marriage.
- Some 91 percent of parents want teens to be taught that “the best choice is for sexual intercourse to be linked to love, intimacy, and commitment. These qualities are most likely to occur in a faithful marriage.”

By contrast, the same poll reveals that parents overwhelmingly oppose the messages conveyed by comprehensive sex education curricula. For example:

- Comprehensive sex education curricula focus almost exclusively on contraception and have little meaningful material on abstinence. However, only 2 percent of parents believe abstinence is unimportant, and only 7 percent believe teaching about contraception should have more emphasis than teaching about abstinence. By contrast, 44 percent of parents believe that teaching about abstinence is more important than teaching about contraception.
- Over 90 percent of parents want sex education programs to teach teens to abstain, at least, until they have finished high school. Comprehensive sex education programs do not contain this message; in fact, much of their material implicitly undermines it.
- Comprehensive sex education programs convey the message that teen sexual activity is okay as long as teens use contraception; only 7 percent of parents agree with that message.
- The majority of comprehensive sex education curricula contain graphic sexual material that is objectionable to most parents.

It is true that around 75 percent of parents want the schools to teach teens about abstinence and the basic biological facts about contraception. Abstinence curricula, in general, do not teach about contraceptive use, except to explain contraceptive failure rates. However, this disparity between abstinence education and parental viewpoints is more apparent than real. Schools that teach about abstinence usually teach the basic biological facts about reproduction and contraception, in a separate class such as health. This arrangement has widespread parental support, since the majority of parents agree

with abstinence educators who argue that abstinence and contraception should not be taught in the same class.

Conclusion

America's teens are surrounded by a vast amount of sexually explicit material in a popular media culture. These messages inundates youth with messages concerning the desirability of early, casual and permissive sexual activity. Unlike what is depicted in many media venues, early introduction into a sexual relationship has severe and lasting consequences for many teens. It is our responsibility to ensure that our policies promote the best and most effective measure that will protect our nation's young people and their future. To end or severely limit or reduce abstinence education funding will not result in protecting America's young people. I believe it will have the exact opposite effect. The answer to turning the tide in our STD rate is not to silence the abstinence message but to bolster it and not silence the often time only small public voice which teens hear in the wake of other harmful messaging—our children deserve nothing less. Again, I thank Chairman Waxman and Ranking Member Davis for this opportunity to share my strong and unwavering support for abstinence education programming.

Chairman WAXMAN. Thank you very much, Senator Brownback.

I want to start off by telling you I agree with you. We ought to see what works. I don't think we ought to ignore the idea of trying to emphasize abstinence. I think we ought to have that emphasis, because the culture does push our young people to become much more sexually active, and it is contrary to what many of us as parents and grandparents want for our children.

But the Federal Government only funds abstinence education programs. We don't fund comprehensive sex education programs for teenagers. That is done at the State and local level. I don't think we ought to fund abstinence-only programs that won't talk about other alternatives, talk about a comprehensive approach, encouraging abstinence but also at the same time explaining some public health realities to young people.

Some States, as Ms. Capps pointed out, Representative Capps said some States have looked at the Federal requirement and it is like the Federal Government telling them they had to do it only one way, and the States didn't like that.

I think we ought to let the States, if we are going to put Federal dollars into it, make a decision. I would hope that all of them would emphasize abstinence, and then I hope all of them would inform people about basic health information.

Ms. Capps, is that the point that you were making?

Ms. CAPPS. I appreciate the chance to respond. I want to also agree with the Senator. There is so much that we have in common in what we desire for our young people. We want them to grow up to be healthy. I will confess my strong bias, which is on behalf of health education, period. When you think about the diseases that are so costly to us today—obesity, heart disease, and sexually transmitted diseases and unwanted pregnancies—so much of it relates to healthy behaviors, which can be taught starting at a very young age.

I have always been in favor of comprehensive health information so that young people know about their bodies, know how their emotions work, and at age-appropriate times, with the permission of parents, that this can be done, including sexuality and reproductive matters.

Now, I am in favor of local decisionmaking about this. That is how important I think it is. It is always the prerogative of parents to have a say on sensitive issues of what their children learn and don't learn. That is why I believe that abstinence-only education really directs something that should be decided at a more local level.

We do have legislation that is in the process of being addressed in the House that undergirds the importance of prevention, and that is something I would champion.

Chairman WAXMAN. Senator Brownback, do you think we ought to look at these programs in a cool, cold-hearted way to see whether they are working or not, and if they are not working say that we ought to adjust them? And, second, do you think that we ought to bar, at the Federal level, any funds for these sex education efforts to talk about anything other than abstinence? Do you think it ought to be possible for the local areas to decide to use the funds, as well, for a more comprehensive approach that talks about ways

to stop the sexually transmitted diseases and unintended pregnancies assuming young people decide to be sexually active?

Senator BROWNBACK. Well, the answer to your first question, absolutely. But I think you have to also then look at the whole gamut, and not just say, OK, we are going after abstinence education, which, Mr. Chairman, that is what this appears to be. And if you say OK, let's look at the whole gamut because we have a crisis here, and STDs, one in four girls, and I think in certain segmented communities it is one in two, and the current approach has not worked.

I believe you have testimony later on five to one on comprehensive. Nationwide, the dollars have been five to one on comprehensive. So, I mean, if I were you as chairman and you are saying let's look at this realistically, then apparently the broad breadth of these dollars, it is not working. I would submit to you that if you are just going to peg in on the abstinence piece of this, OK, that is fair enough, but then I can show you programs in the abstinence field where it is working. I can show you places where it is not. The idea there would be to target more appropriately how you get the abstinence programs to work. But then you should also back up and say obviously the overall approach has not worked. We have to look at all of it. We can't just tag in on the abstinence piece of this because of whatever agenda.

Chairman WAXMAN. Thank you.

Mr. Souder.

Mr. SOUDER. Thank you, Mr. Chairman.

As you know, we have debated this subject before. We held a hearing when I was chairman of the subcommittee and we issued a report, Abstinence and its Critics. I would ask that this would be inserted in the committee report of this hearing.

Chairman WAXMAN. Without objection.

[The information referred to follows:]



**UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT REFORM**

OCTOBER 2006

ABSTINENCE AND ITS CRITICS

STAFF REPORT

**PREPARED FOR THE HON. MARK SOUDER
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TABLE OF CONTENTS

I. EXECUTIVE SUMMARY.....	3
II. BACKGROUND.....	4
A. The Crisis of STDs and Teen Pregnancies.....	4
B. The Need for Abstinence Education.....	5
C. Definition of Abstinence Education.....	6
D. Federal Funding of Abstinence Education.....	6
III. ABSTINENCE EDUCATION.....	9
A. Background.....	9
B. Findings.....	10
C. Evaluation.....	12
D. Polls.....	13
IV. THE WAXMAN REPORT.....	15
A. Background.....	15
B. The Waxman Report is Widely Criticized.....	17
C. The Waxman Report is Misleading.....	17
D. Misrepresentation and Distortion of Abstinence Curricula.....	19
E. Abortion.....	21
F. “Moral Judgments”.....	22
G. Abstinence Education Works.....	22
H. Comprehensive Sex Education Programs are Ineffective.....	24
I. Comprehensive Sex Education Programs are Not Age-Appropriate.....	25
J. Medical Accuracy.....	28
V. CONCLUSION.....	31
VI. APPENDIX	34

I. EXECUTIVE SUMMARY

In December of 2004, the Democrat Staff of the House of Representatives' Government Reform Committee released the report *The Content of Federally Funded Abstinence-Only Education Program*.¹ Commonly known as the Waxman Report, it is ostensibly an objective review of federally-funded abstinence education. While the stated purpose of the Waxman Report to "examine the scientific and medical accuracy of the most popular abstinence curricula used by programs receiving funds from the largest federal abstinence initiative" is welcomed, the Report fails to offer a fair and accurate assessment of abstinence education programs. Unfortunately, the Report has been heralded as an official and trustworthy review of abstinence education even though it is riddled with errors, half-truths and mischaracterizations.

This report is a review of the findings of the Waxman Report. While admittedly there is room for more studies to assess the accuracy and effectiveness of all sex education programs (abstinence and comprehensive sex education), the content and conclusions of the Waxman Report fail to provide a fair evaluation of abstinence curricula. By any reasonable standard, it cannot be considered a definitive statement on abstinence education and should not be taken as such.

The Waxman Report also fails to offer any review of comprehensive sex education. While this is not the stated purpose of the Report, there is an implied message that comprehensive sex education programs are the only curricula that should be supported by taxpayer dollars. Comprehensive sex education, however, already receives a disproportionate amount of funding relative to abstinence education and its effectiveness is suspect at best.

The content of comprehensive sex education often contains graphic discussion about sex acts divorced from emotional content that, for many parents, is inappropriate for their children. There are examples where comprehensive sex education curricula encourage experimentation with condoms and other contraceptives in provocative ways. Some curricula encourage sexual contact (including masturbation, or even bathing together) for students too young for consensual sex under applicable state law, and in some instances for students as young as nine.² In fact, while such curricula encourage sexual activity,

¹ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>.

² See *Becoming a Responsible Teen*, ETR Associates, Santa Cruz, California, 1998, at 114-115, Id at 119; *Be Proud! Be Responsible*, Select Media, New York, NY, 1996, at 80; *Teen Talk: Reproduction and Contraception Curriculum*, Sociometrics Corporation, Los Altos, CA, at 16; *Focus on Kids*, ETR Associates, Santa Cruz, CA, 1998, at 108; <http://www.siecus.org/pubs/biblio/bibs0010.html> and <http://www.plannedparenthood.com/pp2/portal/files/portal/educationoutreach/educationprograms/programs-responsible-choices-2nd.pdf>.

there is rarely any mention of the benefits of abstinence as the healthiest choice and the only certain and effective means to avoid STDs and unplanned pregnancies.³

Additionally, the information offered through comprehensive sex education is often directly contrary to the interest of parents, and even the students themselves. In recent polls over 90 percent of teens and adults, not to mention pre-teens, believe that teens should be given a strong abstinence message not to have sex until they are at least out of high school. Nearly 80 percent of parents think teens should be taught to delay sexual activity until marriage or in an adult relationship leading to marriage. Over 60 percent of teens say morals and values are equally important as health information and services in influencing teen sexual behavior and preventing teen pregnancy, and by contrast nine percent of teens believe that health information and services are *more* influential.⁴ And yet, the Waxman Report defends comprehensive sex education curricula that rejects the clear desires of parents and their children.

This report is an effort to correct many of the errors of the Waxman Report. The physical, mental and emotional health of America's youth is tied in part to their decision of whether they engage in sexual behavior at an early age. The value of abstinence for young people cannot be overestimated, and it is the duty of Congress to support programs that serve the interests of America's youth.

II. BACKGROUND

A. The Crisis of STDs and Teen Pregnancies

According to the Center for Disease Control and Prevention (CDC), there are approximately 19 million new sexually transmitted disease (STDs) infections in the United States each year. Nearly half of these new STD infections are among youth ages 15 to 24, and the number of new infections in adolescents under the age of 19 is approximately three million annually.⁵

Using data through the year 2003, the CDC estimated that 38,490 young people in the United States have been diagnosed with AIDS, 4,000 of whom were diagnosed in 2003 alone.⁶ Approximately 10,041 young people with AIDS have died through 2003, and

³ Shanna Martin, Robert Rector and Melissa Pardue, "Comprehensive Sex Education Versus Authentic Abstinence: A Study of Competing Curricula", Heritage Foundation, 2004, p11; at <http://www.heritage.org/Research/Welfare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=67539>.

⁴ *With One Voice 2004: America's Adults and Teens Sound Off About Teen Pregnancy*, National Campaign to Prevent Teen Pregnancy, Dec. 2004; at <http://www.teenpregnancy.org/resources/data/pdf/WOV2004.pdf>.

⁵ *Healthy Youth! Health Topics and Sexual Behaviors*, Centers for Disease Control and Prevention; at <http://www.cdc.gov/HealthyYouth/sexualbehaviors/index.htm>. See also, *Initial Announcement for Community-Based Education Program*, Department of Health and Human Services Administration for Children and Families; at <http://www.acf.hhs.gov/grants/open/HHS-2006-ACF-ACYF-AE-0099.html>.

⁶ *HIV/AIDS Among Youth*, Centers for Disease Control and Prevention, May 2005; at <http://www.cdc.gov/hiv/pubs/facts/youth.pdf>.

there has been a 37 percent increase in the number of young people living with AIDS since 1999.

Approximately 820,000 young women under the age of 19 become pregnant every year, and 34 percent of young women become pregnant at least once before they reach the age of twenty.⁷ Although teen pregnancy and birthrates have improved in recent years,⁸ U.S. rates are still higher than any other developed nation. Teen mothers are less likely to complete high school, more likely to be single parents and more likely to live in poverty than other teens.⁹

B. The Need for Abstinence Education

With these statistics setting the background, the CDC recommends that “adolescents need accurate, age-appropriate information about HIV infection and AIDS, including the concept that abstinence is the only 100 percent effective way to avoid infection.”¹⁰ Funding for abstinence education has increased steadily under the Bush administration, growing almost \$100 million between FY 2001 and FY 2005. Abstinence funding was \$79 million in FY 2001, \$100 million in FY 2002, \$115 million in FY 2003, \$135 million in FY 2004 and \$168 million in FY 2005. The funding for abstinence education increased again for FY 2006 to a total of \$178 million for FY 2006.¹¹

As the funding for abstinence education has increased, so has the debate between abstinence education and comprehensive sex education, which are the two main educational approaches to reducing teen pregnancy and STDs. The approach of comprehensive sex education programs is that today’s youth need information to make decisions about whether to engage in sexual activities, that teens should be empowered to make their own decisions regarding sexual activity and that contraceptives as well as abstinence are effective in preventing pregnancy and sexually transmitted diseases. Abstinence education programs, on the other hand, promote the message that abstinence is the most effective means of preventing unwanted pregnancy and sexually transmitted diseases, that sex outside of marriage is harmful to teens’ physical and emotional health, that youth can and should be empowered to say no to sex and that promoting birth control along with abstinence undermines the strength of an abstinence message.¹² Abstinence education programs also place a large emphasis on character education and decision-making skills for dealing with peer-pressure, drugs and alcohol.

⁷ *Healthy Youth! Health Topics and Sexual Behaviors*, Centers for Disease Control and Prevention; at <http://www.cdc.gov/HealthyYouth/sexualbehaviors/index.htm>.

⁸ From 1990 to 2000, the pregnancy rate decreased 33% and the birth rate declined 42% from 1991 to 2003. *MMWR Weekly*, Feb. 4, 2005; at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5404a6.htm>.

⁹ *Healthy Youth! Health Topics and Sexual Behaviors*, Centers for Disease Control and Prevention; at <http://www.cdc.gov/HealthyYouth/sexualbehaviors/index.htm>.

¹⁰ *HIV/AIDS Among Youth*, Centers for Disease Control and Prevention, May 2005; at <http://www.cdc.gov/hiv/pubs/facts/youth.pdf>.

¹¹ *Reducing Teen Pregnancy: Adolescent Family Life and Abstinence Education Programs*, Congressional Research Service Report for Congress, Carmen Solomon-Fears Domestic Social Policy Division. Updated Feb. 14, 2006.

¹² *Id.*

The Waxman Report has received an enormous amount of media attention and blurred the debate between abstinence education and comprehensive sex education with mischaracterizations of the former. This report seeks to correct the errors of this report and media statements regarding abstinence education.

C. Definition of Abstinence Education

Section 510 of the Social Security Act, created under Section 912 of the 1996 Welfare Reform law, established a new categorical program of grants to states for abstinence education.¹³ Abstinence education is defined in the law as an educational or motivational program which:

- A. has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- B. teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
- C. teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- D. teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;
- E. teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- F. teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
- G. teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- H. teaches the importance of attaining self-sufficiency before engaging in sexual activity.

While there are a wide range of abstinence education programs, all the federally-funded programs are required to include the definitions A-H.

D. Federal Funding of Abstinence Education

¹³ Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193 (1996) (hereafter "PRWORA"). See also, *Initial Announcement for Community-Based Abstinence Education Program*, supra note 5.

Abstinence education programs are awarded federal funds through the Adolescent Family Life Act, The Temporary Assistance for Needy Families Act and the Community-Based Abstinence Education Program. Each of these programs is distinct from the others, but together they were appropriated roughly \$178 million for FY06.

Adolescent Family Life Act: The Adolescent Family Life Act (AFLA) was signed into law in 1981 as Title XX of the Public Health Service Act to provide support for pregnant and parenting teens. This legislation has a pregnancy prevention component aimed at discouraging premarital sexual behavior among teens, and beginning in FY97, funds within AFLA were tied to the “A-H” standard of abstinence education found in Title V. From 1981 until 1996, the AFL program was the only federal program that focused directly on the issues of adolescent sexuality, pregnancy and parenting. AFL provides approximately \$13 million in funding for abstinence education per year, and these funds are provided through a competitive grants process.¹⁴

Title V: Congress created the Title V abstinence education program in the original 1996 welfare reform act, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Specifically, Section 510(b) of Title V of the Social Security Act created a new funding stream to provide grants to states to conduct abstinence education activities. Title V funds are administered by the Administration for Children and Families (ACF) and Family Youth Services Bureau (FYSB) of the Department of Health and Human Services (HHS). Title V provides a mandatory appropriation of \$50 million annually in federal funds that are distributed on a formula basis to states.¹⁵ States that choose to accept these funds must match every four federal dollars with three state-raised dollars and are then responsible for using the funds or distributing them to community-based organizations, schools, county and state health departments, media campaigns or other entities. Currently every state except California, Pennsylvania and Maine accept Title V funding.¹⁶ In addition to providing a funding stream for abstinence education, Title V established the “A-H” definition of abstinence education.¹⁷

Title V State Abstinence Education Program grants are formula grants to states that are awarded based on a statutory formula determined by the proportion of low-income children in a state to the total number of low-income children nationally according to the latest census data. Applications are submitted by states and reviewed by ACF to ensure the grant requirements are met. While it is unusual for an application to be rejected for

¹⁴ Adolescent Family Life Act, 42 U.S.C. § 300 (1982 & Supp. III 1985). See also, *Reducing Teen Pregnancy: Adolescent Family Life and Abstinence Education Programs*, and Title XX of the Public Health Service Act P.L. 97-35.

¹⁵ See U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, fact sheet, “Section 510 Abstinence Education Grant Program” (Apr. 2002); at <ftp://ftp.hrsa.gov/mchb/abstinence/statefs.pdf>.

¹⁶ California has consistently elected not to receive Title V funds, and so the actual Title V spending is less than the \$50 million appropriated each year. In 2002, for example, the federal government spent a total of \$43.4 million to fund Title V abstinence programs, which is thirteen percent less than the \$50 million appropriated.

¹⁷ PRWORA, §510(b).

conformity purposes, approval of the New Mexico Department of Health's application for a FY06 State Abstinence Education grant was recently withheld because New Mexico's proposed program did not target the age groups that are most at-risk for pregnancy and STDs.¹⁸

Community-Based Abstinence Education: Community Based Abstinence Education (CBAE) was created in the FY01 Labor/HHS Appropriations bill as an effort to supplement the abstinence education funds provided by Title V. CBAE dollars were originally designated as a "Special Project of Regional and National Significance" (SPRANS), which was administered by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). In FY2005, this program was moved to the Department of Health and Human Services' ACF division and is now overseen by the Family Youth Services Bureau (FYSB). Funding for the CBAE program has grown from \$20 million for FY01 to \$113 million (proposed by Congress) for FY07. CBAE grantees are required to adhere to the "A-H" definition of abstinence education.

Through these three programs the total funding for abstinence education for FY06 totaled \$177.5 million: \$13 million for the AFLA abstinence education projects, \$50 million for Title V abstinence education programs, \$110 million for the CBAE programs and \$4.5 million for an evaluation of CBAE programs.¹⁹

Comparison of Funding for Abstinence Education vs. Comprehensive Sex-Ed: Congressman Waxman and many of his Democratic colleagues have argued that \$177.5 million is an excessive amount of funding for abstinence programs, if they allow for *any* expenditure on alternatives to comprehensive sex education. In comparison, however, federal funding for comprehensive sex education, which often includes instruction that undermines a strong abstinence message, receives at least ten times the amount for authentic abstinence education. While it is difficult to get precise numbers as to the federal spending on the full range of comprehensive sex education programs, one recent study states that in 2002 an estimated \$1.73 billion was spent on comprehensive sex education programs.²⁰ In that same year, \$144.1 million was spent on abstinence programs.²¹ In comparison, then, the federal government spent \$12 to promote comprehensive sex education programs for every \$1 spent on abstinence programs.²²

This wide disparity in funding is directly contrary to the desires of the vast majority of parents. A 2004 Zogby poll indicates that only seven percent of parents surveyed approve of teaching teens that it is okay for them to have sex as long as they use a condom. By contrast, 96 percent of parents said that sex education class should teach that abstinence from sexual activity is best for teens. Also, 91 percent of parents said

¹⁸ *State Can't Limit Abstinence Ed to Younger Kids*, ALBUQUERQUE JOURNAL, May 4, 2006.

¹⁹ *Reducing Teen Pregnancy: Adolescent Family Life and Abstinence Education Programs*, Congressional Research Service Report for Congress, Carmen Solomon-Fears Domestic Social Policy Division. Updated Feb. 14, 2006.

²⁰ Melissa Pardue, Robert Rector and Shanna Martin, *Government Spends \$12 on Safe Sex and Contraceptives for Every \$1 Spent on Abstinence*, The Heritage Foundation, Jan. 14, 2004.

²¹ *Id.*

²² *Id.*

teens should be taught that the best choice is for sexual activity to be linked to love, intimacy and commitment – qualities most likely to occur in faithful marriages.²³ And yet the Ranking Member of this Committee would have abstinence programs stripped of federal support and have all funding go to programs that often endanger our youth with classes that undermine a strong abstinence message.

Most abstinence programs are run by small non-profits with small budgets that rely on donations, the sale of their material and government funding. Because abstinence is the only 100 percent effective means to prevent out-of-wedlock pregnancy and STDs, abstinence programs should receive government support. In fact, more funding will enable these programs to help more young people to live happy and healthy lives.

The disparity in funding between comprehensive sex education and abstinence education is dramatic and limits the alternatives for state and local entities to provide the type of instruction that most parents want for their children. If parents, who are the most responsible for their children's health and well-being, support the principles behind abstinence-based programs over the deceptively named "safe-sex" alternatives, then it is only fitting that these programs continue to be funded and made available to the nation's youth. To cut funding for abstinence programs, as is the recommendation of the Waxman Report, would significantly undermine the authority of parents to provide the type of formation that they want their children to receive.

Comprehensive sex education programs already receive significantly more funding than abstinence programs, and there is no effort to eliminate federal support for comprehensive sex education, so the question is not whether the comprehensive approach will be funded, but whether there will be the opportunity to offer abstinence programs as an alternative. The Minority Report would prefer to eliminate support for abstinence programs, whereas the Majority has consistently supported abstinence education as a viable alternative to the well-funded comprehensive sex education programs that exist today.

III. ABSTINENCE EDUCATION

A. Background

As the funding for abstinence education has increased, so has the debate between abstinence education and comprehensive sex education, which are the two main educational approaches to reducing teen pregnancy and STDs. The approach of comprehensive sex education programs is that today's youth need information to make decisions about whether to engage in sexual activities, that teens should be empowered to make their own decisions regarding sexual activity and that contraceptives as well as abstinence are effective in preventing pregnancy and sexually transmitted diseases.

²³ Zogby International Poll for Focus on the Family, "Survey on Parental Opinions of Character – or Relationship-Based Abstinence Education vs. Comprehensive Sex Education," Jan. 2004.

There is some confusion about the distinctions between abstinence education and comprehensive sex education. Abstinence education programs are not the same as comprehensive sex education or “abstinence-plus” programs. In abstinence education programs, information about contraception is included only as it supports the abstinence message: contraception information must be age-appropriate, abstinence education programs do not distribute or endorse contraceptive usage.²⁴ Contraception is usually discussed in terms of its failure rates and inability to completely protect individuals from pregnancy and sexually transmitted diseases.

Comprehensive and abstinence-plus programs endorse and instruct teens how to use contraception and, as this report will examine later, often contain explicit sexual content and encourage sexual activity other than sexual intercourse. Furthermore, as this report discusses below, “abstinence-plus” is a misleading label for comprehensive sex education programs that contain little, if any, abstinence-related material.

B. Findings

Data shows that abstinence programs are effective.

- In the 1980s, a five year study was conducted in South Carolina to determine the effectiveness of an abstinence education program intended to decrease teen pregnancy. This highly successful, well-documented study, which has been published in peer-reviewed literature, found that the half of the counties using the abstinence education program remarkably reduced the teen pregnancy rate in comparison to the surrounding areas and the portion of the targeted area that did not use the abstinence education material.²⁵
- In an attempt to lower the high teen pregnancy rate in the area, a health department in Monroe County, NY implemented a successful abstinence education program in the 1990s. Pregnancy rates in Monroe County declined faster than the comparison areas, and there was a drop in self-reported sexual activity. The study concluded that well-designed and competently-implemented abstinence programs “can have a measurable community impact.”²⁶
- There were also several other existing studies showing the effectiveness of abstinence education in decreasing sexual activity²⁷ that had been criticized by

²⁴Initial Announcement for Community-Based Education Program, Department of Health and Human Services Administration for Children and Families; at <http://www.acf.hhs.gov/grants/open/HHS-2006-ACF-ACYF-AE-0099.html>.

²⁵ Vincent, et al. *Journal of the American Medical Association*, 1987; 257, 3382-3386.

²⁶ Doniger A., Adams E., Utter C. and Riley J., “Impact Evaluation of the ‘Not me, Not Now’ Abstinence-Oriented, Adolescent Pregnancy Prevention Communications Program,” Monroe County, New York, *Journal of Health Communications*, Jan.-Mar. 2001; 6(1):45-60.

²⁷ Elaine Borawski, et al., *Evaluation of the Teen Pregnancy Prevention Programs Funded through the Wellness Block Grant (1999–2000)*, Center for Health Promotion Research, Department of Epidemiology and Biostatistics, Case Western Reserve University School of Medicine, Mar. 23, 2001. The program

some researchers due to differences of opinion in proper sample size, duration, and research design.²⁸ Despite the criticisms of the individual studies, the existence of several studies all showing positive effects of abstinence programs viewed together offers evidence supporting the overall effectiveness of abstinence education.

In addition, since the publication of the Waxman Report, there have been several more studies supporting the effectiveness of abstinence education.

- An analysis of the *Best Friends* program, an abstinence education program that began in the District of Columbia in 1987 and is now used in over 100 schools nationwide, found that the program participants were nearly seven times more likely than the control group to practice abstinence/abstain from sex/not have sex/avoid sexual activity.²⁹
- A study to determine the effectiveness of abstinence education programs in middle school teens analyzed seven middle schools throughout the Midwest that were using an abstinence education program. The study found that the program increased knowledge and abstinence beliefs and decreased intentions to have sex. Participating students who had sex during the evaluation period reported fewer sexual episodes and fewer partners than did controls. The study also found that the program reduced condom use intentions, but the researchers noted that this could quite possibly be due to participants' intentions to remain abstinent until marriage. Overall, the study found that abstinence-until-marriage programs "can influence knowledge, beliefs, and intentions, and among sexually-experienced students, may reduce the

effects on sexual activity were significant at the 93 percent confidence level. Stan E. Weed, *Title V Abstinence Education Programs: Phase I Interim Evaluation Report to Arkansas Department of Health, Institute for Research and Evaluation*, Oct. 15, 2001. The effects of the program in reducing the onset of sexual activity were statistically significant at the 98 percent confidence level. Stan E. Weed, *Predicting and Changing Teen Sexual Activity Rates: A Comparison of Three Title XX Programs*, report submitted to the Office of Adolescent Pregnancy Programs, U.S. Department of Health and Human Services, Dec. 1992. The effects the programs on at-risk high school students were significant at the 99 percent confidence level. Stephen R. Jorgensen, Vicki Potts, and Brian Camp, "Project Taking Charge: Six-Month Follow-Up of a Pregnancy Prevention Program for Early Adolescents", *Family Relations*, Oct. 1993, pp. 401-406. The effects of the program in reducing the rate of onset of sexual activity were statistically significant at the 94.9 percent confidence level. The effects of the program on specific areas of knowledge were significant at the 95 percent confidence level and above.

²⁸ Douglas Kirby, The National Campaign to Prevent Teen Pregnancy, *Emerging Answers : Research Findings on Programs to Reduce Teen Pregnancy (Summary)*, 18 (May 2001) ; at www.teenpregnancy.org/resources/data/pdf/emerswsum.pdf; Douglas Kirby, The National Campaign to Prevent Teen Pregnancy, *Do Abstinence Programs Delay the Initiation of Sex Among Young People and Reduce Teen Pregnancy ?* 6 (Oct. 2002) ; at www.teenpregnancy.org/resources/data/pdf/abstinence_eval.pdf.

²⁹ Lerner, Robert, "Can Abstinence Work? An Analysis of the Best Friends Program," *Adolescent and Family Health*, 2005 Apr. Vol. 3, No. 4: 185-192.

prevalence of casual sex. Reduction in condom use intentions merits further study.”³⁰

- An evaluation of abstinence education authorized by Congress is being carried out by Mathematica Policy Research Inc.³¹ The first of several reports from this study were released in June 2005. This report evaluated the first-year impact of these programs and found that “the programs led youth to report views more supportive of abstinence and less supportive of teen sex than would have been the case had they not had access to the abstinence education programs. In addition, the programs increased perceptions of potential adverse consequences of teen and non-marital sex. There is also some evidence that the programs increased expectations to abstain from sex and reduced dating.”³²
- There is hard evidence that there has been a national decline in teen sexual activity. In 2003, 46.7 percent of all high school students reported that they had sexual intercourse. This is a 13.7 percent decrease from 1991 (54.1 percent).³³ Additionally, the teen birth rate has declined steadily from 1991 to 2004, with an overall decline of 33 percent for those aged 15 to 19. This reverses the 23 percent rise in the teenage birthrate from 1986 to 1991.³⁴

C. Evaluation

It is important to remember that abstinence programs are new, and Congress and the Department of Health and Human Services are continuing to study their effectiveness with positive results. Regardless of the form of sex education (abstinence education or comprehensive sex education), the measurement for its success should be rates in sexual activity, non-marital pregnancy and STIs since these rates are scientifically measurable.

Secretary Leavitt recently offered congressional testimony regarding the work of HHS to review abstinence education. He testified that HHS spends \$4.5 million annually on evaluation, and that the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is developing a multi-year evaluation of the CBAE program and other teen pregnancy prevention programs and is planning to award a competitive contract for the evaluation in FY2006. This study will follow a sample of youth from age 12 to age 18 in participating programs.³⁵

³⁰ Elaine Borawski, *Effectiveness of Abstinence Intervention in Middle School Teens*, AMERICAN JOURNAL OF HEALTH BEHAVIOR, 2005 Sept-Oct; 29(5): 423-434.

³¹ As part of the 1996 Social Security Act, Title V, §510 that authorized funding for abstinence education programs, Congress authorized an evaluation these §510 programs. Pub. L. No. 105-33.

³² *First Year Impact of Four Title V, §510 Abstinence Education Programs*, (Executive Summary), Mathematica Policy Research, Inc., June 2005.

³³ *National Youth Risk Behavior Survey: 1991-2005*, Department of Health and Human Services, Centers for Disease Control and Prevention.

³⁴ MMWR Weekly, Feb. 4, 2005; at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5404a6.htm>.

³⁵ Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies Hearing, Questions for the Record, Mar. 8, 2006.

Several evaluation efforts are also underway:

- An independent, rigorous, longitudinal evaluation of abstinence education programs funded through the State Abstinence Education grant program. Last year, HHS released a report from this evaluation, conducted by Mathematica Policy Research, on the first-year impacts of four federally-funded abstinence programs. The results showed that abstinence programs led youth to report views more supportive of abstinence and less supportive of teen sex. The programs also increased teens' understanding of the potential harmful consequences of non-marital sex. A final report which examines the impact of these programs on behavioral outcomes is expected at the end of the contract.³⁶
- HHS is developing evaluation designs for a rigorous study of Community-Based Abstinence Education programs and other teenage pregnancy prevention approaches.
- Rigorous research takes time and money. These two efforts are long term studies of a relatively new programmatic approach. The goal of these studies is to determine the effectiveness of abstinence education. Once these studies are completed there will be more scientific evidence upon which abstinence education can be evaluated.

Most programs, given time, include information about reproductive anatomy, fetal development, major STD's, including HIV/AIDS, and condoms. It is also important to note that abstinence programs receiving federal funds are prohibited from using the money for religious purposes. Federal oversight includes the protection of the First Amendment, and the grant process should include strict protections from the use of federal money for the promotion of faith.

D. Polls

Abstinence programs have broad support. They are available to communities with no requirement that they accept federal funds, and no prohibition on offering contraceptive education. National polls consistently show that parents and students believe that abstinence is a valuable decision, and that students should receive a strong abstinence message from sexual health education programs.

Illustrating the point, every year the National Campaign to Prevent Teen Pregnancy conducts a nationally-representative survey on a variety of issues related to teen pregnancy. The following statistics are results from the 2004 survey.³⁷

³⁶ Id.

³⁷ "With One Voice 2004: America's Adults and Teens Sound Off About Teen Pregnancy," National Campaign to Prevent Teen Pregnancy, Dec. 2004; at <http://www.teenpregnancy.org/resources/data/pdf/WOV2004.pdf>.

- 94% of teens and 91% of adults believe that teens should be given a strong abstinence message not to have sex until they are at least out of high school;
- Nearly seven in ten teens do not think it is okay for high school teens to have sexual intercourse;
- Two-thirds of all sexually experienced teens wish they had waited longer to have sex;
- 56% of the teens surveyed said that the appropriate number of sexual partners for teens to have is “none;”
- 85% of the teens surveyed said that sex should only occur in a long-term committed relationship;
- Support for a strong abstinence message has remained “rock solid (90% or better) in every National Campaign survey conducted since 1997;
- 64% of teens say morals and values are equally as important as health information and services in influencing teen sexual behavior and preventing teen pregnancy, while nearly one quarter of teens (23%) say that morals and values are more influential than health information and services. By contrast, nine percent of teens believe that health information and services are *more* influential.

A survey conducted by the Kaiser Family Foundation and *Seventeen* magazine produced similar results.³⁸

- Nearly half of teens surveyed (49%) wish they waited until they were older to have sex;
- 28% of teens surveyed regret the decision to have sex altogether;
- 92% of teens surveyed think that being a virgin in high school is a good thing.

A new Harris Poll gathered enlightening information about the perception of abstinence education, showing that “adults under the age of 30 are more likely to believe that abstinence programs are effective, and it is of course these adults who are the main targets for the programs.”³⁹

- 56% of people ages 18 to 24 and 60% of those 25 to 29 think abstinence programs effectively reduce or prevent the occurrence of HIV/AIDS;

³⁸ *SexSmarts Survey: Virginity and the First Time*, Kaiser Family Foundation, Oct. 2003; at <http://www.kff.org/entpartnerships/upload/Virginity-and-the-First-Time-Summary-of-Findings.pdf>.

³⁹ Jennifer Harper, *Youths Support Abstinence as Sex Education*, WASHINGTON TIMES (Jan. 22, 2006).

- 49% of people ages 18 to 24 and 52% of those ages 25 to 29 say the programs reduce or prevent unwanted pregnancies.

Adults and parents of teens also believe that students should be given a strong abstinence message:

- 79% of parents surveyed think teens should be taught to delay sexual activity until marriage or in an adult relationship leading to marriage;⁴⁰
- 91% of parents surveyed want students to be taught that adolescents should abstain from sexual activity through the high-school years;⁴¹
- 62% of the persons surveyed agree that abstinence from sexual activity outside of marriage is the expected standard for all school age children;⁴²
- 57% of the persons surveyed agree that sexual activity outside of marriage is likely to have harmful psychological and physical effects.⁴³

Parental and student support for abstinence education is very strong. Comprehensive sex education programs that devote 4.7 percent of their curricula to abstinence-related material are not meeting their own claims nor the desires of parents or students, who are footing the bill with their education tax dollars.

IV. THE WAXMAN REPORT

A. Background

The Democrat Office of the House of Representatives' Committee on Government Reform released a report in December 2004 entitled "The Content of Federally Funded Abstinence Education Programs." The stated purpose of the report, hereafter referred to as the Waxman Report, was to "examine the scientific and medical accuracy of the most popular abstinence curricula used by programs receiving funds from the largest federal abstinence initiative."⁴⁴ The report reviewed the most popular abstinence curricula and claimed that most of the curricula contain false, misleading or distorted information about

⁴⁰ *Survey on Parental Opinions of Character- or Relationship-Based Abstinence Education vs. Comprehensive Sex Education*, Zogby International, Jan. 2004.

⁴¹ *Id.*

⁴² See *Sex Education in America: General Public/Parents Survey*, National Public Radio/Kaiser Family Foundation/Kennedy School of Government (Jan. 2004); at <http://www.npr.org/programs/morning/features/2004/jan/kaiserpoll/principalsfinal.pdf>.

⁴³ *Id.*

⁴⁴ Undated Press Release from the Minority Office of the Committee on Government Reform, U.S. House of Representatives; at <http://www.democrats.reform.house.gov/Documents/20041201095458-38938.pdf>.

reproductive health.⁴⁵ This Democrat Office review of the abstinence curricula contains numerous inaccuracies and is severely flawed, as discussed below. Nonetheless, the partisan report received widespread and favorable media coverage.

Since its publication, the flawed report has been used to discredit abstinence education. For instance, the American Civil Liberties Union (ACLU) used the Waxman Report as its basis for launching *Not In My State*, a nationwide action program aimed at combating what it characterized as “dangerous” abstinence-until-marriage curricula.⁴⁶ *Not In My State* encourages ACLU members to write their local school superintendents and request that “unsafe” abstinence curriculum be kept out of the classroom. Four out of the nine citations contained in the sample letter posted on ACLU’s website refer to the Waxman Report.⁴⁷ A letter from the Illinois Division of the ACLU to a school superintendent criticizing abstinence education and asking for documentation of the present sex education curricula used the Waxman Report for over half of its citations.⁴⁸ The *Journal of Adolescent Health* published a paper entitled *Abstinence-only education and programs: A position paper of the Society for Adolescent Medicine* which simply adopts the so-called findings of the Waxman Report as scientific, thereby giving the Waxman Report more standing than it has on its own.⁴⁹ The report has also been used by various sexual health organizations to sharply criticize abstinence education.⁵⁰ The unverified Waxman Report is being referenced as a legitimate Congressional study, and the purported findings are being used to affect public perception, local school systems and their students.

While the Waxman Report is flawed, being neither a representative nor conclusive study of abstinence education curricula, it does raise some important questions about abstinence education and comprehensive sex education:

⁴⁵See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 5.

⁴⁶ ACLU Press Release, “ACLU Announces Nationwide Action”, Sep. 21, 2005; at http://www.aclu.org/reproductiverights/gen/20117_prs20050921.html.

⁴⁷“Not In My State: Sample Letter”, ACLU website; at <http://www.takeissuecharge.org/resource/?release=16> (last visited Mar. 14, 2006).

⁴⁸ Letter from Lorie A. Chaiten, Director of Reproductive Rights Project, ACLU-Illinois, to Illinois School Superintendent (Sep. 21, 2005) (on file with Subcommittee on Criminal Justice, Drug Policy and Human Resources).

⁴⁹ *Journal of Adolescent Health*, *Abstinence-only Education and Programs: A Position Paper of the Society for Adolescent Medicine*, 2006; 38: 85. See also, *Journal of Adolescent Health*, *Abstinence and abstinence-only education: A review of US policies and programs*, 2006; 38:72-81. For a refutation of the errors contained in these articles, see *The Attack on Abstinence Education: Fact or Fallacy?*, The Medical Institute, May 5, 2006.

⁵⁰“Planned Parenthood Applauds New Report Confirming That Abstinence Sex Education Contains False and Misleading Information”, <http://www.plannedparenthood.com/pp2/portal/files/portal/media/pressreleases/pr-041202-waxman.xml>; See *It Gets Worse: A Revamped Federal Abstinence Program Goes Extreme*, SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES SPECIAL REPORT, SIECUS Public Policy Office http://www.siecus.org/policy/Revamped_Abstinence_Goes_Extreme.pdf.

- Are abstinence education programs accurate and effective, or are they as misleading, error-filled and ineffective as the Waxman Report suggests?
- How should the effectiveness and accuracy of abstinence education and comprehensive sex education be determined, and what exactly determines “medical accuracy?”
- How are recipients of Federal Abstinence and Sex Education Grants selected, and how are their curricula selected and approved?

Examining the scientific and medical accuracy of abstinence curricula, as well as sex education and any health information taught to youth, is vitally important. Nonetheless, it is important to note that the Waxman Report is not a thorough examination of the issue and does not constitute any scientific or official Congressional findings. This report was funded and conducted solely by a partisan committee staff and was never submitted to the full Committee on Government Reform for review. Furthermore, there were no Congressional hearings held to discuss this issue and the Waxman Report’s findings.

B. The Waxman Report is Widely Criticized

The Waxman Report was severely criticized by some Members of Congress. For example, Congressman Joseph Pitts (R-PA 16), said the Waxman Report “was prepared at taxpayer expense by partisan committee staff and was not reviewed in any hearings or publicly discussed with experts in abstinence education. Instead, Representative Waxman took advantage of a slow news cycle to pass off his ideological attack as a legitimate congressional study.”⁵¹

While it is important that content of the curricula used in both abstinence and comprehensive sexuality education be reviewed for accuracy, it is equally important that such evaluations are themselves accurate. The Waxman Report claimed to be “a comprehensive evaluation of the content of curricula used in federally funded abstinence education programs” and “an overall assessment of the accuracy of the curricula.”⁵² The actual product is a gross misrepresentation of abstinence education and curricula.

Alma Golden, MD, then serving as the Deputy Assistant Secretary for Population Affairs, Office of Public Health and Science for the U.S. Department of Health and Human Services, publicly stated that the Waxman Report “misses the boat. These issues have been raised before and discredited. Unfortunately, what they continue to do for purely political reasons is to take issues and information out of context to try and discredit

⁵¹ Representative Joseph Pitts (R-PA), from a letter submitted to the Editor of the WASHINGTON POST on Dec. 3, 2004. (on file with Subcommittee on Criminal Justice, Drug Policy and Human Resources).

⁵² See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 5.

abstinence education, which is a disservice to our children.”⁵³ A comparison of the Waxman Report and the actual abstinence curricula reviewed therein reveals that the Waxman Report relies heavily on information taken out of context.

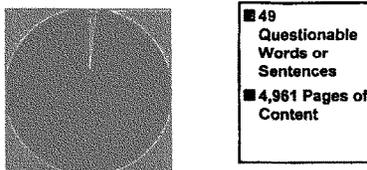
C. The Waxman Report is Misleading

The report claims that “over 80% of the abstinence curricula, used by over two-thirds of SPRANS (Special Projects of Regional and National Significance) grantees in 2003, contain false, misleading, or distorted information about reproductive health.”⁵⁴ This sweeping statement is extremely misleading.

Out of the thirteen curricula most commonly used by SPRANS recipients and reviewed by Representative Waxman’s staff, eleven were alleged to contain at least one instance of false, misleading or distorted information. This finding does not mean that 80 percent of the entire information contained in these curricula is false, misleading or distorted. In fact, although the Waxman Report claims that abstinence curricula are riddled with “numerous” and “serious and pervasive” errors, “major errors and distortions,” and “multiple scientific and medical inaccuracies,”⁵⁵ the actual number of alleged errors found by Representative Waxman’s staff is very small.

Despite its assertions, the Waxman Report is actually evidence of the high quality of abstinence curricula. Representative Waxman’s staff listed only some forty-nine occurrences of allegedly questionable information in the thirteen curricula they reviewed. These curricula contained 4,961 pages of reviewable material. In nearly 5,000 pages of material, 49 questionable words or sentences represent less than one percent of all pages in the reviewed curricula.

Abstinence Curricula



By way of comparison, a 2001 study of the twelve most popular middle school science textbooks, used by approximately 85 percent of students nationwide, found 500 pages of

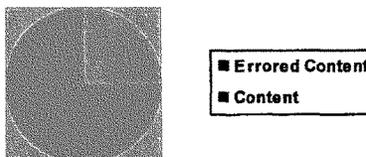
⁵³ Alma Golden, MD, Deputy Assistant Secretary for Population Affairs, Department of Health and Human Services, Office of Public Health and Science; Official Response to Critical Abstinence Education Report; at <http://www.medicalnewstoday.com/medicalnews.php?newsid=17268>.

⁵⁴ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at Executive Summary.

⁵⁵Id. at ii, 7, 22.

scientific errors.⁵⁶ A review of the math textbooks submitted for use in California found numerous mistakes and as many as one error for every four pages, which is 25 percent of the curriculum.⁵⁷

California Math Textbooks



This one percent of questionable material found by the Waxman Report becomes even smaller when the purported inaccuracies are adjusted for misunderstandings of the curricula, good faith typographical errors, trivialities and outright distortion and bias.

D. Misrepresentation and Distortion of Abstinence Curricula

In a section entitled *Abstinence Curricula Contain False and Misleading Information about the Effectiveness of Contraceptives*, the Waxman Report criticizes the *A.C. Green's Game Plan Coach's Clipboard*, a publication of the abstinence education group Project Reality, for allegedly distorting public health data on the effectiveness of condoms in preventing sexually transmitted diseases (STDs). The Waxman Report considers the statement, "The popular claim that condoms help prevent the spread of STDs is not supported by the data" to be wrong.⁵⁸ However, the curriculum's statement is supported by the 2001 National Institute of Health Report which states that "epidemiological evidence is insufficient to determine the effectiveness of condoms" for preventing most STDs.⁵⁹

In a section entitled *Abstinence Curricula Contain False and Misleading Information about the Risks of Sexual Activity*, the Waxman Report claims that another curriculum of Project Reality entitled *Navigator Guidebook*, "explicitly states: 'It is critical that students understand that if they choose to be sexually active, they are at risk' for cervical

⁵⁶ Hubisz, John L. Ph.D. (2001), *Review of Middle School Physical Science Texts*, Final Report, David and Lucile Packard Foundation, Grant 1998-4248; at http://www.ncsu.edu/ncsu/pams/science_house/middleschool/reviews/hubisz.rtf.

⁵⁷ Andrew Goldstein, *Amending the Texts: New technology promises to make them more accurate, up-to-date, interactive—and lightweight*, TIME MAGAZINE (Feb. 12, 2001).

⁵⁸ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 10.

⁵⁹ See *Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease Prevention*, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Department of Health and Human Services Report, July 20, 2000, at 3; at <http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>.

cancer.”⁶⁰ This is a blatant distortion of the *Navigator* curriculum, which clearly states that sexually active students need to understand that they are at risk for human papillomavirus (HPV). The curriculum does state the fact that cervical cancer can be a result of HPV, but it also states that “most cases of HPV do not result in cervical cancer.”⁶¹ This sentence directly contradicts the Waxman Report statement that this curriculum does not mention “that HPV, though associated with most cases of cervical cancer, rarely leads to the disease.”⁶² The Waxman Report’s assertion that the *Navigator* curriculum “explicitly” states sexual activity leads to cervical cancer is entirely wrong.

The *Friends First/Stars* curriculum and the *Choosing the Best Way* curriculum are both considered to be “misleading” by the Waxman Report for stating that there is no evidence for condom prevention against the transmission of HPV.⁶³ However, both these curricula cite the leading condom study by the National Institute of Health, which found that there is no evidence that condom use reduces the risk of HPV infection, although study results did suggest that condom use might reduce some risk of HPV-associated diseases, including warts in men and cervical neoplasia in women.⁶⁴

In addition to taking information out of context, the Waxman Report also includes some inconsistencies that should deter readers from considering the report as an objective or scientific document. For example, the report criticizes abstinence curricula for supposedly drawing a strong correlation between HPV and cervical cancer: “Neither of these curricula mentions that human papilloma virus, though associated with most cases of cervical cancer, rarely leads to the disease.”⁶⁵ Only a few sentences later the Waxman Report criticizes two other curricula for *failing* to draw a strong correlation between HPV and cervical cancer: “Other curricula advise that condoms have not been proven effective in blocking the transmission of HPV and that ‘no evidence’ demonstrates condoms’ effectiveness against HPV transmission. According to the CDC, however, evidence indicates that condoms do reduce the risk of cervical cancer.”⁶⁶

That the Waxman Report is unusually critical about assertions that condom use cannot prevent the transmission of HPV is not surprising. In 2004, Mr. Waxman stated at a hearing entitled “Cervical Cancer and Human Papillomavirus” that “I am concerned that this hearing will instead pursue a different question entirely – how the science of HPV

⁶⁰ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 19.

⁶¹ Libby Gray and Scott Phelps, *Navigator Guidebook*, Project Reality, Illinois 2003.

⁶² *The Content of Federally Funded Abstinence Education Program*, supra note 1 at 19.

⁶³ Id at 12.

⁶⁴ *Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease Prevention*, supra note 60 at 29. “For HPV, the panel concluded that there was no epidemiological evidence that condom use reduced the risk of HPV infection, but study results did suggest that condom use might afford some protection in reducing the risk of HPV-associated diseases, including warts in men and cervical neoplasia in women.”

⁶⁵ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 19.

⁶⁶ Id.

can be used to advance the ideological agenda of abstinence-only education.”⁶⁷ He accused critics of the policy of relying on condoms as the primary method of prevention of HPV infection of using “the example of HPV to try to undermine public confidence in any other approach besides abstinence”⁶⁸ while conceding that “it is true that condoms have not been proven to reduce the risk of HPV infection.”⁶⁹ Notwithstanding the importance of communicating the weight of scientific evidence to consumers, Mr. Waxman asserted that “anything that undermines the effectiveness of condoms for these uses will have serious public health consequences.”⁷⁰

Another curriculum severely distorted by the Waxman Report is the middle school FACTS curriculum. The Waxman Report claims that the FACTS curriculum “scrambles the CDC data in a way that suggests greatly exaggerated HIV rates among teenagers. For example, where the CDC chart showed that 41 percent of female teens with HIV reportedly acquired it through heterosexual contact, the curriculum’s chart suggests that 41 percent of heterosexual female teens have HIV. It similarly implies that 50 percent of homosexual male teens have HIV.”⁷¹ Contrary to the Waxman Report’s claims, the text of the curriculum immediately preceding the chart clearly states that “the table below displays the incidence of transmission for HIV infection in the U.S. as reported from confidential reports from states to the CDC.”⁷² The curriculum is clearly presenting information on HIV transmission, not the overall infection rates as the Waxman Report claims.

In yet another instance of blatant or careless distortion, the Waxman Report claims that a curriculum by *The Medical Institute for Sexual Health* teaches that touching another person’s genitals can result in pregnancy.⁷³ The material referred to by the Waxman Report, which is not a curriculum although erroneously designated as such, actually states that “mutual masturbation is activity which can spread STDs and can result in pregnancy.”⁷⁴ The curriculum is clearly talking about a specific sexual act and not the mere touching of another person’s genitals.⁷⁵ This information is scientifically accurate

⁶⁷ “Cervical Cancer and Human Papillomavirus,” hearing before the House Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform, 108th Cong. (March 11, 2004) (statement of Henry Waxman, Ranking Minority Member, House Government Reform Committee); at [http://reform.house.gov/UploadedFiles/96225\[1\].pdf](http://reform.house.gov/UploadedFiles/96225[1].pdf)

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 20.

⁷² FACTS Middle School Curriculum, 112-113, Northwest Family Services, 2001.

⁷³ *Id.* at 12.

⁷⁴ *Sexual Health Update*, The Medical Institute, Spring 2005; at <http://www.medinstitute.org/includes/downloads/ishspring2005.pdf>.

⁷⁵ Response to The Waxman Report in *Sexual Health Update*, Spring 2005, The Medical Institute; at <http://www.medinstitute.org/includes/downloads/ishspring2005.pdf>, at 12.

and presented by organizations that support comprehensive sex education, including Planned Parenthood.⁷⁶

The Waxman Report faults two other curricula, *Choosing the Best Way Leader Guide* and *Why kNOw*, for understating condom effectiveness by “neglecting to explain that failure rates represent the chance of pregnancy over the course of a year.”⁷⁷ The curricula do not distinguish between annual failure rates and per-act failure rates, but that is because published failure rates are assumed to be annual rates. Furthermore, the *Choosing the Best Way Leader Guide* is intended for sixth grade students, and the next curriculum in the *Choosing the Best* program intended for seventh graders contains an entire page discussing and defining failure rates.⁷⁸ The Waxman Report either overlooked this page or chose to ignore it.

E. Abortion

The Waxman Report also alleges that “a high number of the programs receiving SPRANS funding are formally opposed to abortion.”⁷⁹ However, there are only two programs cited in the report, out of more than 100 programs that actually receive SPRANS funding.⁸⁰ Few would agree with the Waxman Report statement that two programs constitute a “high number.”⁸¹ Furthermore, this matter has nothing to do with the *content* of federally-funded abstinence education programs, and the organizations cited did not produce any of the reviewed curricula.

Why is the Waxman Report evaluating whole organizations, when its purpose is to evaluate curricula? Here, the Waxman Report is not merely taking information out of context; it is taking information out of an unrelated source and using it to criticize the reviewed curricula. The Waxman Report does not contain any examples from the reviewed curricula of formal opposition to abortion.

F. “Moral Judgments”

⁷⁶ “Ask the Experts,” Teenwire of Planned Parenthood; at <http://www.teenwire.com/ask/2005/as-20051212p1175-sperm.php>. Dec. 12 2005 and <http://www.teenwire.com/ask/2005/as-20050505p1022-pregnant.php>, May 5, 2005.

⁷⁷ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 12.

⁷⁸ Cook, Bruce, *Choosing the Best Path* (Student Manual), Choosing the Best Publishing, LLC, 2001 at 19.

⁷⁹ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 13.

⁸⁰ HHS, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau, *HRSA SPRANS Community Based Abstinence Education Program Grantee Address List FY 2003* (online at www.mchb.hrsa.gov/programs/Adolescents/03granteedir.htm); HHS Office of Budget, *2005 President's Budget All-Purpose Table*; Administration for Children and Families, *supra* note, 5. On June 9, 2004, the SPRANS program was transferred from HRSA to the Administration for Children and Families (see www.mchb.hrsa.gov/programs/adolescents/abstinence.htm).

⁸¹ *Id.*

In a section entitled *Abstinence Curricula Blur Religion and Science*, the Waxman Report claims that “abstinence curricula teach moral judgments alongside scientific facts.”⁸² Besides the fact that what the report pejoratively deems as “moral judgments” are simply the federally-defined standards for abstinence education, as mentioned above, the footnote for this assertion does not even cite any of the curricula: “Many SPRANS recipients are religious organizations; for example, \$800,000 was awarded to the Catholic Diocese of Orlando on September 15, 2004. HHS, *HHS Awards \$800,000 to Diocese for Abstinence Education; “Think Smart” Program to Help Youth Make Positive Choices in Life*.”⁸³ The fact that some religious organizations are using the reviewed abstinence curricula does nothing to prove that the curricula blur religion and science.

The Waxman Report continues to criticize abstinence curricula without finding evidence for the criticisms within the curricula. The Waxman Report states, “In some of the curricula, the moral judgments made are explicitly religious.”⁸⁴ To support its claim, however, the Waxman Report fails to give an example from any of the curricula. Rather, the Report’s assertion stems from a newsletter that purportedly accompanied one popular curriculum. However, the Report fails to establish whether the newsletter was an essential part of the curriculum – funded by SPRANS – or was an entirely separate part of the organization’s wide-ranging programs.

G. Abstinence Education Works

While the Waxman Report’s review of the leading abstinence curricula contains numerous inaccuracies, the report is also inaccurate in its discussion regarding the effectiveness of abstinence education and comprehensive sex education. The Waxman Report states that, “There have been several studies of the effectiveness of abstinence education. These studies have found that abstinence education does not appear to decrease teen pregnancy or the risk of sexually transmitted diseases.”⁸⁵ For evidence, the Waxman Report cites portions of two studies by Dr. Douglas Kirby (2001, 2002) which state that the abstinence studies completed to that date did not show an overall impact on contraceptive use, sexual behavior or teen pregnancy.⁸⁶ The Waxman Report fails to mention that both these studies go on to state the following:

“The primary conclusion that can be drawn from these three⁸⁷ studies is that the evidence is not conclusive about abstinence programs [...] given the paucity of

⁸² See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 15.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.* at 3.

⁸⁶ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>. See also *supra* note 28.

⁸⁷ *Supra* note 28, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy (Summary)*. “Very little rigorous evaluation of abstinence-only programs has been completed; in fact, only three studies met the criteria for this review.”

the research and the great diversity of abstinence programs that is not reflected in these three studies, one should be very careful about drawing conclusions about abstinence programs in general. Fortunately, results from a well-designed, federally-sponsored evaluation of Title V- funded abstinence programs should be available within the next two years.”⁸⁸

“This does not mean that abstinence programs are not effective, nor does it mean that they are effective. It simply means that given the great diversity of abstinence programs combined with very few rigorous studies of their impact, there is simply too little evidence to know whether abstinence programs delay the initiation of sex. That is, “the jury is still out.” Increasingly it seems likely to this author that sooner or later studies will produce strong evidence that some abstinence programs are effective at delaying sex and that others are not.”⁸⁹

Furthermore, although the latter study did not classify the findings as “strong evidence” it did state that an abstinence education program “produced *some* evidence that the program delayed the initiation of sex and reduced teen pregnancy rates.”⁹⁰ Nonetheless, the Waxman Report jumps to the very conclusion that its own cited studies say cannot be supported or substantiated.

Since the publication of the Waxman Report, the 2001 Kirby study that the Waxman Report cites has received some criticism. One review noted that:

“Kirby commits what statisticians refer to as “Type II error.” Type II error occurs when the research hypotheses is falsely, often prematurely, rejected because of a lack of statistical significance (e.g., Agresti & Findlay, 1986; Cohen, 1988). In nonstatistical terms, this is the assertion of the false negative. Such false and premature rejection of the hypothesis is often due to factors that can be corrected in subsequent research. One such correctable factor is sample size. Kirby observes that proper studies require samples of at least 500 subjects to attain statistically significant results (Kirby, 2001). Many abstinence studies contain far fewer than 500 subjects. Findings of nonsignificance cannot be considered proper tests of either the particular abstinence education program under investigation or the underlying abstinence paradigm.”⁹¹

The Waxman Report failed to mention then-existing studies that find that abstinence education programs do decrease teen pregnancy and the risk of sexually transmitted diseases as noted above in Section III, B.

⁸⁸Id.

⁸⁹ Douglas Kirby, The National Campaign to Prevent Teen Pregnancy, *Do Abstinence Programs Delay the Initiation of Sex among Young People and Reduce Teen Pregnancy?* 6 (Oct. 2002); at www.teenpregnancy.org/resources/data/pdf/abstinence_eval.pdf.

⁹⁰Id at 3.

⁹¹ Lerner, Robert, “Can Abstinence Work? An Analysis of the Best Friends Program,” *Adolescent and Family Health*, Apr. 2005, Vol. 3, No. 4: 185-192.

The Waxman Report fails to fully evaluate abstinence education programs and ignores evidence showing the effectiveness of abstinence programs.⁹² The Waxman Report also fails to examine the comprehensive sex education programs that it presents as the alternative to abstinence programs and the solution to the sexual health epidemic. Equal standards should apply to abstinence education and comprehensive sex education if there is to be an honest comparison in effectiveness.

H. Comprehensive Sex Education Programs are Ineffective

The Waxman Report claims that comprehensive sex education has been shown to be effective in delaying sex, reducing the frequency of sex and increasing the use of condoms and other contraceptives.⁹³ However, these factors seem to have little impact on the desired outcomes of teen pregnancy, STDs and HIV.

Despite studies claiming that comprehensive sex education programs are effective, very few, if any school-based sex education programs measure their program's effect on sexually transmitted diseases, HIV and non-marital pregnancy, which are all outcomes they claim to reduce.⁹⁴ The few programs that have measured these outcomes have not demonstrated reduced rates of these desired outcomes.⁹⁵

Furthermore, while comprehensive sex education programs continue to promote condoms and other forms of contraceptives, 50% of cohabiting teens using contraception get pregnant within a year,⁹⁶ 23.2% of unmarried women under the age of 20 using condoms get pregnant within a year⁹⁷ and 20% of teens aged 12-18 using the pill get pregnant within six months.⁹⁸

In fact, the only comprehensive sex education program that has been clearly shown to reduce teen pregnancy is a highly-touted pregnancy prevention mentoring program in New York that provides Depo-Provera to young women. Depo-Provera, an injectable contraceptive that prevents ovaries from releasing eggs, prevents the girls from becoming

⁹² A recent report from a longitudinal study on four Title V abstinence programs found that abstinence education is effective in changing young people's attitudes with regard to sexual behavior. See Rebecca Maynard, et al., "First-Year Impacts of Four Title V, Section 510 Abstinence Education Programs", Mathematica Policy Research, Inc., June 2005.

⁹³ See *The Content of Federally Funded Abstinence Education Programs*, COMMITTEE ON GOVERNMENT REFORM—MINORITY STAFF SPECIAL INVESTIGATION DIVISION REPORT, Dec. 2004; at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf>, at 4.

⁹⁴ Daniels, Dr. Scott E., *In Defense of Abstinence*, The Medical Institute, 2005, at 1.

⁹⁵ Response to Rep. Waxman's Report, "The Content of Federally-Funded Abstinence Education Programs, Sexual Health Update, Spring 2005, The Medical Institute; at <http://www.medinstitute.org/includes/downloads/ishspring2005.pdf?PHPSESSID=35ce97988ad6d2182414f5cc5366de7>.

⁹⁶ Dinerman L., Wilson M., Duggan A. and Joffe A., "Outcomes of adolescents using levonorgestrel implants vs. oral contraceptives or other contraceptive methods," *Arch Pediatrics Adolescent Medicine*, 1995; 149: 967-972.

⁹⁷ Haishan Fu, et al. "Contraceptive Failure Rates: New Estimates from the 1995 National Survey of Family Growth," *Family Planning Perspectives*, 1999; 31(2): 56-63.

⁹⁸ CDC, *1995 Survey of Family Growth, Table 45: Oral Contraceptive Use and Consistency of Oral Contraceptive Use*.

pregnant, but does not protect them from STDs. In addition to the high cost of adding Depo-Provera to comprehensive sex education programs, there are also harmful side effects from the contraceptive drug, including bone loss and the loss of bone mineral density.⁹⁹

I. Comprehensive Sex Education Programs are Not Age-Appropriate

While it is important to evaluate comprehensive sex education programs for their effectiveness or lack thereof, it is also important to evaluate their content. Comprehensive sex education, especially when it is described as “abstinence-plus” education, is misleading because most of the curricula are hardly “comprehensive.” An analysis of nine so-called comprehensive/abstinence-plus curricula promoted by the *National Campaign to Prevent Teen Pregnancy*, *Division of Adolescent and School Health (DASH) of the CDC*, *Advocates for Youth*, and the *Sexuality Information and Education Council of the United States (SIECUS)*, found the curricula contained very little information about abstinence. Despite claims that comprehensive/abstinence-plus education programs contain a strong abstinence message,¹⁰⁰ the average page content of the curricula devoted to abstinence-related material is only 4.7 percent.¹⁰¹

Dr. Douglas Kirby, who sits on the board of The National Campaign to Prevent Teen Pregnancy, describes abstinence-plus education as giving “real weight to abstinence, you give it serious attention, you say that abstinence is the only method that is 100 percent effective against pregnancy and sexually transmitted diseases. But then you also talk about condoms and contraception in a balanced accurate manner.”¹⁰² When only 4.7 percent of the curricula mention abstinence, abstinence is not being given “real weight” or “serious attention.” When 28.6 percent of the content of the reviewed curricula is devoted to promoting and encouraging contraception use,¹⁰³ the curricula is anything but balanced. The *average* curriculum allocates nearly seven times more content to

⁹⁹ Depo-Provera’s website (<http://www.depoprovera.com>) contains warnings of the side effects and contains a link to a press release by Pfizer, the drug’s maker, warning of these side effects. http://www.pfizer.com/pfizer/are/news_releases/2004pr/mn_2004_1118.jsp.

¹⁰⁰ Advocates for Youth defines comprehensive sex education: “Comprehensive Sexuality Education teaches about abstinence as the best method for avoiding STDs and unintended pregnancy but also teaches about condoms and contraception to reduce the risk of unintended pregnancy and of infection with STDs, including HIV.” See Advocates for Youth, “Sexual Education Programs: Definitions & Point-by-Point Comparison,” *Transitions*, Vol. 12, No. 3 (Mar. 2004), p. 4; at www.advocatesforyouth.org/publications/transitions/transitions1203_3.htm. SIECUS states that, “Helping adolescents to postpone sexual intercourse until they are ready for mature relationships is a key goal of comprehensive sexuality education. Such education has always included information about abstinence . . . Effective programs include a strong abstinence message as well as information about contraception and safer sex.” See Sexuality Information and Education Council of the United States, “Fact Sheet: Adolescence and Abstinence,” *SIECUS Report*, Vol. 26, No. 1 (Oct./Nov. 1997). SIECUS and Advocates for Youth, in a joint statement, claim that comprehensive sexuality education programs “emphasize the benefits of abstinence while also teaching about contraception and disease prevention methods.” See Advocates for Youth and SIECUS, “Toward a Sexually Healthy America: Roadblocks Imposed by the Federal Government’s Abstinence-Until-Marriage Education Program,” 2001, p. 7.

¹⁰¹ Shanna Martin, Robert Rector and Melissa Pardue, *supra* note 3 at 11.

¹⁰² E. J. Dionne, Jr., *Abstinence Plus*, THE WASHINGTON POST, July 16, 1999, p. A23.

¹⁰³ Shanna Martin, Robert Rector and Melissa Pardue, *supra* note 3.

contraception than abstinence, but in some curricula the ratio is as imbalanced as 27 to one.¹⁰⁴ These programs would be more accurately described as “Contraception-plus Sex Education” because they fail to present a strong abstinence message at all. “Abstinence plus” is a misnomer, and entirely misleading.

While it is important to note what comprehensive sex education does *not* contain – a strong abstinence message – it is equally important to examine the information that is contained in comprehensive sex education curricula. It is an unfortunate fact that many comprehensive/abstinence-plus sex education curricula contain sexually explicit information that is both irrelevant for sexual health education, and inappropriate for the targeted age groups.

Listed below are several examples from sex education curricula intended for high school students. These examples all come from curricula promoted on the websites of SIECUS (Sexuality Information and Education Council of the United States) and Planned Parenthood, two of the nation’s largest sex education advocacy groups.¹⁰⁵

“Sometimes people don’t have a water-based lubricant handy. If you were trying to find something around the house, or at a convenience store, to use as a substitute what would be safe?...Some ‘grocery store’ lubricants are safe to use if they do not contain oil: grape jelly, maple syrup, and honey.”¹⁰⁶

Give each group a penile model, some lubricant, spermicide and paper towels, then say... “One step at a time, I want each of you to practice the condom application and removal steps, with or without a lubricant. Your teammates have a task, too... They are going to give you a round of applause and praise what you did right.”¹⁰⁷

“Go to the store together. Buy lots of different brands and colors [of condoms]. Plan a special day when you can experiment. Just talking about how you’ll use all of those condoms can be a turn on.”¹⁰⁸

“Invite students to brainstorm ways to increase spontaneity and the likelihood that they’ll use condoms...Examples: Store condoms under mattress...Eroticize condom use with partner...Use condoms as a method of foreplay...Think up a sexual fantasy using condoms...Act sexy/sensual when putting the condom on...Hide them on your body and ask your partner to find it...Tease each other manually while putting on the condom.”¹⁰⁹

¹⁰⁴ Id.

¹⁰⁵ See <http://www.siecus.org/pubs/biblio/bibs0010.html> and <http://www.plannedparenthood.com/pp2/portal/files/portal/educationoutreach/educationprograms/programs-responsible-choices-2nd.pdf>.

¹⁰⁶ *Becoming a Responsible Teen*, supra note 2.

¹⁰⁷ Id at 119.

¹⁰⁸ *Be Proud! Be Responsible*, supra note 2, at 80.

¹⁰⁹ Id at 78-79.

“Show condoms. Have several different brands including lubricated and reservoir tip. Open packages and unroll condoms for students to inspect. You may pass them around. Use plastic model of penis or two fingers for demonstration... You may blow up rubber to demonstrate how strong they are.”¹¹⁰

While these curricula are intended for high school-aged students, the highly-explicit information they contain encourages students to think, even fantasize about sexual activity. Furthermore, it is also important to note that a large portion of high school students are too young for consensual sex under applicable state law.

The following examples come from a curriculum that is intended for students 9-15 years of age. Most 9 year olds are in fourth or fifth grade and 15 year olds, while in high school, are still too young for legal consensual sex.

“Assign teens to create a list of ways to be close to a person without having intercourse, including, body massage, bathing together, masturbation, sensuous feeding, fantasizing, watching erotic movies, reading erotic books and magazines.”¹¹¹

“Youth will practice the proper way to put on a condom... Divide youth into two teams and give everyone a condom. Have the teams stand in two lines and give the first person in each line a dildo or cucumber. Each person on the team must put the condom on the dildo or cucumber and take it off... The team that finishes first wins.”¹¹²

While these curricula contain plenty of content encouraging the use of contraception, tips for performing sexual activities, and suggestions to increase sexual arousal, *none of these curricula contain content encouraging youth to abstain from sexual activity*. In fact, out of 942 pages of reviewed comprehensive sex education curricula, there is not one single sentence encouraging youth to delay sexual activity at least through high school.¹¹³

SIECUS in its guidelines for comprehensive sexuality education suggests that children ages five through eight be taught the following about masturbation:

- touching and rubbing one’s own genitals to feel good is called masturbation
- some boys and girls masturbate and others do not
- masturbation should be done in a private place¹¹⁴

¹¹⁰ *Teen Talk: Reproduction and Contraception Curriculum*, Sociometrics Corporation, Los Altos, CA, at 16.

¹¹¹ *Focus on Kids*, ETR Associates, Santa Cruz, CA, 1998, at 137.

¹¹² *Id* at 108.

¹¹³ Shanna Martin, Robert Rector and Melissa Pardue, *supra*, note 3.

¹¹⁴ *Guidelines for Comprehensive Sexuality Education*, 3rd Edition, SIECUS; at <http://www.siecus.org/Pubs/guidelines/guidelines.pdf>, at 51.

These guidelines for curricula seem shockingly explicit and hardly relevant for children between kindergarten and the third grade. It does not seem wise to introduce sexual activity to children at such a young age if the goal of these programs is to delay the onset of sexual activity when they are older.

Clearly, the state of abstinence education is far more positive and accurate than the Waxman Report portrays, and while all sexual health education programs merit more study, there is a credible body of evidence suggesting that abstinence education is indeed effective. Just as more studies need to be conducted to evaluate the effectiveness of abstinence education, comprehensive sex education programs need to be studied and evaluated to make sure they are age-appropriate, effective and medically accurate.

J. Medical Accuracy

One of the reasons there is so much controversy and confusion about the effectiveness of sex education is because the term “medical accuracy” is widely used but has no clear definition and carries no guidelines for determining either the medical accuracy of a curriculum or the effectiveness of a program.

Currently, sexual health education providers commonly cite peer-reviewed journals to appear medically accurate, promote the effectiveness of a sexual health education programs and criticize other sexual health education programs. However, this method alone is insufficient for ensuring the accuracy of sexual health education material and the effectiveness of programs, since the goal of journal reviews is primarily to examine proper use of statistical methods and statistical significance, not the medical accuracy of content within programs themselves. For example, as cited in Section IV, I of this report, few would agree that encouraging teens to use grape jelly or maple syrup as a lubricant would be considered “medically accurate,” however, the program that contains this information was evaluated and published in a peer reviewed journal, then was touted as an effective program. A recent lead editorial in *The Wall Street Journal* raised serious doubts regarding the impartiality of the peer review process.¹¹⁵ While this example should not discredit the peer review process across the board, it does raise serious questions about its credibility in all cases and suggests that there needs to be other ways of authenticating data.

In its final guidelines for ensuring and maximizing the quality, objectivity, utility, and integrity of information disseminated by Federal agencies, the Office of Management and Budget stated the following:

“Some comments argued that journal peer review should be adequate to demonstrate quality, even for influential information that can be expected to have major effects on public policy. OMB believes that this position overstates the effectiveness of journal peer review as a quality-control mechanism. Although

¹¹⁵ *New England Journal of Politics*, THE WALL STREET JOURNAL, Jan. 16, 2006.

journal peer review is clearly valuable, there are cases where flawed science has been published in respected journals. (66 Fed. Reg. 52137, October 12, 2001).¹¹⁶

In an article discussing the abuse of science in public policy debates, the Guttmacher Report on Public Policy warned that “there are no guarantees, of course, that even the most rigorous study in the most prestigious journal is correct in its conclusions. Science progresses by accumulating evidence from multiple studies, a key reason why transparency and replicability are vital. Moreover, science advances: over time, scientists develop more refined methods, acquire more appropriate data and explore new explanations for old mysteries.”¹¹⁷

The goal of any sexual health education program should be to provide information that is consistent with the current state of scientific knowledge. Providing medically accurate and referenced information allows students to make informed decisions and increases the probability that their decisions will lead to healthy behavioral choices.

While both abstinence education and comprehensive sex education groups strive to present “medically accurate” information, the differing philosophies of what constitutes healthy information for teens causes a serious problem when it comes to defining medical accuracy. For example, the quotes from comprehensive sex education curricula in Section IV, I of this report contain information that most citizens would not consider to be “medically inaccurate.” Therefore, the only way to ensure that actual curricula are medically accurate is to review the content of curricula itself. Many federally-funded programs do not review curricula at all before granting funding for these programs.

Without review of actual curricula content, achieving such an elusive standard as “medical accuracy” will be a difficult task. Sexual health education programs of all varieties have at least occasionally presented information that lacked a clear scientific basis. Some of the assertions are based on morality, some on ideology and some on matters of simple opinion. For example, in the past, some sexual health education providers claimed that condoms had “holes” which permitted the passage of HIV.¹¹⁸ At the other extreme, some claim even today that condoms provided nearly 100 percent protection against pregnancy.¹¹⁹ Currently, some claim that the term “protect” accurately describes the action of condoms against pregnancy and STDs since condoms reduce the risk. Others, however, claim that the term “protect” is inaccurate and misleading to

¹¹⁶ Office of Management and Budget, Executive Office of the President. *Guidelines for Ensuring and Maximizing the Quality, Objectivity, Utility, and Integrity of Information Disseminated by Federal Agencies*; at <http://www.whitehouse.gov/omb/fedreg/reproducible.html> (last visited Apr. 27, 2006). See also 66 Fed. Reg. 52137, Oct. 12, 2001.

¹¹⁷ Sonfield, Adam, *The Uses and Abuses of Science In Sexual and Reproductive Health Policy Debates*, The Guttmacher Report on Public Policy, Vol. 8 (4), Nov. 2005; at <http://www.guttmacher.org/pubs/tgr/08/4/gr080401.html>.

¹¹⁸ Heritage House '76, *Condoms – Do They Really Work?* 1998 Heritage House 76, Inc.; at http://www.abortionfacts.com/literature/literature_9331cd.asp.

¹¹⁹ Sexuality Information and Education Council of the United States (SIECUS), *The Truth About Condoms*; at <http://63.73.227.69/pubs/fact/fact0011.html>.

describe the action of condoms against pregnancy and STDs, since condoms do not eliminate the risk.¹²⁰

The dissemination and acceptance of inaccurate or incomplete information could have a negative impact on public health and discredit the sexual health education curricula, or parts of the curricula – that are medically accurate. The failure to review and ensure the validity of sexual health education curricula has greatly harmed students, the public in general and sexual health education providers. It has also lead to the inefficient use of taxpayer and government dollars for educational programs that are not medically accurate.

The current federal guidelines regarding curricula review need to be changed and replaced by a fair, balanced and accurate assessment of curricula content. The current guidelines are intended to “ensure and maximize the quality, objectivity, utility, and integrity of information disseminated.”¹²¹ To date most attempts to define medical accuracy have been inadequate for the following reasons:

- the criteria suggested are not directed toward all sexual health education providers—i.e., comprehensive sex education *and* abstinence education programs
- there is no objective measurable standard of determining whether the data and other material included in the particular sexual health education curricula are accurate
- there is no objective measurable standard of determining whether there are serious omissions from the material presented which render such material inaccurate or deceptive
- there is no across-the-board review of curricula itself

It is equally important for federally-supported programs to use the same source data, both within the various programs and in their evaluation. How the data is used can be a matter of methodology and interpretation, but the data itself should be verifiably accurate.

One possible solution to this problem would be for the government agencies reviewing grants for comprehensive sex education programs and abstinence education programs to review curricula for accuracy during the grant review process. Because these programs are funded under many different funding streams and agencies, each agency would be required to establish and implement a curricula review protocol within its grant review process. This curriculum review process would be subject to oversight by the Office for

¹²⁰ Daniels, Dr. Scott E., *In Defense of Abstinence*, The Medical Institute, 2005, at 7.

¹²¹Office of Management and Budget, Executive Office of the President. *Guidelines for Ensuring and Maximizing the Quality, Objectivity, Utility, and Integrity of Information Disseminated by Federal Agencies*; at <http://www.whitehouse.gov/omb/fedreg/reproducible.html>. See also 66 Fed. Reg. 52137, Oct. 12, 2001.

Evaluation and Planning to ensure fair, balanced and accurate review and funding. In many cases, potential grantees are not required to submit curricula for review before receiving funding. This increases the risk of funding out-of-date or inaccurate curricula.

The general basis for curricula accuracy review for agencies to use in their grant review process would include the following:

- A review for accurate footnoting and referencing of recent medical data before funding is given. If minor corrections are needed, they should be made before funding is granted.
- A general overview of data to ensure that government agencies and reputable sources are referenced for any medical fact stated in the curricula.
- A check for bias among curricula reviewers to ensure that science—not politics—is applied in the process of reviewing curricula.
- A review of all curricula material—including pamphlets, videos/DVDs and teachers' guides—to ensure that all materials are consistent in their citations of source data.
- A review to make certain that curricula marketing material matches curricula content. For example, if a comprehensive sex education curriculum claims to have a strong emphasis on abstinence, the curriculum contents should match that description.

Reviewers of abstinence and/or comprehensive sex education curricula would then be able to review curricula based on whether information contained in the curricula is “medically referenced.” Reviewers of curricula would be advised of the national and governmental organizations (such as the CDC, NIH, et al.) that are acceptable to reference for accurate information on teen health. Reviewers can then check each fact referenced in both abstinence and/or comprehensive sex education curricula to ensure that it is correctly footnoted and referenced by a recognized, respected source that is not outdated or incorrect.

Ensuring that sexual health education information is medically accurate is vitally important to public health, but doing so is impossible if there is no accountability by the curriculum providers and the government agencies funding these programs. This issue must be resolved before any form of sexual health education can be written off as being false, misleading or distorted.

Currently there is also no formal process by which inaccurate data is corrected. Guidelines should be adopted in order to correct inaccurate data for both comprehensive sex education programs and abstinence programs. This would be helpful in maintaining the integrity of federal sponsored programs.

Not only do abstinence education and comprehensive sex education programs need to be reviewed for medical accuracy, they must also be awarded their grants through a competitive process to make sure that only suitable programs receive funding. A competitive process will also ensure that medically inaccurate or inappropriate curricula will not be used by grant recipients and that inaccurate or inappropriate information will be kept out of the classroom.

That being said, if the same criteria were used to critique the claims of the Waxman Report as the Report uses against abstinence programs, then the Waxman Report itself would be discredited. As already noted, its criticism of abstinence programs is filled with errors and half-truths that betray any sense of objective analysis. Its failure to critique the obvious failure of comprehensive sex education is also a discredit to the Report. Any objective standard of review should dismiss the Waxman Report as a failed attempt to discredit the success of abstinence education.

V. CONCLUSION

The Waxman Report outlines a number of serious concerns regarding abstinence education and challenges Congress's support of these programs. Its criticisms, however, are unfounded and falsely portray abstinence education as ineffective. In truth, abstinence programs provide character development and health education that empowers children and adolescents to make healthy decisions. Studies indicate that abstinence education serves to reduce teen pregnancy and the contraction of STDs, as well as guarding the emotional health of those who participate in abstinence programs.

Currently, abstinence education receives only a small percentage of total federal expenditure on sex education programs. However, should the policy of the Democrats as reflected in the Waxman Report be adopted and abstinence education be stripped of federal funding, then the only programs receiving federal support would be those whose effectiveness is highly questionable and that are contrary to the wishes of the vast majority of parents and students. Parents and teens would be denied any alternatives to the already highly-funded comprehensive sex education programs that undermine a strong abstinence message. Rather than providing state and local entities more flexibility in their programs, Congress would limit state and local choices in the character formation and health education of America's youth.

Therefore, the Waxman Report should be rejected as authoritative, and abstinence education should receive the continued support of the U.S. Congress as it empowers state and local entities and parents to provide invaluable formation for the physical and emotional health of America's youth.

Mr. SOUDER. I also would like to make a brief statement because of my involvement. I would like to use some of my time for that at this point.

I share some of Senator Brownback's concerns that we are not addressing the fact here that two-thirds of the money that goes for education on this issue is not abstinence-only. This hearing seems to be stacked against abstinence-only. If your intent was truly to assess the evidence on abstinence education, then why are we hearing from only one single proponent of the important public health approach? Where are the physicians who diagnose young girls, despite having used condoms, who now have the cancer-causing virus HPV? Where is the official who will talk about twice the amount of funding being used on things other than abstinence education?

Extreme interests groups believing in sexual freedom and sexual justice have denigrated the debate over abstinence education by turning it into a vehicle to promote their own ideological agenda of radical sexual autonomy. We ought not to be persuaded by these groups who, although adopting the language of science and reason, are really just evangelists of a competing though tragically incorrect moral vision. This debate is not between those who on one side are trying to impose their values on others and those who on the other are proclaiming a purely disinterested and amoral rationality. Indeed, despite protests to the contrary, the other side, too, makes more arguments tethered to a particular ideology.

While this hearing has been convened to assess the evidence, we must also realize that this debate involves deep disagreements between competing values. Abstinence education is a medically accurate, age-appropriate method that promotes character, healthy relationship building skills, and self worth to young people. It is far more than a just say no approach to public health.

The name of this hearing, for example, wrongly suggests that teens who receive abstinence-only education are only taught to say no to sex. Mr. Chairman, this simply is not true. Abstinence education is a holistic approach to preventing the physical and emotional distress that premarital sex can bring, especially to teenagers. Abstinence education does, in fact, teach teens about contraceptives. It does teach teens about HIV/AIDS. It does teach teens about how to prevent pregnancy and disease. It encourages teens who are already sexually active to get tested for STDs, unlike the so-called comprehensive sex education curriculum, which often tells teachers specifically not to raise the failures of condoms or STDs.

What abstinence education does not do, unlike contraception-based programs, is suggest to teens that they should "wear shades as a disguise" when buying condoms so adults don't recognize them, or encourage teens to "fantasize" about using a condom.

The Department of Health and Human Services reports that most popular so-called comprehensive programs spend less than 10 percent of their class time promoting important health message of abstaining. The curriculum does, however, instruct girls on how to help their partner maintain an erection and other graphic behaviors too explicit to submit to the record.

We can parade as many critics of abstinence education before this committee as we want, and nothing will change the fact that the only fully reliable way for young people to protect themselves

from pregnancy or STDs is by abstaining from sex until a committed, faithful relationship with a partner who is also free of STDs. To withhold this evidence from our young people and the members of this committee is not only wrong but inexcusable and unjust. I would like to ask our two witnesses—and I find some of these questions, quite frankly, shocking, but since it is used in schools down to age 9—do you believe this is appropriate to ask kids these questions which are: do you think a person is abstinent if he or she does the behaviors below: cuddle with someone with no clothes on, give oral sex, masturbate with a partner, receive oral sex, touch a partner's genitals? Do you believe those are appropriate for kids in school as an alternative to abstinence, or whether it should be defined as abstinence? Ms. Capps.

Ms. CAPPS. Do I think this is appropriate personally? Not at all. I have been a part of many, many sex education classes, and I have never had this or been a witness to any discussion anything like this, particularly at the age that you are talking about.

Mr. SOUDER. My time is on yellow. Let me ask Senator Brownback.

Ms. CAPPS. Surely.

Mr. SOUDER. This is a 2005 plan, Making Sense of abstinence Lessons for Comprehensive Sex Education for New Jersey.

Senator BROWNBACK. No. I don't think that is appropriate. And as a parent, if that were being taught to my kids I would find it very offensive. I think it is why most parents really get upset about a lot of these things, is that there are things being put forward that a lot of times are just really trying to encourage our kids, look, let's be responsible. We don't do these sort of things. It goes against what the parents are trying to teach.

Chairman WAXMAN. Thank you, Mr. Souder.

Mr. Sarbanes, I want to recognize you if you have any questions.

Mr. SARBANES. Not at this time.

Chairman WAXMAN. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

I am wondering, Senator Brownback, I think there is great agreement. As parents we all tell our children that they should delay sexual activity for many reasons—emotional, health, our family values, and that. But knowing what the statistics are from the CDC for the number of young adults that do engage in sexual activity, do you believe that we have a responsibility when Federal dollars are being used, especially in abstinence-only programs, that if they do refer to condoms—and there are examples in here that the GAO cites in its report where inaccurate statements were made that condoms are porous, therefore a condom doesn't protect you against sexually transmitted disease—that we should not allow Federal dollars to be used to transmit misinformation, information that is not scientifically accurate, that is not a good use of our tax dollars? Would you at least agree with that, that we need to make sure that anything that is said in these abstinence programs must be scientifically accurate?

Senator BROWNBACK. I would. I would hope they would be applied to all sex education programs, the comprehensive ones, too. I would tie back in to your earliest piece of your statement. What about the emotional. There is an emotional issue that is involved

here. Having three children either in or recently gone through teenage time periods, this is a big emotional time period. I would hope we would have scientific evidence on all of it.

Ms. MCCOLLUM. Reclaiming my time, my challenge is, as an appropriator, with the limited amount of dollars that are available for public health, that every single penny that is spent should be made sure that the information is scientifically accurate.

Ms. Capps, it is my understanding—and I am sure you have read the GAO report—that it has only been recently that there has been any scrutiny on these programs to make sure that they are scientifically accurate. As a nurse, as a mother, how do you feel about that? As a taxpayer, how do you feel about that?

Ms. CAPPs. That distresses me because I have had personal experience in reviewing some of the abstinence-only materials. I will agree with the ranking member that they do discuss contraception, but I never saw one that said anything positive about it. It was always the failure rate. In other words, to infuse a sense of distrust among the students that they should rely on anything like this.

I am concerned that we are spending Federal dollars on misinformation.

Ms. MCCOLLUM. Representative Capps, as a person who has worked in public health, you know that we might have juniors and seniors in high school who don't have parents such as Senator Brownback, myself, you, and other members of the panel who would sit down and discuss fully options with our children as they are getting ready to perhaps even enter marriage. So knowing that we have 17 and 18-year-olds, do you feel that for many of these young adults in committed relationships who might be getting married at a very early age, that this might be the only information that is available to them?

Ms. CAPPs. I can tell you I have heard it with my own ears, I have seen, and, as I mentioned in my testimony, I worked in a program for parenting teens. Teens already having chosen to keep their parents (sic) and go to a comprehensive high school, we provided them with life skills. Many of them were married. They were asking us for help because they got pregnant in the first place because they didn't know enough, and now they wanted to make sure that they took good care of the child that they had and were able to plan their families in the future.

So there is a cry on the part of many teenagers for accurate information. Then, of course, we need to always be teaching them the life skills in order to make the good decisions about it, as well. The two go hand in hand.

Ms. MCCOLLUM. Thank you.

Chairman WAXMAN. Thank you, Ms. McCollum.

Mr. Burton.

Mr. BURTON. I can wait.

Chairman WAXMAN. Mr. Shays.

Mr. SHAYS. I thank the colleague.

Sometimes I think we are trying to repeal the law of gravity. There are natural instincts that young people have, and they are educated by their parents hopefully first to know proper conduct, and hopefully are given informed information in their process of going to school and so on. I am a chief cosponsor of the Responsible

Education About Life [REAL] Act, which was introduced by Barbara Lee, and its whole purpose is to provide a comprehensive approach to sex education that includes information both about abstinence and contraception.

I read these questions and I thought, you know what? Maybe they shouldn't have been asked by someone in school in a program, but they turn on their TV and they see it.

We have had testimony in Congress where young people didn't realize that oral sex they could transmit disease. They just weren't informed, and they thought that wasn't sex, maybe as defined by the former President of the United States.

But the bottom line is I don't understand why you wouldn't make sure that young people had all the information to counteract all the information they are getting every day from the news media, from TV, from programs, from books. I mean, the books I used to read were so ridiculous compared to what kids read today. But, frankly, if it be told, probably every one of my fellow boys and young men that were at school would have had sex if the girl had said yes. So your parents basically tried to determine who you were going out with, what kind of girl you were out with. It is a different world today. It is a different world, Senator, than you grew up in.

I just don't know how we are going to help young people if we don't give them the information they need to make the choices, to know that they could get ill if they do certain things, to know the benefits of abstinence in the context of truly loving someone.

I would like you both to speak to that, in terms of what kids get every day in the media. So these questions aren't shocking. They get it every day. They see it. They read about it. Why shouldn't they talk about it?

Senator BROWNBACK. Well, first, thanks, Chris, and, believe me, I know we are not in the world I grew up in. I have children operating in this culture. My older daughter is doing Teach for America in Houston in 7th grade, and the things she hears, that does shock me. So I am getting that.

But I think there is an issue here. What about setting a high expectation? What if she in that 7th grade class sets a very low expectation and, you know, whatever you want with it.

Mr. SHAYS. I don't know what you mean by expectation. A high expectation to me means treating a young people with respect that they get the information they need to counteract the information they are getting from somewhere else, so I don't know what you mean by respect.

Senator BROWNBACK. Well, what I mean by high expectation is maybe buttressing the expectations of their parents instead of attacking them or saying, well, we don't think you are really going to make that, so therefore let's go this route.

There is a downside to not having high expectations. There is a clear downside. I think we should do that even in behavior areas.

What I am submitting here is that I think you can look at all these abstinence programs and find ones that haven't worked. I think that is good. Let's not do that. But let's fund the ones that do work so you really are buttressing what 80 percent of the parents want.

Mr. SHAYS. Thank you.

Ms. Capps.

Ms. CAPPS. Again, I agree with so much of what the Senator is saying, and I totally support you. I am on the same legislation that you are co-authoring with our colleague, Barbara Lee. I would simply say that the studies are showing that the more information young people have the better decisionmaking skills they can employ, if they are taught some decisionmaking skills along the way. Schools are asked to do a lot of things today. They are asked to be parents and they are asked to bring up, for those kids who come, you know, with limited foundation at home, they are asked to teach young people to make good decisions, how to do that. But I believe that when you tie a hand behind your back when you are withheld information, you set up a sense of lacking trust. In fact, comprehensive sex education classes have encouraged young people to delay sex because they know all of the information.

Our teen program where the babies were there with the moms in a classroom setting was a big deterrent for kids having sex. They saw what happens when you do.

Mr. SHAYS. Thank you.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Shays.

Mr. Welch, you are next.

Mr. WELCH. Thank you, Mr. Chairman.

Senator Brownback, in listening, everyone agrees that we want to have kids protected as much as possible, so really it seems like this is a tough discussion and debate about what is effective to help kids make the right choices. But, as I understand your testimony, your view is that there should be no sex before marriage?

Senator BROWNBACK. I am saying 8 of 10 parents surveyed want that, and I am saying in our family that is what we talk about.

Mr. WELCH. And I obviously completely respect that. But I understand the statistics are that 95 percent of the American people do have sex before marriage.

Senator BROWNBACK. Well, the material I was looking at and that I think even the ranking member was citing was below 50 percent on teens, and I don't know of the full number of what you are talking about on before marriage activities.

Mr. WELCH. I think it was a USA Today survey, and my understanding is that is a pretty accepted figure. But the question here I think that we have to resolve is effective use of taxpayer dollars to achieve the goal of diminishing teen pregnancy and diminishing sexually transmitted disease. Would you agree that is a shared goal?

Ms. CAPPS. Yes.

Mr. WELCH. All right. So I would ask really both of you, bottom line, whether it is a comprehensive sex education program or an abstinence-only sex education program, that those programs should be subject to strict scrutiny for effectiveness before we allocate a taxpayer dollar. Do each of you agree with that?

Senator BROWNBACK. If I could, absolutely. But you can't just look then at abstinence programs, you need to look at comprehensive ones that get, by far, the lion's share of the dollars, and obviously it has not worked.

Mr. WELCH. I agree that they should be both looked at. That is what I am asking. Any time we spend money, we have to do oversight to see whether the intended purpose is being achieved with the money we are spending.

Ms. CAPPS. Can I respond to that? You are talking about tax dollars, and it has come up before. To my knowledge, I want to address something that has come up where these figures come around like we spend \$12 for comprehensive sex education, Federal dollars, for every dollar that is spent on abstinence-only education. The truth is very different. To my knowledge the Federal Government has never funded comprehensive sex education as taught in a classroom, but rather these dollars are lumped together which are part of Title X, and all of the services, direct services that we provide for every age group through the Federal programs that we provide in family planning and contraception. I think those are very different.

I am not so sure that we want the Federal Government doing anything prescriptive about what curriculum my grandchildren and your children would be taught in a school district. I think school districts and school boards and parents have the right and obligation really to choose what is appropriate for them. What I think we can lay out in these bills that I mentioned and that our colleague Mr. Shays is a coauthor of talk about the importance of doing that and making funds available so that districts can choose the appropriate methods that they want to teach.

Mr. WELCH. Thank you.

You know, we have been referring to this GAO report that has done a study of abstinence education programs and come to the conclusion that they are not effective. Now, if that is the report that gives us guidance and money spent on these programs is not achieving the intended result, would it be your position, Senator, that we should continue to spend more money on programs that are judged to be ineffective?

Senator BROWNBACK. My position would be I think you should look at all the studies. There are studies that I cited. You are going to have another witness here today that is citing studies of ones that have worked. My position would be that you should look at those that work so that you are really going in flow with what the parents of the country want. The parents of the country want their children to be abstinent. That is what they do in the survey results. So why would we flow against it? Why wouldn't you find the ones that are working well and then let's fund those? And you really should look at comprehensive, because that is where we put most of the money, and that hasn't worked.

Mr. WELCH. Well, the dilemma we have is this: those of us who advocate always find something to hang our hat on to justify our position. That is you, it is me, it is all of us. But there are referees, and the GAO, when they do these studies at our request, is, in effect, an arbiter, and we either can disregard their study or accept the results and act accordingly.

My understanding is that the study that the GAO has done, kind of a peer reviewed study, has concluded that these abstinence-only programs are not achieving the results that you would like to see achieved, so why would we spend more money?

Senator BROWNBACK. I would hope you would look at all studies, sir.

Mr. WELCH. OK. Thank you, Senator.

Chairman WAXMAN. Thank you, Mr. Welch.

Mr. Burton.

Mr. BURTON. Thank you, Mr. Chairman.

Let me just say I am going to yield to my colleague from Indiana, Mr. Souder, but before I do let me just whistle into the wind a little bit. Mr. Shays mentioned what children are exposed to all the time, and I am sure this isn't going to change, but one of the things that disturbs me so much is there is a constant barrage of sex and violence on television all the time. I know that you can't really stop it, I guess, but that has to be a contributing factor to the violence that we have seen in places like Columbine and this boy that was stopped from blowing up his school the other day and these college campus attacks. We have to figure out some way as a society to cut back on the sex and violence that we are consuming, because as long as we do that, the kids are going to get a steady diet and you are going to have this thing go on and on.

With that, I yield to Mr. Souder.

Mr. SOUDER. I would first like to correct the record on a couple of things. I didn't use 12-to-1. I used 2-to-1 Federal funding for—

Ms. CAPPS. I am sorry. I have seen 12-to-1.

Mr. SOUDER. And you said that. You said you have seen 12-to-1. You didn't say that I said that, but I wanted to point out that I said 2-to-1 in direct Federal funding, 68 percent of the schools offer contraceptive education compared to 25 percent offering abstinence education. Not all of that is Federal funding and not all of it is even dollars, but that is also a fact. And there are 10 Federal sources for funding for contraceptive education and just 1 for abstinence education.

Now, depending on what a school does with that funding, they may not use it for the curriculum. They may be blending this with local funding from different health groups, like in our community part of it is funded by Planned Parenthood directly, maybe not from Government funds, or from a health center, not from Government funds. But the fact is that the disproportionate amount of money in the United States is, in fact, going to contraceptive education.

And we are also really happy to see that a number of people here seem to be expressing disappointment, even on the majority side, that we aren't looking at science on not only abstinence education but on the other, because clearly study after study have shown that contraceptive education hasn't worked on HPV, has not worked, either. And you can't just apply science when you ideologically oppose one goal but then not look at science, and we shouldn't pretend like science, GAO, or otherwise has defended the effectiveness of contraceptive programs.

But there is another fundamental question here that we are debating, and that is that 70 to 90 percent of American people oppose explicit sexual content in comprehensive sex education; 67 percent of teens who have initiated sex express regret for doing so; 90 percent of American people believe adolescents should not become sex-

ually active; 70 to 90 percent want a strong abstinence message taught.

Do you believe, Senator Brownback and then Ms. Capps, that the public, what they want from the schools, is at all relevant in this debate?

Senator BROWNBACK. I would hope it is relevant in this debate, and if it is not, you are going to be running at counter purposes and people are going to be arguing with it all the time and it is not going to be effective. But if we will work in concert with parents, I think we can have an effective program moving on forward.

Ms. CAPPS. Thank you. I want to stress again that all of us—and I am now going back to my past life as a school nurse—in the local schools I don't know a person who doesn't favor abstinence-only until it comes to the point of the knowledge that is available should abstinence not work for a particular child. We can't control what happens to them after school. Most of us want not abstinence-only but abstinence coupled with an understanding of available resources should they need it.

Now, I also would like to say that I have never been a part of a plan or program that is called contraceptive education. I have only been associated with anything in my schools where I worked that was comprehensive sex education that included abstinence and also gave other information.

Now, what I would say is that this decision, the public has its way of recording its desires and what it believes in and so forth, but really the important people in this conversation who we are talking about are the parents who send their kids to public school every day.

Mr. SOUDER. How do you handle this question, and that is that those using the male condom at first sex has tripled from 22 to 67 percent, contraceptive use has nearly doubled since the 1970's to 79 percent, and yet STDs and other problems are still increasing. How can anything but abstinence be said to be working?

Ms. CAPPS. Abstinence works 100 percent, and that is why it should be the core of any kind of comprehensive education that involves sexuality with teenagers. Again, the decision should be made by the parents, and the young people are asking for information, and if they are asking they should get reliable information.

Chairman WAXMAN. Thank you very much.

I am going to now recognize Ms. Norton, but I want to indicate that our second panel will discuss evaluations of both and all sex education classes, which I think will be very helpful for the committee.

Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

I have had the pleasure of working with you both, and I want to thank you both for very important leadership that I am personally aware of. Ms. Capps, you have become a particular leader on health issues here in the Congress, and Mr. Brownback and I have worked together on a number of issues, including issues that proved controversial in some forms—the marriage issue, where there has been a decline among African Americans. It is catastrophic. And I must say a similar decline among white people, except for people in the upper middle and upper classes.

May I thank you, Mr. Brownback, for what you said about Best Friends. Best Friends has done an extraordinary job in the District of Columbia with its abstinence-only approach. The kind of caring attention that it gives is rare for any program. I know you did not mean to indicate that was what abstinence programs usually offered; nevertheless, this has been an extraordinary program of great value to us and the children and the parents that have chosen it.

I don't understand why this subject has been so contentious. I agree with Mr. Brownback we ought to look at all the studies. Don't put a dime on comprehensive sex education programs that don't work. Test them in the same way that we test abstinence-only programs.

The concern that many of us have with abstinence-only programs is the notion that there would be any such matter where one size could possibly fit all. It is so individual, so family oriented.

Mr. Brownback, you have been Chair of the D.C. Appropriations Subcommittee. I don't need to tell you that you would be laughed out of many classrooms in the District of Columbia if you talked about abstinence where the children come to junior high school and high school already experiencing sex. This troubles me greatly. I wish there were some way. I cannot imagine wanting my own child to do anything but abstain until marriage. Frankly, that would be my wish. I would do everything I could to encourage that to happen, and many parents find that is a failing effort today.

My question is particularly, Mr. Brownback, I know from my friendship with you, from your own work, your respect for local control, for the views of parents, the sensitive way you have handled the marriage funding that we did here, all with consent and encouraging greater marriage in some of our poorer communities. I am wondering why committing this to local control, where you might have some people—and I can tell you there would be some in the District that would say, I want a program like Best Friends in my community, and where you would have others with parents who are at their wits' end. Many of them are poor parents and single parents. Many of them are single parents of boy children. They can't begin to even talk with them about sex. If there is somebody in school that will give them the whole deal when this mother who works every day as a single mother doesn't even know how to approach the subject, is poorly educated, if you tell her that her son or her daughter should have an abstinence-only program she will be puzzled.

Would there be any harm in allowing local communities to make this decision based on their own family needs, based on the composition of the community? Would that be consistent with your values and mine?

Senator BROWNBACK. First, let me say it has always been my pleasure to work with you, and I was looking at you and thinking there is nobody on your side of the aisle that has gotten more votes out of me than you on a whole range of topics, and I can't recall me getting one back from you.

Ms. NORTON. There is one more I want from you, too.

Senator BROWNBACK. I just want my first out of you. That is all I am looking for. I can't even get her to—I don't know, did you cheer for the Jayhawks in the final four?

Ms. NORTON. Don't change the subject, Sam.

Senator BROWNBACK. I just wanted you to at least give me that.

You know, I have enjoyed working with you. I have enjoyed working in D.C. I know you say I would get laughed out of the classroom. I recall I think we were getting laughed out when we were promoting marriage. There are certain areas that people getting married is unusual within that block or that area. Now we have people that are getting married in some of these communities.

Ms. NORTON. Yes, but we don't have marriage only. We encourage them to come in. It is the exclusivity of the approach.

Senator BROWNBACK. I know, but let me make my point on this. Let me make my point, because you are very good at making yours.

Ms. NORTON. OK.

Senator BROWNBACK. Senator Moynihan, I took a lot of guidance from him before he left this body and passed away, and his view was the key thing we ought to be focused on is how you raise your next generation. The key thing you ought to be focused on is how you raise your next generation. I think for us, the Federal Government, to say, here are funds that we believe this is the high expectation approach is fully appropriate for the Federal Government to do, of a high expectation.

Now, you are saying a bunch of States say we don't want it. Maybe the District of Columbia has said the same thing. We have a lot of money going to the sex education programs. GAO says it is 5-to-1 on comprehensive. There is a lot of funds going in there. I think this amount that we are putting in, what I would be critical of on it is that I think we need to make sure we are at ones like Best Friends that work and not ones that don't work. I think that really is where our focus should be.

Chairman WAXMAN. Thank you, Ms. Norton.

Let me advise the members of the committee that our two witnesses have other responsibilities and are anxious to go to them. I don't want to deny or deprive any Member of an opportunity to ask questions, because our rules do provide for 5 minutes.

Let me ask Members who are cognizant of that fact to try to limit your questions, recognizing the time constraints of our witnesses.

Ms. FOXX. Mr. Chairman.

Chairman WAXMAN. Yes.

Ms. FOXX. I am having difficulty hearing people down here. I would just like to ask if people could really put the mics close and speak up. I just ask for clarity. I would really appreciate that. Thank you.

Chairman WAXMAN. Good point.

Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman. I have someone waiting in my office, so I will be very brief.

Senator Brownback just said a few minutes ago that the culture is pushing in the opposite or harmful direction at times, and someone else mentioned the TV shows and the movies, and they all work together to almost seem to pressure young people into think-

ing that they are odd if they don't have early sex. But Senator Brownback just mentioned Senator Moynihan, and Senator Moynihan made a famous statement several years ago. He said we have been defining deviancy down, accepting as a part of life what we once found repugnant. That seems to become more true with each passing year. So I think Senator Brownback is right when he says that we should encourage people to higher expectations or higher or better goals.

There is some discrepancy that I don't understand. Maybe the witnesses can explain it later. But there is a Heritage study that came out yesterday that said we spend 12 times this much on comprehensive sex education as opposed to abstinence-only education, but the Zogby poll that has been mentioned showed that by more than a 2-to-1 margin that parents want or prefer the abstinence approach, and it seems rather elitist to me for people who maybe have degrees in this field to feel that they, because they have studied it, somehow know better than the parents what is best. I still think parents know what is best for their children.

The message that teens receive from abstinence is pretty simple and very clear. The only way to avoid all the harmful consequences of sexual activity is to abstain. Education about abstaining teaches young people how to set goals and build healthy relationships. So I don't think it is something that we should abandon, which seems to be sort of the thrust of where we are headed.

The people who want to encourage young people to abstain could have produced numerous witnesses here to support or to show that this type of training is working, and so with that I will yield whatever time I have left to Mr. Issa.

Mr. ISSA. I thank the gentleman, and I will try to use this time rather than any further time.

Lois, Sam, if we can get you two to agree on things I think it would go a long way toward this committee doing the right thing. Nancy Reagan, a famous California lady, had the expression Just Say No when it came to drugs. It didn't work, did it? People still use illegal drugs, don't they?

Ms. CAPPS. Yes, they do.

Mr. ISSA. OK. We agree. But don't we also agree that the message of not doing illegal drugs is a good one to continue having?

Ms. CAPPS. Are you asking me?

Mr. ISSA. Both of you.

Ms. CAPPS. All right. I will answer quickly.

Mr. ISSA. I am looking for all yeses, because I think in a sense we are concentrating on what we disagree on rather than what we agree on.

Ms. CAPPS. We agree on that, but I guess I would say knowing why you are saying no is a good idea.

I apologize. I am going to have to leave the rest of this.

Senator BROWNBACK. I agree.

Mr. ISSA. So, Senator, continuing on with you, when we get to what is being called abstinence here, aren't we really just saying no, but the reason it is a chorus and not just abstinence is that it takes longer to explain to young and women why there are advantages health-wise, relation-wise, future-wise, that, in fact, absti-

nence training is a process of teaching why waiting makes sense, isn't it?

Senator BROWNBAC. Absolutely. And you didn't touch on the emotional side of it, but you are dealing with a teenage person generally with this, and the emotional side of this is so critical. And you are finding, too, in these studies that I have reviewed, that the abstinence programs that work the best generally spend the most time. They spend a lot of time drilling into these concepts as to why. And those are the ones that are more successful, not a superficial deal.

Mr. ISSA. So, just to conclude, because my time is limited, too, or Mr. Duncan's time is limited, two things: one, even though we will not have 100 percent success in abstinence, even though the figures will show that it does not work all the time, there is no reason not to continue doing it, for the same reason as we continue to teach not to take illegal drugs because men and women are dying in America.

Senator BROWNBAC. Agreed.

Mr. ISSA. And then, last, when it comes to the other side of the issue, teaching people that transmittable diseases have to be prevented and teaching about the consequences of those, that has to be done regardless of whether you are teaching it through abstinence or you are teaching it through other parts of sex education. That is just as important for men and women for their protection, young men and women.

Senator BROWNBAC. I have a book here that we could enter into the record that is an abstinence education booklet that teaches about that, as well.

Mr. ISSA. Thank you. Mr. Chairman, I would ask the chairman's consent that be entered into the record.

Chairman WAXMAN. Without objection, that will be the order.

Mr. ISSA. Thank you, Senator.

Thank you, Mr. Chairman.

Chairman WAXMAN. Ms. Watson, do you wish to take your time? What some of the Members are going to be doing on the other side is splitting their time.

Ms. WATSON. OK. I will be real quick. I would like permission to submit my speech into the record, please.

Chairman WAXMAN. Without objection.

Ms. WATSON. I just wanted to say this. As I listened to these two very fine, fine colleagues of mine, I see an ideological discussion versus a reality discussion. Abstinence-only is more ideological rather than comprehensive sex education programs. Reality.

I represent a community called Hollywood, and so many of the young people in my District and in California look at these performers as idols, and we watch their behavior and they pattern after that behavior. Abstinence-only does not reach in a comprehensive way these young people, because they take their lead from what they see on the Internet, what they see on television, what they hear in terms of music.

So my question is: how do we get to the range of experiences when we talk about abstinence-only? Also, I represent an area where there are no fathers in the home, and mothers are there taking care the best they can. They are busy working one, two, and

three jobs. They don't have time to focus on discussions of sex when the youngsters are on the streets and they take the lead from their peers. So my question to you, Senator Brownback: how do we then convey with funding only for—California turned down the abstinence-only funds. How do we convey to our young people when we don't have an intact home, we don't have a functioning home, we don't have two parents in the home, and we don't have the resources to really address abstinence-only? We really need to look at a comprehensive sex education program.

Senator BROWNBACK. Well, No. 1, I think you and the chairman probably represent the Districts that could affect this debate more than anybody else in the whole world, and your working with people in your Districts would probably do the most to change this whole debate of anybody anywhere because of what is coming out culturally—

Ms. WATSON. Taking back my time for a second, I have a bill out there that we are using films as diplomacy. It happens to be down in South Africa, because we are looking at the spread of HIV/AIDS. I would like to talk to you about going on as an author, because what we are trying to do is use those quality films to impress certain behaviors in other people and certain respect for us here in the United States. I would like to talk to you about it, because we are trying to use a media to give the right messages.

But I don't see it in a narrow perspective of abstinence-only. We have to face the reality of the audiences that we are dealing with, and we are trying to do that through a means of communication. We are going to use films, Hollywood.

Senator BROWNBACK. I work with a number of people from Hollywood a lot on African issues, because I have been involved a lot with the African continent. They are the ones that could change this debate more than anybody else. I would hope and pray they would do it in an abstinence and be faithful setting.

Ms. WATSON. But, you see, that is not the only means.

Senator BROWNBACK. I know that.

Ms. WATSON. Yes.

Senator BROWNBACK. You know that. But there is an expectation that we can set for society, we can set for our kids. You know, I want you to make all A's.

Chairman WAXMAN. And not see those movies and not listen to those records.

Senator BROWNBACK. But my point is I don't set a low expectation—

Chairman WAXMAN. I think you can do it in Kansas, not only in Hollywood.

Senator BROWNBACK [continuing]. And nor should the Federal Government set a low expectation.

Ms. WATSON. Just the bottom line is I don't think one size fits all, and that is the reason why California turned, because we deal with the realities of our various diversified segments of California, and we have to send a comprehensive message out there and hope that it can be backed up in the home and in the community as a whole.

Senator BROWNBACK. The comprehensive message hasn't worked. We have one in two African American teenage girls with an STD.

Ms. WATSON. Well, abstinence-only, and we have results from other areas where it has not worked, so I don't know if we are using our money wisely.

Thank you, and I yield back my time.

Senator BROWNBACK. The current approach hasn't worked.

Chairman WAXMAN. We are going to find out from the next panel, because they have done actual measurements, not just given us opinions. Let's find out what has worked.

Senator, we still have some other Members who wish to ask you some questions.

Senator BROWNBACK. I am way past due on another set of activities that I was supposed to go to. I need to move on if I can, Mr. Chairman.

Chairman WAXMAN. Well, my colleagues, I don't know what to do here, but I think out of respect to the Senator, who has given us very generously a great deal of his time, I think we ought to release him, unless there is objection.

Mr. SOUDER. Reserving the right to object, what I have said is I will yield my time first on the next panel to the Members on our side who didn't get a chance.

Senator BROWNBACK. Mr. Chairman, thanks for your time and thanks for your courtesy. I appreciate both greatly.

Chairman WAXMAN. Thank you so much.

For our next panel we have the following witnesses who will share their assessment of the existing body of evidence on abstinence-only and comprehensive sex education programs.

Dr. John Santelli is a professor and Chair of the Halbren Department of Population and Family Health at the School of Public Health at Columbia University and a senior fellow at the Guttmacher Institute. He is a pediatrician, an adolescent medicine specialist who has conducted research on HIV/STD risk behaviors, programs to prevent STD, HIV, and unintended pregnancy among adolescents, women, school-based health centers, and research ethics.

Dr. Georges Benjamin has been the executive director for the American Public Health Association, the oldest and largest organization of public health professionals in the United States, since December 2002. His prior positions include chief of staff for Emergency Medicine at Walter Reed, and he is also a member of the Institute of Medicine, National Academies of Science.

Dr. Margaret J. Blythe is Chair of the Committee on Adolescence for the American Academy of Pediatrics. She is a professor of pediatrics at Indiana University School of Medicine.

Dr. Stanley Weed is the director of the Institute for Research and Evaluation, which he and colleagues formed in 1988 to focus on social problems and programs related to adolescence, including teen pregnancy, drug abuse, and delinquency.

Finally, we are very honored to have Dr. Harvey Fineberg, president of the Institute of Medicine of the National Academies. At the IOM he has chaired and served on numerous health policy panels ranging from AIDS to new medical technology.

The last two speakers on this panel will help us put a face on the scientific evidence we discuss here today.

At the age of 15, Shelby Knox led a campaign to replace her high school's abstinence-only curriculum with medically accurate, comprehensive sex education after realizing the programs were ineffective in preventing rising teen pregnancy and sexually transmitted diseases. Today she is a writer and speaker on youth and reproductive health.

And Max Siegel leads student-based HIV prevention interventions and is a policy associate at the AIDS Alliance for Children, Youth and Families.

We are pleased to have you here us at this hearing. Your prepared statements will be made part of the record in its entirety. We would like to ask each of you, however, to limit your oral presentations to no more than 5 minutes.

Dr. Santelli, we will start with you. There is a button on the base of the mic. Please be sure it is pressed in so that the mic is working. We will start with you.

STATEMENTS OF JOHN SANTELLI, DEPARTMENT CHAIR, PROFESSOR OF CLINICAL POPULATION AND FAMILY HEALTH, MAILMAN SCHOOL OF PUBLIC HEALTH, AND PROFESSOR OF CLINICAL PEDIATRICS, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY; GEORGES BENJAMIN, EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION; MARGARET J. BLYTHE, M.D., CHAIR OF AMERICAN ACADEMY OF PEDIATRICS' COMMITTEE ON ADOLESCENCE; STANLEY WEED, PH.D., DIRECTOR, INSTITUTE FOR RESEARCH AND EVALUATION; HARVEY FINEBERG, M.D., PH.D., PRESIDENT, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES; MAX SIEGEL, POLICY ASSOCIATE, AIDS ALLIANCE FOR CHILDREN, YOUTH AND FAMILIES; AND SHELBY KNOX, YOUTH SPEAKER

STATEMENT OF JOHN SANTELLI

Dr. SANTELLI. Thank you, Chairman Waxman, distinguished members of the committee, and guests. Thank you all for the opportunity today to speak to you about the health needs of adolescents and my own research on abstinence-only education.

My name is John Santelli, as the chairman indicated. I am a pediatrician, a father, and chair a department at Columbia.

Importantly, before moving to New York City I worked for 13 years with the CDC and, in fact, 5 years as a school health doctor for Baltimore City, worked extensively in research ethics.

In the past few years I have conducted research that seeks to understand adolescent sexual behavior and the reasons for the recent declines in teen pregnancy rates. That is what I would like to speak with you about today.

My written testimony goes into some of the other important scientific and ethical critiques that have been raised about abstinence-only education for young people. I brought slides today, so I hope this works.

[Simultaneous slide presentation.]

Dr. SANTELLI. First I would like to speak about some of the demographic realities for young people. I would suggest to you that the current U.S. emphasis on abstinence-only or abstinence-until-

marriage is out of touch with the broad demographic trends and the realities of young people's lives. Premarital sex is nearly universal among young people. Based on CDC data, by the time one reaches age 44, 99 percent of Americans have had sex, and 95 percent have had premarital sex.

This reality is the result of both trends toward an earlier age of sex, beginning in the 1960's at some point, but also later trends in marriage. So, as the slide shows, in 1970 there was a gap, a small gap of only about a year-and-a-half between first sexual intercourse and marriage, but by 2002 the gap for young women was a full 8 years. For young men it is more like 10 years. This is a fairly universal phenomenon. It is seen around the globe, this rising age at marriage. And it suggests that trying to get young people to wait until marriage is going to be somewhat unrealistic.

This is just to remind you of the statistic that has already been mentioned today. Teen pregnancy rates really declined fairly dramatically. Beginning around 1990 both teen birth rates and teen pregnancy rates declined pretty dramatically. The biggest declines have been among young people, often among minority youth, and that is all good news.

Of course, there is this worrisome trend that is a little hard to see, but in 2006 the birth rates went up. Let me then talk about some of the explanation for that.

Recent declines in teen sexual activity appear to be unrelated to the Federal program. According to data from CDC, rates of sexual experience among high school kids grades 9 to 12 declined from about 54 percent in 1991 to about 47 percent in 2002, and essentially have been flat since 2001.

Much of the reduction in the rates of adolescent sexual activity occurred before the Federal Government began widespread funding of abstinence education in 1998. You can see the points at which the two Federal programs were instituted.

My own research suggests that most of the decline in teen pregnancy rates, about 86 percent among 15 to 19-year-olds between 1995 and 2002 was the result of improved contraceptive use. Not surprisingly, abstinence played a somewhat greater role for the younger kids, those 15 to 17, but even in that group three-quarters of the decline was the result of improved contraceptive use. This is data based on the CDC's National Survey of Family Growth, but we have recently repeated that data using the Youth Risk Behavior Survey data, and again we found about 70 percent of that decline was the result of improved contraceptive use, consistent, I would suggest, with the European experience where European teens have much lower pregnancy rates, similar rates of sexual involvement, but much, much better contraceptive use, and therefore much lower pregnancy rates.

Unfortunately, these positive trends in contraceptive use reversed in 2005. Again, the top line is condom use, but you can see many of the other methods listed there. And you can see that in 2005, again in the high school data, condom use declined somewhat. Use of no method increased somewhat. This lines up precisely with the increase in birth rates. It is only a 1-year change, but we need to keep monitoring this.

Chairman WAXMAN. Thank you very much, Dr. Santelli.

Dr. SANTELLI. Am I out of time?

Chairman WAXMAN. You are.

Dr. SANTELLI. OK.

Chairman WAXMAN. Do you want to make a concluding statement?

Dr. SANTELLI. Let me just say one thing. I think a lot of what we are going to hear today or we have already heard today are differences of opinion about the facts. Good commonality on our goals. We all care about young people and I am glad to hear that. I think the panel today represents the folks who put together scientific and medical consensus in this country, and I hope we will stop arguing over the facts and move on to what we know works.

Thank you.

[The prepared statement of Dr. Santelli follows:]

Testimony of Dr. John Santelli, Committee on Oversight and Government Reform,
April 23, 2008

**Committee on Oversight and Government Reform
Hearing on Abstinence-Only Programs
April 23, 2008**

**Testimony of Dr. John Santelli
Professor and Chairman, Department of Population and Family Health
Mailman School of Public Health
Columbia University**

Chairman Waxman, ranking member Davis, distinguished members of the Committee and guests, thank you for the opportunity to speak with you today about the needs of today's adolescents and my professional findings about abstinence-only education. My name is John Santelli and I am the Chairman of the Department of Population and Family Health at the Mailman School of Public Health at Columbia University. I am also a Senior Fellow at the Guttmacher Institute. I am a pediatrician, a father, and have served in leadership positions in medical and public health organizations including the Society for Adolescent Medicine and the American Public Health Association. I also directed the Applied Science Branch of the Division of Reproductive Health at the U.S. Centers for Disease Control and worked for the CDC for 13 years. I have worked extensively in research ethics for 15 years and chaired an Institutional Review Board at CDC for five years.

I have conducted research in the past few years that seeks to understand trends in adolescent sexual behavior and the reasons for recent declines in teen pregnancy rates. I have also actively monitored the scientific literature on adolescent development, trends in sexual behavior, and effective programs to help teens avoid unplanned pregnancy and sexually transmitted diseases.

Summary of Concerns About Abstinence-Only Education

Numerous scientific and ethical critiques have been raised about abstinence-only education for young people. These concerns are articulated in the reports from the Society for Adolescent Medicine, the American Public Health Association, and others. The Society for Adolescent Medicine's position paper on abstinence-only education and policies is attached to my testimony. Key critiques include:

- Abstinence-only-until-marriage as a program goal is out of touch with broad demographic trends toward both an earlier age at first sex and a later age at marriage. Indeed, 95 percent of Americans have intercourse prior to marriage (Finer, 2007).
- Recent declines in adolescent sexual activity precede widespread federal funding of abstinence-only education in the U.S.; as such, federal abstinence-only programs are not responsible for reductions in adolescent sexual experience and teen pregnancy in the U.S. Rather, most of the decline in teen pregnancy rates in the U.S. can be attributed to better contraceptive use among adolescents.

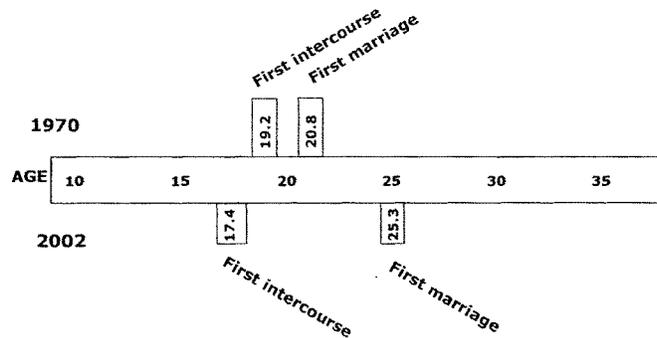
Testimony of Dr. John Santelli, Committee on Oversight and Government Reform,
April 23, 2008

- Evaluations of comprehensive sexuality education programs show that many programs help young people to delay intercourse. In addition these programs help young people use contraception and condoms when they do have intercourse. In contrast, abstinence-only programs that have been carefully evaluated have failed to demonstrate behavioral results.
- Many abstinence-only programs withhold critical information or include misinformation, particularly about important health topics such as contraception and condoms. This puts young people at risk. Such programs are contrary to the medical ethical principle of informed consent and are a violation of human rights principles.

Demographic Trends

Evidence from the past several decades indicates that establishing abstinence until marriage as normative behavior is a highly challenging policy goal. In 1970, [See Figure 1] there is a gap of only one and a half years between first sex and marriage; by 2002 this gap was a full eight years. Research has shown that over the past 40 years, the median age at first intercourse has dropped (and stabilized) at around age 17 in most developed countries (Teitler, 2002). At the same time, the median age at marriage has risen dramatically. Thus, expecting people to wait until marriage to engage in sexual intercourse is increasingly unrealistic. Almost all Americans initiate sexual intercourse before marriage (Finer, 2007). By the time they reach age 44, 99 percent of Americans have had sex, and 95 percent have done so before marriage.

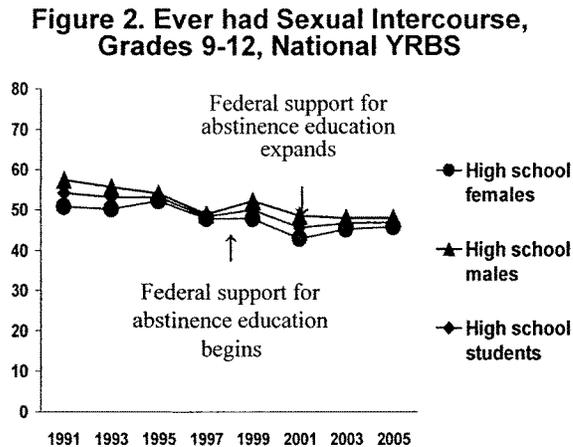
Figure 1. Declining Age of First Intercourse & Increasing Age of First Marriage in Women



Testimony of Dr. John Santelli, Committee on Oversight and Government Reform,
April 23, 2008

Trends in Adolescent Sexual Activity and Teen Pregnancy

Recent declines in teen sexual activity appear to be unrelated to federal abstinence programs [See Figure 2]. According to the Centers for Disease Control and Prevention, rates of sexual experience declined from 54 percent in 1991 to 46 percent in 2001 and have been unchanged since 2001. Note that much of the reduction in rates of adolescent sex occurred before the federal government began widespread funding of abstinence-only education in FY1998.



Teen birth and pregnancy rates declined impressively between 1991 and 2005. Two behaviors contribute directly to teen pregnancy: engaging in sexual intercourse and contraceptive use. From the 1960s through 1990, *increasing* involvement in sexual activity by teenagers in Western Europe and the United States was accompanied by sharply *lower* teen birth and pregnancy rates in most countries, due to greatly improved contraceptive use. Today, better use of contraceptives is the major behavioral difference between European and U.S. teenagers (Santelli, Sandfort, and Orr, 2008). Rates of sexual activity are similar, but European teens have much higher use of oral contraceptives and use of the “double Dutch” method - simultaneous use of condoms and hormonal methods.

Throughout the 1990s, teen sexual activity in the U.S. decreased and contraceptive use improved. Much of the improvement in contraceptive use was related to increasing condom use: between 1991 and 2001 condom use at last intercourse by young women

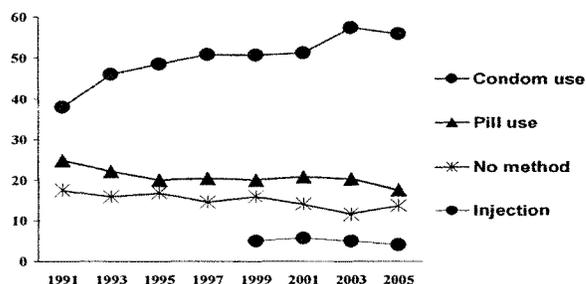
Testimony of Dr. John Santelli, Committee on Oversight and Government Reform,
April 23, 2008

rose from 38 percent to 51 percent (Santelli et al., 2004). Increases in teen condom use in the 1980s were even more dramatic.

My own research suggests that 86 percent of the decline in teen pregnancy rates among 15-19 year olds between 1995 and 2002 was the result of improved contraceptive use. Among younger teens (15-17 years old), three-quarters of the decline was the result of improved contraceptive use. I have attached my paper entitled "Explaining Recent Declines in Adolescent Pregnancy in the United States: The Contribution of Abstinence and Improved Contraceptive Use" to this testimony. My colleagues and I have recently repeated this calculation for 1991 to 2003 using data from the Youth Risk Behavior Survey which is conducted nationwide with high schools students and found similar results. Improvements in contraceptive use between 1991 and 2003 were responsible for 70 percent of the decline in teen pregnancy.

Thus, while an increase in abstinence (i.e., fewer teens having sexual intercourse) explains some of the decline in teen pregnancy rates in the 1990s, more recently there appears to be little impact of abstinence on teen birth or pregnancy rates.

Figure 3. Contraceptive Use at Last Sex, Women in Grades 9-12, National YRBS



Unfortunately these positive trends in contraceptive use reversed in 2005. Both no use of contraception and decreases in condom use occur in the most recent data (Santelli, Orr, and Lindberg, in preparation). These reversals coincide with increases in teen birth rates in 2006 – after steady declines over the previous 14 years.

Evaluations of Comprehensive Sexuality Education and Abstinence-Only Programs

There is now an extensive body of research that demonstrates that comprehensive sexuality education programs that include information about both abstinence and contraception and share several other key characteristics, are effective in helping young

Testimony of Dr. John Santelli, Committee on Oversight and Government Reform,
April 23, 2008

people to delay the onset of sexual intercourse and to use contraception and/or condoms when they do have intercourse (Kirby, 2007). Dr. Douglas Kirby conducted an analysis for the National Campaign to Prevent Teen and Unintended Pregnancy that examined well-designed studies and evaluated whether or not programs designed to reduce teen pregnancy and sexually transmitted infections, including HIV, actually worked in changing behavior. That meta-analysis shows compelling evidence that programs that include information on both abstinence and contraception and display a number of other characteristics are effective in helping young people to abstain or protect themselves from pregnancy and STDs. In fact, his review carefully examined 48 comprehensive programs and found that nearly half of them delayed the initiation of sex, nearly half increased condom use and 63 percent reduced sexual risk through changes in multiple behaviors (Kirby, 2007; Kirby, 2008).

In contrast, rigorous evaluations of abstinence-only programs find little evidence of efficacy for abstinence-only education. None of the well-designed evaluations of abstinence-only programs has presented strong evidence of an impact on behaviors.

The Mathematica evaluation of the Title V program (Trenholm et al., 2007), released in April 2007, found no measurable impact on increasing abstinence or delaying sexual initiation among participating youth or on other important health behaviors such as condom use. This well funded and well conducted evaluation examined four abstinence-only programs, tracking youth over four years. One of the few measurable impacts of the programs was a decrease in adolescent confidence regarding the ability of condoms to prevent HIV and other sexually transmitted diseases. Similar results on program efficacy were found by Underhill, who conducted a systematic review of abstinence-only programs (Underhill, 2007). In other words, comprehensive sexuality education programs are actually better than abstinence-only programs at helping young people to abstain from sex.

Virginity Pledges

Virginity pledging, one which is one approach to encouraging abstinence until marriage among youth, appears to have little long-term benefit in preventing outcomes such as sexually transmitted infections. A longitudinal study by Bruckner and Bearman found that teens who signed abstinence pledges, when compared to non-pledgers, experienced similar rates of sexually transmitted infection (Bruckner and Bearman, 2005). Pledgers did delay sexual intercourse for a limited period, but when they did start having sex, they were less likely to use condoms. They were also less likely to seek reproductive health care compared to non-pledgers leaving them at increased risk for unintended pregnancy and sexually transmitted infections.

Medical Accuracy and Complete Information for Youth

A December 2004 Congressional report on federal abstinence programs from the U.S. House of Representatives' Committee on Government Reform - Minority Staff found that 11 of the 13 most frequently used curricula contained false, misleading or distorted

Testimony of Dr. John Santelli, Committee on Oversight and Government Reform,
April 23, 2008

information about reproductive health — including inaccurate information about contraceptive effectiveness, purported health risks of abortion, and other scientific errors (Waxman Report, 2004). Concerns about the accuracy of information included in abstinence-only programs have also been raised by many different professional organizations. Over the past several years, my colleagues and I at Columbia University have explored this issue. Our recent review of abstinence-only curricula found similar inaccuracies, particularly misinformation about the efficacy of condoms and contraception. A copy of my analysis entitled, “The Accuracy of Condom Information in Three Selected Abstinence-Only Education Curricula,” is attached to this testimony (Santelli, 2008). In addition, I have developed an overview article entitled, “Medical Accuracy in Sexuality Education: Ideology and the Scientific Process,” which explores the concept of medical accuracy in sexuality education and is attached to this testimony for your review (Santelli, in press). That article includes information about the 21 states that require medical or scientific accuracy in the provision of sexuality or HIV/AIDS education and an overview of the systems that are in place to determine scientific consensus.

Ethical and Human Rights Concerns

As a physician, I am expected to provide information that is both accurate and complete to my patients. The premise of federal abstinence-only programs is antithetical to this basic principle of medical ethics. Abstinence-only programs require teachers and health educators to conceal information about risk reduction measures such as condoms and contraception – or risk loss of federal funding. Misinformation about condoms is of particular concern given the high rates of sexually transmitted diseases among young people in the United States.

For all of these reasons and more, the leading medical and health organizations in this country have taken the position that abstinence-only education is inappropriate for young people. On this panel you are hearing from two of the key organizations with concerns about abstinence-only approaches, the American Public Health Association and the American Academy of Pediatrics. Abstinence-only education is also opposed by the American Medical Association, the Society for Adolescent Medicine, the Institute of Medicine, and the American Foundation for AIDS Research.

Recommendations:

As someone who is deeply committed to the well-being of young people, I urge the committee to encourage policies that will better serve the needs of America’s youth.

- Congress should develop policies to improve adolescent reproductive health based on sound scientific evidence and the realities of adolescents’ lives. Policies should support what we know works in helping young people to stay healthy.
- Congress should require medical accuracy in all federally-supported health education activities.

Testimony of Dr. John Santelli, Committee on Oversight and Government Reform,
April 23, 2008

- Congress should end federal support for abstinence-only programs that require withholding potentially life-saving information. Teachers should be allowed to teach. Indeed, policy makers have an ethical obligation to ensure that young people have the critical information they need to protect their health.
- Congress should help ensure that every American adolescent has access to age-appropriate, comprehensive sexuality education and comprehensive health care services to help young people to avoid HIV, other STDs and unplanned pregnancy. This approach is consistent with the scientific evidence about what works and echoes the overwhelming support of America's parents and physicians.

Thank you.

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Testimony of Dr. John Santelli, Committee on Oversight and Government Reform,
April 23, 2008

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Position paper

Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine

Summary

Abstinence from sexual intercourse represents a healthy choice for teenagers, as teenagers face considerable risk to their reproductive health from unintended pregnancy and sexually transmitted infections (STIs) including infection with the human immunodeficiency virus (HIV). Remaining abstinent, at least through high school, is strongly supported by parents and even by adolescents themselves. However, few Americans remain abstinent until marriage, many do not or cannot marry, and most initiate sexual intercourse and other sexual behaviors as adolescents. Abstinence as a behavioral goal is not the same as abstinence-only education programs. Abstinence from sexual intercourse, while theoretically fully protective, often fails to protect against pregnancy and disease in actual practice because abstinence is not maintained.

Providing “abstinence only” or “abstinence until marriage” messages as a sole option for teenagers is flawed from scientific and medical ethics viewpoints. Efforts to promote abstinence should be based on sound science. Although federal support of abstinence-only programs has grown rapidly since 1996, the evaluations of such programs find little evidence of efficacy in delaying initiation of sexual intercourse. Conversely, efforts to promote abstinence, when offered as part of comprehensive reproductive health promotion programs that provide information about contraceptive options and protection from STIs have successfully delayed initiation of sexual intercourse. Moreover, abstinence-only programs are ethically problematic, being inherently coercive and often providing misinformation and withholding information needed to make informed choices. In many communities, abstinence-only education (AOE) has been replacing comprehensive sexuality education. In some communities, AOE has become the basis for suppression of free speech in schools. Abstinence-only education programs provide incomplete and/or misleading information about contraceptives, or none at all, and are often insensitive to sexually active teenagers. Federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning youth,

as federal law limits the definition of marriage to heterosexual couples.

Schools and health care providers should encourage abstinence as an important option for teenagers. “Abstinence-only” as a basis for health policy and programs should be abandoned.

Background

Abstinence from sexual intercourse is an important behavioral strategy for preventing STIs and unwanted pregnancy among adolescents and adults. Sexually active teenagers face considerable risk to their reproductive health from unintended pregnancy and STIs including infection with HIV. Although health professionals often are primarily concerned with the potentially serious consequences of adolescent sexual behavior, we also recognize that sexuality is integral to human nature and has many positive mental health consequences.

Abstinence, as the term is used by program planners and policymakers, is often not clearly defined in behavioral terms, nor is the term used consistently. Abstinence may be defined in behavioral terms, such as “postponing sex” or “never had vaginal sex,” or refraining from further sexual intercourse if sexually experienced. Programmatically, abstinence is also frequently defined in moral terms, using language such as “chaste” or “virgin,” and framing abstinence as an attitude or a commitment in addition to a behavior [1]. Federal regulations for state abstinence education funding adopt a moral definition of abstinence, requiring that abstinence education “teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity” [2].

Although abstinence until marriage is the goal of many abstinence policies and programs, few Americans wait until marriage to initiate sexual intercourse. Recent data indicate that the median age at first intercourse for women was 17.4 years, whereas the median age at first marriage was 25.3 years [3,4]. For men, the corresponding median age at first intercourse was 17.7 years, whereas the age at first marriage was 27.1 years [3,4].

Although advocates of abstinence-only government policy have suggested that psychological harm is a consequence of sexual behavior during adolescence, there are no scientific data suggesting that consensual sex between adolescents is harmful. Mental health problems are associated with early sexual activity, but these studies suggest that sexual activity is a consequence not a cause of these mental health problems [5–8]. We know little about how the decision to remain abstinent until marriage may promote personal resilience or sexual function/dysfunction in adulthood.

Opinion polls suggest considerable support for abstinence as a public health goal, but also indicate strong support for education about contraception and for access to contraception for sexually active teenagers [9]. Most teens (94%) and adults (91%) think it is somewhat or very important for society to give teens a strong message that they should not have sex until they are at least out of high school [9]. However, most adults (75%) and teens (81%) want young people to receive more information about both abstinence and contraception [9].

Current federal policy and programs

The federal government has greatly expanded support for abstinence-only programs since 1996. This support includes funding to states provided under Section 510 of the Social Security Act, originally enacted in 1996, and under Community-Based Abstinence Education projects, funded through the Special Projects of Regional and National Significance (SPRANS) program established in 2000. These programs focus on a restricted vision of abstinence promotion and prohibit disseminating information on contraceptive services, sexual orientation and gender identity, and other aspects of human sexuality [10]. Federal funding language promotes a specific moral viewpoint, not a public health approach. These federal programs present questionable and inaccurate opinions as fact, and specifically prohibit information about healthy alternatives to abstinence such as condom and other contraceptive use.

Section 510 programs must have as their “exclusive purpose” the promotion of abstinence outside of marriage for people of any age and may not in any way advocate contraceptive use or discuss contraceptive methods except to emphasize their failure rates [10]. Section 510 provides an eight-point definition of abstinence-only education. Under Section 510, abstinence education is defined as *an educational or motivational program which:*

1. has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
2. teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;

3. teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
4. teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;
5. teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
6. teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;
7. teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
8. teaches the importance of attaining self-sufficiency before engaging in sexual activity.

The initial implementation of Section 510 has allowed funded programs to emphasize different aspects of these eight points as long as the program did not contradict any of them. The intent of the SPRANS program has been more rigid: to create “authentic” abstinence-only programs, in response to concerns that states were using funds for “soft” activities such as media campaigns instead of direct classroom instruction and were targeting younger adolescents. Programs funded under SPRANS must teach all eight components of the federal definition, they must target 12–18-year-olds, and, except in limited circumstances, they cannot provide young people they serve with information about contraception or safer-sex practices, even with their own nonfederal funds. Funding for this program also bypasses the 510 program’s state approval processes and makes grants directly to community-based organizations, including faith-based organizations. Virtually all the growth in funding since FY2001 has come in the SPRANS program.

Evaluations of abstinence-only education and comprehensive sexuality education programs in promoting abstinence

To demonstrate efficacy, evaluations of specific abstinence promotion programs must address a variety of methodological issues including clear definitions of abstinence, appropriate research design, measurement issues including social desirability bias, the use of behavioral changes and not just attitudes as outcomes, and biological outcomes such as STIs [11]. Two recent reviews [12,13] have evaluated the evidence supporting abstinence-only programs and comprehensive sexuality education programs designed to promote abstinence. Neither review found scientific evidence that abstinence-only programs demonstrate efficacy in delaying initiation of sexual intercourse. Likewise, research on adolescents taking virginity pledges suggest that failure rates

for the pledge are very high, especially when biological outcomes such as STIs are considered [14]. Although it has been suggested that abstinence-only education is 100% effective, these studies suggest that, in actual practice, efficacy may approach zero.

A recent Congressional committee report [15] found evidence of major errors and distortions of public health information in common abstinence-only curricula. Eleven of the 13 curricula contained false, misleading, or distorted information about reproductive health, including inaccurate information about contraceptive effectiveness and risks of abortion. The report found that several of the curricula handle stereotypes about girls and boys as scientific fact (e.g., portraying girls as weak or dependent or men as sexually aggressive and lacking emotional depth) or blur religious and scientific viewpoints.

A rigorous national evaluation of abstinence-only education is currently being conducted with support from the Department of Health and Human Service's Office of the Assistant Secretary for Planning and Evaluation [16].

Adverse impact of abstinence-only policies on sexuality education and other public programs

Although health professionals have broadly supported comprehensive sexuality education [17–20], increasingly abstinence-only education is replacing more comprehensive forms of sex education in the nation's schools. Recent reports describe teachers and students being censured for responding to questions or discussing sexuality topics that are not approved by the school administrators [21]. Data from the School Health Policies and Programs Study in 2000 found that 92% of middle and junior high schools and 96% of high schools taught abstinence as the best way to avoid pregnancy, HIV, and STIs; only 21% of middle schools and 55% of high schools taught how to correctly use a condom [22]. Between 1988 and 1999, there was a sharp decline in the percentage of teachers who supported teaching about birth control, abortion, and sexual orientation and in the percentages who actually taught these subjects [23]. In 1999, 23% of secondary school sexuality education teachers taught abstinence as the only way to prevent pregnancy and STIs, compared with only 2% who had done so in 1988. In 1999, one-quarter of sex education teachers said they were prohibited from teaching about contraception. Similar declines in school-based sexuality education are reported by teens [3]. In 2002, about one-third of teens 15–19-year-olds reported not having received any formal instruction about methods of birth control before turning 18.

Likewise, federal funding requirements in the Title X program and for HIV/AIDS prevention programs have increasingly focused on abstinence promotion [24]. Such requirements have redirected efforts from other important objectives.

Abstinence-only policies by the U.S. government have

also influenced global HIV prevention efforts. The President's Emergency Plan for AIDS Relief (PEPFAR), focusing on 15 HIV-afflicted countries in sub-Saharan Africa, the Caribbean and Asia, requires grantees to devote at least 33% of prevention spending to abstinence-until-marriage programs. The U.S. government policy has become a source for misinformation and censorship in these countries and also may have reduced condom availability and access to accurate HIV/AIDS information [25].

Abstinence-only sex education and sexually active and GLBTQ youth

Programs geared to adolescents who have not yet engaged in coitus systematically ignore sexually experienced adolescents, a group with different reproductive health needs who likely require a different approach to abstinence education [26]. Sexually experienced teens need access to complete and accurate information about contraception, legal rights to health care, and ways to access reproductive health services, none of which are provided in abstinence-only programs.

Likewise, federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning (GLBTQ) youth because federal law limits the definition of marriage to heterosexual couples. Approximately 2.5% of high school youth self-identify as gay, lesbian or bisexual [27] and as many as one in 10 teenagers struggle with issues regarding sexual orientation [28]. GLBTQ adolescents often are fearful of rejection or discrimination due to their orientation; they are frequently subjected to harassment, discrimination, and violence. Homophobia may contribute to health problems such as suicide, feelings of isolation and loneliness, HIV infection, substance abuse and violence among GLBTQ youth [29]. Abstinence-only sex education classes are unlikely to meet the health needs of GLBTQ youth, as they largely ignore issues surrounding homosexuality (except when discussing transmission of HIV/AIDS), and often stigmatize homosexuality as deviant and unnatural behavior [30].

The human right to sexual health information

Although abstinence is often presented as the moral choice for teenagers, the current federal approach to abstinence-only funding raises serious ethical and human rights concerns. Abstinence-only education policies have implications at a public and individual level. Access to complete and accurate HIV/AIDS and sexual health information is a basic human right and is essential to realizing the human right to the highest attainable standard of health. Governments have an obligation to provide accurate information to their citizens and eschew the provision of misinformation; such obligations extend to state-supported health education and health care services [31]. These legal guar-

antees are found in a number of international treaties, which provide that all people have the right to “seek, receive and impart information and ideas of all kinds,” including information about their health [32–34]. Access to accurate health information is a basic human right that has also been described in international statements on reproductive rights such as the Programme of Action of the International Conference on Population and Development—Cairo, 1994 [35]. These international treaties and statements clearly define the important responsibility of governments to provide accurate and complete information on sexual health to their citizens.

Ethical obligations of health care providers and health educators

Health care providers and health educators have ethical obligations to provide accurate health information. Patients and students have rights to accurate and complete information from health professionals. Health care providers may not withhold information from a patient in order to influence their health care choices. It is unethical to provide misinformation or withhold information about sexual health that teens need in order to protect themselves from STIs and unintended pregnancy. Withholding information on contraception to influence adolescents to become abstinent is inherently coercive and may cause teenagers to use ineffective (or no) protection against pregnancy and STIs. Current federal abstinence-only legislation is ethically problematic, as it excludes accurate information about contraception, misinforms by overemphasizing or misstating the risks of contraception, and fails to require the use of scientifically accurate information while promoting approaches of questionable value. Additionally, “abstinence until marriage” curricula are commonly provided to those teens who are already sexually experienced and to GLBTQ youth, ignoring their pressing needs for accurate information to protect their health. These ethical obligations to provide complete and accurate information also are the basis for the strong support among medical professionals for comprehensive sexuality education in schools [17–19] and recent state legislative attempts to require that these sexuality education programs provide medically accurate information [e.g., Cal. Education Code § 51933].

Positions of the Society for Adolescent Medicine (SAM)

- Abstinence is a healthy choice for adolescents. The choice for abstinence should not be coerced. SAM supports a comprehensive approach to sexual risk reduction including abstinence as well as correct and consistent use of condoms and contraception among teens who choose to be sexually active.

- Efforts to promote abstinence should be provided within health education programs that provide adolescents with complete and accurate information about sexual health, including information about concepts of healthy sexuality, sexual orientation and tolerance, personal responsibility, risks of HIV and other STIs and unwanted pregnancy, access to reproductive health care, and benefits and risks of condoms and other contraceptive methods.
- Individualized counseling about abstinence and sexual risk reduction are important components of clinical care for teenagers.
- Health educators and clinicians caring for adolescents should promote social and cultural sensitivity to sexually active youth and gay, lesbian, bisexual, transgendered and questioning youth. Health education curricula should also reflect such sensitivity.
- Governments and schools should eliminate censorship of information related to human sexual health.
- Government policy regarding sexual and reproductive health education should be science-based. Governments should increase support for evaluation of programs to promote abstinence and reduce sexual risk, including school-based interventions, media efforts and clinic-based interventions. Such evaluations should utilize rigorous research methods and should assess the behavioral impact as well as STIs and pregnancy outcomes. The results of such evaluations should be made available to the public in an expeditious manner.
- Current U.S. federal law and guidelines regarding abstinence-only funding are ethically flawed and interfere with fundamental human rights. Current federal funding requirements as outlined in Subsections A–H of Section 510 of the Social Security Act should be repealed. Current funding for abstinence-only programs should be replaced with funding for programs that offer comprehensive, medically accurate sexuality education.

Endorsement

This position paper has been endorsed by the American College Health Association.

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Explaining Recent Declines in Adolescent Pregnancy in the United States: The Contribution of Abstinence and Improved Contraceptive Use

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In recent years, the United States has had the highest rate of adolescent pregnancy of any of the world's developed nations.^{1,2} However, since 1991 these rates have declined dramatically. Pregnancy rates among 15- to 19-year-olds declined 27% from 1991 to 2000,³ and birth rates (for which more recent published data are available) dropped 33% between 1991 and 2003.⁴

The pattern of decline in US birth rates among adolescents is considerably different from the pattern in non-English-speaking European countries, where adolescent pregnancy rates peaked between 1965 and 1980 and then dropped dramatically.⁵ Little of the decline in Europe seems attributable to delay in initiation of sexual intercourse, given that the median age at initiation has fallen since 1965, indicating that more teens were having sex.^{1,5} In fact, the age at which young people initiate sexual activity has become increasingly similar across developed countries.^{1,5} A mid-1990s analysis of 5 developed countries showed that adolescents in the United States initiated sexual activity at an age similar to that of adolescents in Sweden, France, Canada, and Great Britain but that they used contraceptives less frequently.⁶

Reductions in adolescent pregnancy rates are the result of shifts in 2 key underlying behaviors: sexual activity and contraceptive use. Between 1971 and 1988, age at sexual initiation among US teenagers became increasingly younger, as demonstrated by increases in the proportion of adolescents who had ever experienced coitus.⁷⁻⁹ At the beginning of the 1990s this trend reversed, and declines in early sexual experience have since been documented in both school-based and household surveys.¹⁰⁻¹²

Social conservatives in the United States have ascribed much of the recent decline in adolescent pregnancy rates to increased

Objectives. We explored the relative contributions of declining sexual activity and improved contraceptive use to the recent decline in adolescent pregnancy rates in the United States.

Methods. We used data from 1995 and 2002 for women 15 to 19 years of age to develop 2 indexes: the contraceptive risk index, summarizing the overall effectiveness of contraceptive use among sexually active adolescents (including nonuse), and the overall pregnancy risk index, calculated according to the contraceptive risk index score and the percentage of individuals reporting sexual activity.

Results. The contraceptive risk index declined 34% overall and 46% among adolescents aged 15 to 17 years. Improvements in contraceptive use included increases in the use of condoms, birth control pills, withdrawal, and multiple methods and a decline in nonuse. The overall pregnancy risk index declined 38%, with 86% of the decline attributable to improved contraceptive use. Among adolescents aged 15 to 17 years, 77% of the decline in pregnancy risk was attributable to improved contraceptive use.

Conclusions. The decline in US adolescent pregnancy rates appears to be following the patterns observed in other developed countries, where improved contraceptive use has been the primary determinant of declining rates. (*Am J Public Health*. 2007;97:150-156. doi:10.2105/AJPH.2006.089169)

abstinence from sexual intercourse.¹³ Consequently, the US government now promotes abstinence until marriage ("abstinence only") as its primary prevention message for teenagers.¹⁴ Federal government requirements for abstinence-only programs specify that these programs must have as their "exclusive purpose" the promotion of abstinence outside of marriage and that they must not, in any way, advocate contraceptive use or discuss contraceptive methods other than to emphasize their failure rates.¹⁵

Federal government funding for abstinence-only education in the United States has grown rapidly since 1998, despite a lack of scientific evidence in support of these programs and concerns about their informational content and ethical acceptability.^{13,14} In addition, the federal government, through its foreign aid programs, has vigorously promoted abstinence as a means of preventing HIV infection among adolescents.¹⁵

In a previous analysis, we examined nationally representative data derived from samples

of US high-school students in an attempt to understand declining adolescent pregnancy rates.¹⁶ We found significant increases in use of contraception among 15- to 17-year-olds between 1991 and 2001 and estimated that improved contraceptive use and delay in initiation of intercourse made equal contributions to declining pregnancy rates.

In an effort to update that study, we conducted a more comprehensive analysis of the roles of increased contraceptive use and delayed initiation of sexual activity in explaining changes in pregnancy risk over the period 1995 to 2002 among young people aged 15 to 19 years. We used data from the 1995 and 2002 versions of the National Survey of Family Growth (NSFG), a nationally representative household survey that provides more complete coverage of female adolescents (particularly older adolescents and those who are out of school) than high-school surveys. The NSFG also provides detailed information about contraceptive use, allowing assessment of trends in dual- and

multiple-method use, which can greatly reduce pregnancy risk.

METHODS

Data

The NSFG is a periodic (every 7 years) national probability survey conducted among noninstitutionalized adult (15–44 years of age) residents of the United States.¹⁷ Our analyses were limited to young women who were aged 15 to 19 years at the time they were interviewed in 1995 (n=1396) or 2002 (n=1150). Further information about the design of the NSFG is available elsewhere (<http://www.cdc.gov/nchs/nsfg.htm>).

Measures

Sexual activity and contraceptive use. We recoded the publicly available NSFG data to increase the comparability of the relevant measures in the 2 waves of data collection. Our analyses were based on 2 central measures: recent sexual activity and contraceptive use at most recent intercourse. Young women who had engaged in vaginal intercourse at any point during the 3 months before the interview were defined as having been recently sexually active. For comparison purposes, we also examined the percentage of young women in each group who were sexually experienced (i.e., had ever engaged in vaginal intercourse).

We assessed contraceptive use at most recent sexual intercourse only among women who had been sexually active in the preceding 3 months, reducing measurement issues related to recall. Women could report use of up to 4 contraceptive methods in combination at their most recent sexual intercourse or no contraceptive use. Young women who were pregnant at the time of the interview (55 in 1995, 32 in 2002) were coded as having used the contraceptive method they were using when they became pregnant (most were using no method); these data were collected in a separate section of the interview in which detailed histories were obtained.

Contraceptive failure rates. In addition to the sexual activity and contraceptive use measures, our calculations required measures of method-specific contraceptive failure rates (CFRs). A "typical-use" CFR is the number of

pregnancies occurring among 100 women using a specific contraceptive method over a 12-month period. We used published CFRs for women's first year of typical use based on the 1988 and 1995 versions of the NSFG, adjusted for underreporting of abortion.¹⁸ Failure rates from the 2002 NSFG were not available at the time this article was written.

The failure rate for nonuse of contraception was based on widely accepted data provided by Trussell.¹⁹ We estimated failure rates for combined method use at most recent intercourse by multiplying the method-specific failure rates calculated for the 2 methods. Although women could report simultaneous use of up to 4 contraceptive methods, we limited our failure rate calculations to the 2 most effective methods.

Risk indices. We created 2 related indexes for this study: (1) the contraceptive risk index, a weighted-average contraceptive use/nonuse pregnancy risk index (the same as our previously labeled weighted-average contraceptive failure rate index²⁰), and (2) the overall pregnancy risk index. The contraceptive risk index summarizes the overall effectiveness of a group's contraceptive use and essentially represents pregnancy risk for the sexually active proportion of that population by summing the product of each method-specific failure rate and the proportion of those who are sexually active using that method at their most recent sexual intercourse.^{19,20} In these calculations, nonuse of contraception was considered a "method" involving a specific risk of pregnancy. Thus, here the contraceptive risk index can be represented as follows: $\sum(\text{percentage of sexually active women using method } x \times \text{CFR for method } x)$, where x = each specific method or method combination. (The CFR for each method is reported in Table 2.)

The overall pregnancy risk index summarizes the risk of pregnancy among all adolescents (including those who are not currently sexually active), incorporating information about both the level of recent sexual activity and the level of contraceptive risk among those who were sexually active at the time of the study. Thus, the overall pregnancy risk can be defined as follows: percentage of women who were sexually active multiplied by contraceptive risk index

Data on pregnancies. We used data on 1991 to 2000 pregnancy and birth rates obtained from the National Center for Health Statistics to compare our measure of overall pregnancy risk with actual pregnancy rates.³ The pregnancy rates for 2001 were computed using the same method employed by the National Center for Health Statistics. To estimate pregnancy rates for 2002, we calculated a linear extrapolation based on changes from 1995 to 2001.

Analysis

We initially estimated, for both 1995 and 2002, the percentages of female adolescents who were sexually active. We then tested for changes in percentage over time overall and by age and race/ethnicity. Next, we measured the specific contraceptive methods these young women had used at their most recent sexual intercourse, as well as the number of methods they had used and common method combinations. Each sexually active woman was assigned an individual contraceptive risk score on the basis of the 2 most effective contraceptive methods she had used at her most recent sexual intercourse. We used this information to calculate the mean and variance of the contraceptive risk index and test for changes in the index between 1995 and 2002, both overall and separately according to age and race/ethnicity.

In the next part of our analysis, we calculated age- and race/ethnicity-specific changes over time in overall pregnancy risk index values. We computed standard errors and tests of statistical significance using the *svy* series of commands in Stata 8.2 (Stata Corp, College Station, Tex) to account for the stratified survey designs.²⁰ To calculate the mean and variance for the overall pregnancy risk index, we assigned sexually active teenagers a value equal to this contraceptive risk score and assigned those not sexually active a score of zero. Implicit in this index is the fact that adolescents who were not sexually active at the time of the study, even if they had previously been sexually active, did not face a current risk of pregnancy.

Finally, we decomposed the overall pregnancy risk index into its component parts to describe the decline in pregnancy risk from 1995 to 2002 to changes in sexual activity and changes in contraceptive use. The percentage

of the decline in pregnancy rate because of the decline in sexual activity was calculated as

$$(1) \frac{\log(SA_{2002}/SA_{1995})}{\log(SA_{2002}/SA_{1995}) + \log\left[\frac{(CRI_{2002})^3/(CRI_{1995})^3}{(SA_{2002}/SA_{1995})}\right]} \times 100,$$

where *SA* represents the percentage of sexually active young women and *CRI* represents the contraceptive risk index. Similarly, the percentage of the decline in pregnancy rate because of improved contraceptive use was calculated as

$$(2) \frac{\log\left[\frac{(CRI_{2002})^3/(CRI_{1995})^3}{(SA_{2002}/SA_{1995})}\right]}{\log(SA_{2002}/SA_{1995}) + \log\left[\frac{(CRI_{2002})^3/(CRI_{1995})^3}{(SA_{2002}/SA_{1995})}\right]} \times 100.$$

This method produced results that were nearly identical to those obtained with an alternative approach suggested by Preston et al.²¹ We used a bootstrapping procedure with 500 iterations to calculate confidence intervals (CIs) for percentage changes because of sexual activity and percentage changes because of contraceptive use.

RESULTS

Between 1995 and 2002, the number of young women aged 15 to 19 years who had

ever engaged in sexual intercourse declined 10% (52% to 47%; $P=.035$; Table 1). There was a 22% decline in the 15- to 17-year-old group ($P=.003$), and there was no change among 18- and 19-year-olds (71% at both time points). The number of young Hispanic women who had ever engaged in sexual intercourse declined ($P=.003$), but there was no significant change among young non-Hispanic White ($P=.156$) or Black ($P=.415$) women.

More relevant to this analysis, rates of sexual activity (i.e., sexual intercourse during the preceding 3 months) did not decline significantly among either 15- to 19-year-olds (41% to 38%; $P=.244$) or 18- and 19-year-olds. Among 15- to 17-year-olds, the decline in sexual activity (28% to 23%) was of borderline statistical significance ($P=.065$). Hispanic 15- to 19-year-olds exhibited a decline from 46% to 35% ($P=.032$). Again, no significant change was found for non-Hispanic Whites or Blacks in that age group. In general, we found smaller changes in recent sexual intercourse, as a result of small, nonsignificant

increases in sexual activity among sexually experienced teenagers.

Dramatic improvements in contraceptive use occurred between 1995 and 2002, including increases in the use of individual methods, increases in the use of multiple methods, and declines in nonuse (Table 2). Improvements associated with individual methods included increases in the use of condoms (36% to 53%), birth control pills (24% to 33%), injection methods (8% to 10%), and withdrawal (7% to 12%). Use of Norplant ceased after its removal from the US market. The rate of nonuse declined from 34% to 18%. Use of 2 or more methods increased from 11% to 26%. The most common combinations of contraceptive methods used in 2002 included pills and condoms, condoms and withdrawal, pills and withdrawal, and injection and condoms. Overall, the contraceptive risk index declined 34% ($P<.001$).

Improvements in contraceptive use among 15- to 17-year-olds were even larger than changes among 15- to 19-year-olds. The rate of condom use increased from 38% to 58%, whereas pill use increased from 19% to 39%. Nonuse declined from 35% to 14%. Use of 2 or more methods rose from 12% to 33%, the most common combination being use of the pill and condom simultaneously (22%). The contraceptive risk index declined 46% ($P<.001$). Although the increase in contraceptive use was not as dramatic among 18- and 19-year-olds, the decline in the contraceptive risk index (27%) was still considerable ($P=.004$), and the percentage in which 2 or more methods were used rose from 11% to 22%.

Large changes in contraceptive use were observed among non-Hispanic White women, with considerable increases in the use of individual methods and a dramatic decline in nonuse. The rate of condom use increased from 38% to 58%, and use of birth control pills increased from 29% to 40%. Use of 2 or more methods rose from 13% to 31%, and simultaneous pill and condom use rose from 9% to 17%. The contraceptive risk index declined 44% ($P<.001$). The data for non-Hispanic Blacks and Hispanics shown in Table 2 should be considered with caution given the small sample sizes for these groups in both years.

TABLE 1—Percentages of Young Women Aged 15–19 Years Engaging in Sexual Intercourse: National Survey of Family Growth, 1995 and 2002

	1995	2002	Change, 1995–2002, %	P
	No. (%)	No. (%)		
History of sexual intercourse				
Age group, y				
Overall	1396 (51.7)	1150 (46.8)	-9.5	.035
15–17	815 (38.6)	674 (30.3)	-21.5	.003
18–19	581 (71.1)	476 (70.5)	-0.8	.853
Race/ethnicity				
White non-Hispanic	842 (50.9)	613 (46.4)	-8.7	.156
Black non-Hispanic	289 (60.4)	242 (57.0)	-5.8	.415
Hispanic	210 (56.4)	231 (40.4)	-28.4	.003
Recent sexual intercourse*				
Age group, y				
Overall	1387 (40.5)	1149 (37.9)	-6.4	.244
15–17	808 (28.2)	673 (23.4)	-17.0	.065
18–19	579 (58.9)	476 (58.9)	0.0	.999
Race/ethnicity				
White non-Hispanic	837 (40.1)	613 (38.4)	-4.2	.543
Black non-Hispanic	288 (46.9)	241 (41.3)	-12.0	.240
Hispanic	207 (45.7)	231 (34.5)	-24.5	.032

*Defined as within the past 3 months.

RESEARCH AND PRACTICE

TABLE 2—Percentages of Sexually Active Young Women Aged 15–19 Years Who Used Selected Contraceptive Methods at Most Recent Sexual Intercourse and Contraceptive Failure Rates Risk Scores: National Survey of Family Growth, 1995 and 2002

Contraceptive Failure Rate	15–19 Years		15–17 Years		18–19 Years		White Non-Hispanic		Black Non-Hispanic		Hispanic		
	1995	2002	1995	2002	1995	2002	1995	2002	1995	2002	1995	2002	
Method, %													
Condom	13.7	35.7	53.0	38.4	58.3	33.7	50.0	38.4	58.0	37.9	52.7	19.6	30.6
Birth control pill	7.5	23.7	32.5	19.3	38.7	26.8	28.8	28.9	39.7	14.5	24.1	14.1	18.3
Injection	3.5	7.6	9.9	9.2	9.4	6.4	10.2	5.5	7.9	14.7	19.9	8.4	7.8
Norplant	3.5	2.2	0.0	1.8	0.0	2.4	0.0	1.4	0.0	3.2	0.0	4.6	0.0
Withdrawal	24.5	6.7	12.2	6.6	11.5	6.9	12.7	7.7	13.9	2.5	3.6	6.0	8.4
Rhythm	22.9	0.7	0.9	0.0	0.7	1.2	1.0	0.2	1.3	1.7	0.0	1.3	0.0
Vasectomy	0.2	0.2	0.0	0.0	0.0	0.3	0.0	0.3	0.0	0.0	0.0	0.0	0.0
Patch	8.0 ^a	0.0	0.4	0.0	0.0	0.0	0.6	0.0	0.3	0.0	1.0	0.0	0.0
Intrauterine device	3.5	0.0	0.6	0.0	0.6	0.0	0.6	0.0	0.0	0.0	0.0	0.0	1.5
Diaphragm	13.1	0.0	0.2	0.0	0.6	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0
Spermicide	27.6	1.0	0.8	0.0	0.2	0.7	1.1	1.1	1.1	1.0	0.0	0.0	0.0
No method	85.0 ^a	33.9	18.3	35.4	14.3	32.8	20.7	30.7	12.2	33.3	24.8	50.2	39.6
Sexually active, no	560	444	228	156	332	288	327	240	135	98	89	84	
Common method combinations, %													
Pill + condom	1.0	7.0	14.2	6.1	21.9	7.6	9.7	8.9	17.4	4.8	14.3	0.7	3.0
Pill + withdrawal	1.8	1.3	2.6	1.1	3.6	1.3	2.0	1.7	4.0	0.0	0.0	1.2	0.0
Withdrawal + condom	3.4	1.7	3.6	2.0	3.0	1.5	3.9	2.0	4.2	0.0	2.0	2.4	1.4
Injection + condom	0.5	0.5	3.3	1.1	2.6	0.1	3.7	0.0	2.5	2.6	8.8	0.0	0.7
Patch + condom	1.1	0.0	0.4	0.0	0.0	0.0	0.6	0.0	0.3	0.0	1.0	0.0	0.0
No. of methods used, %													
0		33.9	18.3	35.4	14.3	32.8	20.7	30.7	12.2	33.3	24.8	50.2	39.6
≥1		66.1	81.7	64.6	85.7	67.2	79.3	69.3	87.8	66.7	75.2	49.8	60.4
≥2		11.2	26.1	11.5	32.7	10.9	22.2	13.4	30.9	8.8	26.2	4.3	5.0
≥3		0.5	2.3	0.5	1.5	0.6	2.7	0.8	3.3	0.0	0.0	0.0	1.1
4		0.0	0.4	0.0	0.0	0.0	0.6	0.0	0.6	0.0	0.0	0.0	0.0
Contraceptive risk index ^b		33.8	22.3	34.4	18.6	33.3	24.4	31.1	17.3	34.0	26.5	45.6	39.5
Change, 1995–2002, %			-34.0		-45.9		-26.8		-44.3		-22.1		-13.4
t test			4.74		4.47		2.87		5.05		1.42		0.82
P			<.001		<.001		.004		<.001		.158		.413

Note. Typical-use first-year contraceptive failure rates are from Ranjit et al.¹⁸ unless otherwise noted.

^aFrom Trussell.¹⁹

^bWeighted-average contraceptive use or nonuse risk score, abbreviated as contraceptive risk index.

As described in the "Methods" section, the overall pregnancy risk index combined the impact of changes in sexual activity and contraceptive use (Table 3). Overall, pregnancy risk declined 38% (95% CI=23%, 54%), from 13.7 to 8.4. The decline was larger among 15- to 17-year-olds (55%, from 9.7 to 4.4) than among 18- and 19-year-olds (27%, from 19.6 to 14.4). The change in the overall pregnancy risk index observed among non-Hispanic Whites was significant, however, given the small numbers of non-Hispanic

Blacks and Hispanics, changes were of borderline statistical significance for both groups. (Note that, in each case, the decline in actual birth and pregnancy rates fell within the confidence intervals for the change in pregnancy risk. This represents one way to validate the calculation of our overall pregnancy risk index.)

Table 4 summarizes changes between 1995 and 2002 in key components of pregnancy risk and also displays the overall percentages of change that could be attributed to

changes in the 2 key components: sexual activity and contraceptive use. As Table 4 demonstrates, the largest changes in behaviors and pregnancy risks were observed among 15- to 17-year-olds. This finding is consistent with the largest changes in actual pregnancy rates occurring among younger teenagers.

We estimated that 14% of the change observed among 15- to 19-year-olds was attributable to a decrease in the percentage of sexually active young women (95% CI=-18%, 34%) and that 86% was attributable to

TABLE 3—Changes in Pregnancy Risk, by Age and Race/Ethnicity: National Survey of Family Growth, 1995 and 2002

	15-19 Years	15-17 Years	18-19 Years	White, Non-Hispanic	Black, Non-Hispanic	Hispanic
Change, 1995-2002, % (95% confidence interval)	-38.3 (-22.7, -53.9)	-55.2 (-33.1, -77.2)	-26.7 (-6.5, -46.8)	-46.7 (-27.4, -65.9)	-31.5 (-0.1, -63.0)	-34.2 (4.0, -72.4)
t test	4.81	4.90	2.60	4.74	1.97	1.75
P	<.001	<.001	.010	<.001	.05	.08
Change in birth rate, %	-23.2	-34.6	-17.0	-27.5	-29.7	-16.0
Change in pregnancy rate, % ^a	-23.5	-35.5	-17.3			

^aData for 2002 not available; change extrapolated from trend between 1995 and 2001.

TABLE 4—Summary of Changes in Sexual Activity and Risk Index Values and Overall Changes Attributable to Sexual Activity and Contraceptive Use: National Survey of Family Growth, 1995 and 2002

	15-19 Years, Change, %	15-17 Years, Change, %	18-19 Years, Change, %	White, Non-Hispanic, Change, %	Black, Non-Hispanic, Change, %	Hispanic, Change, %
Sexual activity	-6.4	-16.9	0.0	-4.2	-12.0	-24.5
Contraceptive risk index	-34.0	-45.9	-26.8	-44.3	-22.1	-13.4
Overall pregnancy risk index	-38.3	-55.2	-26.7	-46.7	-31.5	-34.2
Overall change attributable to sexual activity (95% CI)	14 (-18, 34)	23 (-6, 45)	0 (-99, 37)	7 (-28, 26)	34 (-125, 172)	66 (-110, 236)
Overall change attributable to contraceptive use (95% CI)	86 (66, 118)	77 (55, 108)	100 (63, 199)	93 (74, 128)	66 (-72, 225)	34 (-136, 210)

Note. CI = confidence interval.

changes in contraceptive method use (95% CI = 66%, 118%); the corresponding percentages among 15- to 17-year-olds were 23% (95% CI = -6%, 45%) and 77% (95% CI = 55%, 106%). (Confidence intervals for attributions [and the attributions themselves] may in theory be below 0% or above 100% because one of the 2 changes may have actually been in the opposite direction of the overall change. For example, if sexual activity actually increased in one group but contraceptive use and the overall pregnancy risk declined, sexual activity would have made a "negative" contribution to the decline in pregnancy risk, and contraceptive use would have been responsible for "more than" 100% of the change.) All of the change in pregnancy risk among 18- and 19-year-olds was the result of increased contraceptive use (95% CI = 63%, 199%).

Among non-Hispanic Whites, we estimated that 7% of the change was attributable to a decrease in the percentage of sexually active young women (95% CI = -28%, 26%) and that 93% was attributable to changes in contraceptive method use (95%

CI = 74%, 128%). As noted earlier, attributions for non-Hispanic Blacks and Hispanics (Table 4) should be interpreted with caution given the limited sample sizes and large confidence intervals.

DISCUSSION

Our data suggest that declining adolescent pregnancy rates in the United States between 1995 and 2002 were primarily attributable to improved contraceptive use. The decline in pregnancy risk among 18- and 19-year-olds was entirely attributable to increased contraceptive use. Decreased sexual activity was responsible for about one quarter (23%) of the decline among 15- to 17-year-olds, and increased contraceptive use was responsible for the remainder (77%). Improved contraceptive use included increases in the use of many individual methods, increases in the use of multiple methods, and substantial declines in nonuse.

These data suggest that the United States appears to be following patterns seen in other developed countries where increased

availability and increased use of modern contraceptives have been primarily responsible for declines in adolescent pregnancy rates.¹ Our findings raise questions about current US government policies that promote abstinence from sexual activity as the primary strategy to prevent adolescent pregnancy.

Other scientific data also challenge the federal government's efforts to promote abstinence-only strategies. The limited evaluations of abstinence-only sex education programs provide no evidence that they are successful in delaying initiation of sexual intercourse.²² Although abstinence is theoretically highly effective in preventing unintended pregnancies and sexually transmitted infections (STIs), in actual practice abstinence intentions often fail.^{14,23} Abstinence programs may undermine the promotion of other prevention behaviors. For example, a longitudinal examination of the virginity pledge movement showed that pledgers did delay initiation of sexual intercourse; however, they were less likely to use contraception when they initiated sexual activity and were less likely to seek STI screenings.²⁴

Identifying changes in the behaviors that result in adolescent pregnancy can provide some insight into the social forces that influence these behaviors. Increases in the use of multiple methods of contraception suggest an increased motivation to avoid pregnancy and STIs, which in turn suggest declines in the social acceptability of adolescent childbearing and increases in educational and employment opportunities. Increasing rates of condom use in the United States reflect continuing concerns about HIV infection and other STIs among adolescents.²⁵

Socially disadvantaged young people and their communities may increasingly see adolescent pregnancy as a barrier to improvements in life circumstances.²⁴ Adolescents who are also parents have become less socially acceptable.²⁷ Delays in initiation of sexual activity are traceable to many factors, including broad public support for delaying initiation of sexual intercourse at least until graduation from high school.²⁷ Ironically, the trend toward later initiation of sexual intercourse and declines in adolescent pregnancy appears to have preceded recent intensive efforts on the part of the US government to promote abstinence-only policies.³⁴

This study provides new and more comprehensive information on the factors underlying recent declines in US rates of adolescent pregnancy. Earlier studies involving NSFG data^{2,6,29,30} focused on the years 1988 to 1995, a period in which there were relatively small changes in rates of adolescent pregnancy. Data available from the 2002 NSFG allow exploration of behavioral changes during the period 1995 through 2002, when larger declines in rates occurred.

Our previous study involving 1991 to 2001 data on high-school students showed that both increased abstinence and increased contraceptive use contributed to the decline in pregnancy rates among 15- to 17-year-olds.¹⁹ Relative to school surveys, the NSFG includes more data on older teenagers and those who have left school and collects more detailed information about contraceptive use. In comparison with our school-based study, this analysis of the NSFG showed a larger contribution of contraceptive use to declines in adolescent pregnancy rates. We believe that these differences in attribution are the

result of differences in age groups and time periods, inclusion of young people who are not in school, and more complete measurement of contraceptive use.

Limitations

Our study had several limitations. When self-reported information is used, one must always consider the potential for over- and under-reporting. Adolescents are generally reliable reporters of information on sexual health.⁴¹ However, given increasing social pressure to delay sexual initiation and avoid pregnancy, adolescents may be more likely today than in the past to underreport sexual activity or overreport contraceptive use.

Although the overall NSFG sample size is adequate, sample sizes become problematically small in analyses of subgroups. This was particularly true for the Black and Hispanic subgroups, in which the numbers of sexually active young women fell below 100. Moreover, variance around changes in percentages or around attribution was much larger than variance around estimates for a single point in time. As such, care should be taken in interpreting our estimates for these smaller subgroups.

There appears to be a specific problem with instability in the NSFG data for Hispanic adolescents. In our analyses, the decline in sexual experience among Hispanic teenagers (from 56% to 40% in 7 years) was much larger than the changes observed in other groups. Likewise, a comparison of the 1988, 1995, and 2002 versions of the NSFG¹⁹ revealed wide differences over time in sexual experience estimates among young Hispanic women aged 15 to 17 years (35%, 49%, and 25%, respectively). These differences seem implausible and may have resulted from the limited sample size or other problems involved in sampling an ethnic group that is heterogeneous with respect to national origin and sexual mores.

We assumed that there were no changes in whether contraceptives were used correctly or in biological fecundity. Correct use of contraception can be assessed via measuring changes in typical-use CFRs. We used the most recent available failure rates (for 1995). Ranjiti et al. found no changes between 1988 and 1995 in typical-use CFRs (note that

questions about contraception use at most recent intercourse did assess consistency of use).¹⁸ No data are available to measure changes in biological fecundity among teenagers (or adults).

Implications

What policy recommendations arise from our results? Although more adolescents in the United States are delaying initiation of sexual intercourse, the impact of this change on pregnancy risk is small and confined to younger teenagers (i.e., 15- to 17-year-olds). Overall, increasing rates of contraceptive use appear to be the primary determinant of declining pregnancy rates between 1995 and 2002, and this assessment appears to be consistent with the pattern in other developed countries. Public policies and programs in the United States and elsewhere should vigorously promote provision of accurate information on contraception and on sexual behavior and relationships, support increased availability and accessibility of contraceptive services and supplies for adolescents, and promote the value of responsible and protective behaviors, including condom and contraceptive use and pregnancy planning.

Abstinence promotion is a worthwhile goal, particularly among younger teenagers; however, the scientific evidence shows that, in itself, it is insufficient to help adolescents prevent unintended pregnancies. The current emphasis of US domestic and global policies, which stress abstinence-only sex education to the exclusion of accurate information on contraception, is misguided. Similar approaches should not be adopted by other nations. ■

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This article was accepted August 25, 2006.

Contributors

J S Santelli originated the study and assumed primary responsibility for the writing of the article. L. Duberstein Landberg was the primary data analyst and was involved in the origination of the study. L. B. Finer

provided expertise on advanced statistical methods. S. Singh provided expertise on research methods and policy implications.

Acknowledgments

This study was supported by the Ford Foundation through the Guttmacher Institute (grant 1055-0169).

Human Participant Protection

The institutional review board at Columbia University declared this study exempt from protocol approval because the data were anonymous.

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Santelli, J.S., Lin, A.J. (2008, in press). The Accuracy of Condom Information in Three Selected Abstinence-Only Education Curricula. *Sexuality Research & Social Policy*, 5(2).

The Accuracy of Condom Information in Three Selected Abstinence-Only Education
Curricula

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Abstract: While previous reports identified inaccuracies in abstinence-only education, many do not detail the specific informational problems. Based on a review of three purposively-selected curricula used in federally-funded programs, we identified the types of scientific errors about condoms in abstinence-only education. These curricula explicitly and implicitly convey the message that condoms fail to provide protection against HIV. References were commonly out of date. In addition the curricula often misrepresented studies, for example only reporting the highest condom failure rates reported within a study. The curricula did not explain differences between typical use and perfect use contraceptive failure associated with condom use and often incorrectly compared HIV transmission risk and pregnancy risk. Finally, these curricula use faulty reasoning in explaining risk and promote misinformation about condoms (such as condom permeability) that have been repudiated by scientific consensus bodies. The information about condoms presented in these curricula does not represent complete, current, or accurate medical knowledge about the effectiveness of condoms in preventing sexually transmitted infections, including HIV.

Key words: sexuality education; abstinence education; adolescent health; medical accuracy, HIV, pregnancy

Condom promotion has been a central public health strategy in preventing HIV and other sexually transmitted infections (STIs). Research in the last decade has greatly advanced understanding of condom effectiveness in protecting against infection from HIV and other STIs. In 2000, the Public Health Service convened a group of scientists and policymakers to review scientific evidence for condom efficacy. This review, referred hereafter as the NIH Condom Report, found that when used correctly and consistently, condoms offer protection against HIV/AIDS, pregnancy, gonorrhea in men, and perhaps diseases caused by human papillomavirus (National Institute of Allergy and Infectious Diseases, 2001). The report also identified the paucity of data on the efficacy of condoms for many other STIs. Since that time additional peer-reviewed evidence has accumulated that suggests condoms provide protection against chlamydia, gonorrhea, syphilis and Herpes Simplex Virus type 2 (Casper & Wald, 2002; Holmes, Levine, & Weaver, 2004; Winer et al., 2006). Recent research also suggests that condoms may provide newly sexually active young women protection from HPV (Winer et al., 2006).

Beginning in 1998, the federal government greatly expanded its support for abstinence-only education (AOE) programs. Federally supported programs must have as their exclusive purpose the promotion of abstinence from sexual intercourse outside of marriage and may not in any way advocate contraceptive use or discuss contraceptive methods or condoms. The only exception to this restriction on contraceptive information is a provision that allows AOE programs to discuss failure rates for condoms and contraception (Administration for Children and Families, 2007; Dailard 2002; Haskins & Bevan, 1997).

In 2004, the minority staff from the Committee on Government Reform of the U.S. House of Representatives, published *The Content of Federally Funded Abstinence Education Programs*, often referenced as The Waxman Report. This was the first report to identify inaccuracies in AOE curricula supported by the federal government. This report found that eleven of the thirteen most commonly used AOE curricula contained misleading and incorrect scientific information about reproductive health including information about condoms and contraceptive efficacy and presented stereotypes of gender roles as facts (United States House of Representatives Committee on Government Reform, 2004). In 2006, the U.S. Government Accountability Office (GAO) issued two reports relating to scientific accuracy in federally funded AOE programs. The first report stated that the Department of Health and Human Services had not put in place a mechanism to review the medical accuracy of AOE programs (U.S. Government Accountability Office, 2006b). The second review suggested that AOE programs were legally required to provide accurate information about condoms under section 317p of Public Health Service Act, enacted in 2000 (U.S. Government Accountability Office, 2006a). While the federal government has neither required nor defined medical accuracy, over 20 states have recently instituted requirements for medical accuracy in regards to sexuality and HIV/AIDS education (Santelli, 2008 in press). Among these, seven states have specifically defined medical accuracy. Key elements of these state definitions include consideration of the weight of scientific evidence and the importance of scientific theory, peer review, and recognition by mainstream scientific and health organizations such as the American Academy of Pediatrics and the U.S. Centers for Disease Control and Prevention (Santelli, 2008 in press).

A recent federally sponsored, longitudinal evaluation of four exemplary AOE programs found no evidence of program efficacy in changing health behaviors but did find that youth in AOE programs, compared to those receiving usual sex education, had less confidence in condoms' abilities to protect from STIs, although no decline in actual condom use (Trenholm et al., 2007). This finding may reflect program restrictions on condom information or inaccuracies within the curricula about condoms.

In light of the continued federal funding for AOE programs and given concern about the scientific accuracy of information in these curricula, we reviewed three federally funded AOE curricula previously identified as containing problems with accurate information. We wished to explore the specifics of medical inaccuracies about condoms. An analysis of purposely-selected curricula, our findings cannot be generalized to all AOE programs; rather our finding should be considered illustrative of the types of inaccuracies that may be found in other AOE curricula.

Method

Three federally funded AOE curricula—*Me, My World, My Future* (published in 1998 by Teen-Aid Inc. for use by middle-school students); *Sexuality, Commitment and Family* (also published in 1998 by Teen-Aid Inc. for use by high school students); and *Why kNOw* (published in 2002 by AAA Women's Services for use by sixth grade through high school students)—were reviewed for medical accuracy with a focus on condom information (Frainie, 2002; Potter & Roach, 1998; Roach & Benn, 1998). *Me, My World, My Future* and *Sexuality, Commitment and Family* are collectively referred to as the Teen-Aid curricula in this article. Teachers' manuals which included the student portions and notes to instructors were used for this study. According to the Waxman Report, eight

Community Based Abstinence Education (CBAE) recipients were using the Teen Aid Curriculum, *Me, My World, My Future*, and seven were using *Why knOw*. These two curricula were part of the 13 most popular curricula funded by CBAE in 2001, out of 69 different curricula that were funded that year (United States House of Representatives Committee on Government Reform, 2004).

These three curricula were purposely selected, i.e., we were asked to review these curricula by the American Civil Liberties Union for medical inaccuracies. Findings from this original review were then presented by John Santelli's as a communication in the form of a legal Declaration from the ACLU to the Department of Health and Human Services (Santelli, 2007). These curricula were chosen because they were previously identified as containing medically inaccurate information and continued to receive federal funding. Thus, the purpose of this paper is to explore the nature of these inaccuracies and not to determine the prevalence of them.

We reviewed specific statements about condoms along with scientific references provided by the curricula. In addition, we conducted searches on Web of Science and Medline for peer-reviewed references on condom efficacy to identify both current medical understanding on this topic and understanding at the time each specific curriculum was published. Each statement involving condoms was placed into a matrix and assessed by both authors for accuracy. We inductively developed a typology to describe the types of inaccuracies we found, including information that was *out of date*, *selectively reported* from study, and *not peer reviewed* (Huberman & Miles, 2002). We also include an *other* category for less common errors that were not classifiable into the first three categories. *Out of date* represented statements whose source of information

were eclipsed by better research and improved understanding in the research literature. *Selectively reported* included instances where a single statistic or finding was taken out of the study context and was therefore not representative of the authors' overall conclusions. Statements based on references which were not peer reviewed were identified as *not peer reviewed*. The *other* category encompassed statements that were inaccurate for other reasons, such as nonparallel comparisons of statistics or concepts. Each inaccurate statement was categorized using this typology.

In addition, we sorted the statements about condoms into themes related to various aspects of condom use, including slippage and breakage, contraceptive efficacy of condoms, condom efficacy in preventing HIV transmission, youth as condom users, and condom availability and distribution programs. The section on condom slippage and breakage included statements relating to how often condoms break or slip off in a variety of clinical trials and population based studies. Statements about condom efficacy as a contraceptive were placed in the section about condoms and pregnancy, while those relating to the efficacy of condoms in reducing HIV transmission were put into the section on condoms and HIV transmission risk. Statements regarding youth's ability to use condoms and the usefulness of condom distribution programs are found respectively in the sections about youth as condom users and on condom availability and distribution programs. In the results section, we review examples of statements about condoms by these themes. We summarize and provide textual examples of the main medical inaccuracies relating to condoms and critique these statements. Finally, we provide two in-depth examples which illustrate multiple inaccuracies.

Findings

Condom Breakage and Slippage

All three curricula address condom breakage and slippage. In the scientific literature, a range of rates for condom slippage and breakage are reported. The NIH Condom Report reports:

Estimates of condom breakage from these [prospective] studies range from 0.4–2.3%. Slippage rates from these three studies ranged from 0.6% to 1.3%.

Slippage rates include both slippage during intercourse and slippage during withdrawal. The combined method failure (slippage plus breakage) is estimated at 1.6% – 3.6%. (National Institute of Allergy and Infectious Diseases, 2001, p. 9)

Similar rates are provided by more recent publications such as *Contraceptive Technology* (Trussell, 2004).

These rates are much lower and in a narrower range than those found in the Teen-Aid curricula. Rates of condom breakage and slippage reported in the Teen-Aid curricula ranged from 0.6% to 44.5%. The rate of 0.6% is qualified by stating that this was for female prostitutes. Rates ranging from 1.3% to 15.1% are presented as rates for “experienced and/or mutually monogamous adults.” Finally the rate of 44.5% is not qualified but, in context, appears to be data about the percent of time condoms break or slip over a year for unmarried Hispanic women (Roach & Benn, 1998, p. 257). In general, the curricula did not differentiate user and method failure in reporting condom breakage and slippage. By listing this wide range of slippage and breakage rates, the curricula seem to imply that condoms are not reliable.

Contraceptive Efficacy of Condoms

When used consistently and correctly, condoms are an effective method of contraception with a perfect use failure rate of 2% and typical use failure rate of 15% as reported across multiple studies (Trussell, 2004, National Institute of Allergy and Infectious Diseases, 2001). Contraceptive failure rates represent the number of women out of 100 who get pregnant within one year of use. Clarifying between perfect use failure rate and typical use failure rate are important when providing information about contraceptives. *Perfect use* rates represent failure rates when a method is used consistently and correctly; *typical use* failure rates reflects the failure of users to do so. Typical use rates generally are calculated for first year of use among new users and among those who are new to the method or are restarting a method. In general, failure rates are lower in subsequent years and among experienced users. Importantly, typical use failures include pregnancies occurring after a user forgot to take the pill as prescribed or when a couple intends to use condoms but fails to do so consistently.

The two Teen-Aid curricula often report the highest failure rates from cited studies, or confuse efficacy in preventing HIV and pregnancy. For instance, the teacher manual for Teen-Aid suggests that “*Contracting HIV is easier than getting pregnant because you can only get pregnant several days a month*” (Roach & Benn, 1998, p. 254). It is important to note that efficacy in HIV transmission and pregnancy prevention are not comparably calculated. In another place, Teen-Aid reports an average rate but also the two highest rates of contraceptive failure from a study: “*Condoms fail 15.7 percent of the time over the course of a year. This is a standardized failure rate—among some groups of women it has gone as high as 36.3 percent and 44.5 percent*” (Roach & Benn, 1998, p. 257).

The Why kNOw curriculum does not differentiate typical use from perfect use condom failure rates and selectively reports higher condom failure rates in stating that “*The condom has a 22.5 % failure rate in preventing pregnancy in unmarried women under the age of 20 during the first 12 months of use. (Fu, Darroch et al. 1999)*” (Frainie, 2002, p. 96). The user failure rate for women in the same age range and time period whose income was above 200% of poverty was 13.3% (Fu, Darroch et al., 1999). This lower rate is not reported.

These three curricula do not report perfect use, nor do they explain the difference between perfect use and typical use. Likewise, they do not explain that correct and consistent use of condoms will result in much lower contraceptive failure.

Condoms and HIV Transmission Risk

Evaluation of condom efficacy in preventing sexually transmitted infection is often methodologically difficult as is well described in the NIH Condom Report (National Institute of Allergy and Infectious Diseases, 2001). However, the best studies for calculating condom efficacy use HIV infection as an outcome. These estimates come from a series of longitudinal studies of HIV serodiscordant couples, where one member of a couple is infected with HIV and the other is not. These studies suggest that correct and consistent use of condoms substantially reduces the risk of HIV infection.

These studies have been systematically reviewed by Weller and Davis in three published meta-analyses (Weller, 1993; Davis and Weller, 1999; and Weller and Davis, 2002). The 1993 meta-analysis found that consistent use of condoms help prevent the transmission of HIV by 69% (Weller, 1993). The two more recent meta-analyses found that condoms afford greater protection. The 1999 analysis found that condoms reduce the

rate of HIV infection by 87% (0.9 per 100 person-years with a confidence interval of 0.4–1.8 for always-users and 6.8% per 100 person-years with a confidence interval of 4.4–10.1 for male to female transmission for never-users) and the 2002 analysis found an 80% reduction rate (1.14 per 100 person-years with a confidence interval of 0.56–2.04 for always-users and 5.75% per 100 person-years with a confidence interval of 3.16–9.66 for never-users) (Davis & Weller, 1999; Weller & Davis, 2002). The 2001 NIH Condom Report relied on the second of these meta-analyses (Davis and Weller, 1999). Their 2002 review for The Cochrane Collaboration is an update of the 1999 analysis which used stricter guidelines for study inclusion.

Despite the more recent estimates, *Why kNOw*, published in 2002 still references the 1993 meta analysis. The Teen-Aid curricula (published in 1998) also references the 1993 meta-analysis and it is unclear to us why Teen Aid has not revised their curricula given the scientific advances in understanding HIV and other STIs. In addition, Teen-Aid curricula report a 1987 study by Fischl et al. (Fischl et al., 1987), “*In one study of heterosexual couples where one partner is HIV infected, over an average of two years sexual exposure [sic] if latex condoms were relied upon, there was still a 10 to 23% risk of transmission of [HIV] infection even with training and proper useage*” (Potter & Roach, 1998, p.19; Roach & Benn, 1998, p. 256). In the Fischl study that the previous quote references, only 1 out of 10 couples who were using barrier protection seroconverted within the 2-year study period (Fischl et al., 1987). Importantly, the estimate of HIV transmission in this study is much higher than the estimate from the most recent meta-analysis by Weller and Davis: 1.14 per 100 person-years (Weller and Davis,

2002). Finally, these curricula do not address HIV transmission when the HIV status of a partner is unknown.

Even more ominous than this confusion about condom efficacy in preventing HIV infection, both Teen-Aid and *Why kNOw* curricula subtly suggest that condoms allow the transmission of HIV. This is addressed below in the teaching examples section.

Youth as Condom Users

Our review of contraceptive efficacy suggests that method-specific contraceptive failure rates for teenagers are similar to women in their twenties. For example, Ranjit, Bankole, Darroch, and Singh (2001) report that condom failure rates over the first two years of use, based on data from the 1988 and 1995 National Surveys for Family Growth, were 25.8% for those under 18 years, 27.5% for 18- to 19-year-olds, 28.2% for 20- to 24-year-olds, 21.8% for 25- to 29-year-olds, and 13.6% for 30- to 44-year-olds. (One reason for the reduced failure rates over age 30 may relate to reduced fecundability.) Thus, evidence shows that teens may be effective condom users. In addition, research shows that high quality sex education classes may facilitate the use of condoms by teaching and demonstrating correct condom use (Kirby et al., 2007).

However, many of the statements in the Teen-Aid curricula contain statistics that suggest that teens are less able to use condoms to prevent pregnancy when compared to adults. Other statements and figures cite rates of condom failure dependent on experience or cohabitation. In one figure, Teen-Aid presents the following statistics without any elaboration: “Pregnancy Rates during the first year of contraceptive use. Condom: method failure 4%, married adult 14.1%, unmarried adolescent 18.4%” (Roach & Benn, 1998, p. 215). As noted above, without explanation, method failure (i.e., perfect use) is

not comparable to the typical use failure rates that are reported for married adults and unmarried youth. Yet Teen-Aid presents them in sequence and thereby implies that unmarried teens are not effective condom users. Many factors influence an individual's success with condoms and age does not preclude correct and consistent condom use.

Condom Availability and Distribution Programs

Leading organizations of health professionals support condom availability programs for youth. The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Medical Association support adolescent access to condoms through comprehensive school health programs (American Academy of Pediatrics, 2001; American Medical Association, 2004; Bethards, 2003). Evaluations of school-based condom availability programs have shown mixed results in increasing condom use but these programs have not reported negative impact on other sexual behaviors (Blake et al., 2003; Furstenberg, Getz, Teitler, & Weiss, 1997; Kirby et al., 1999). Likewise leading STI researchers have supported condom availability. For example, Holmes and colleagues suggest: "Condom promotion represents an important element in approaches to and programs about comprehensive HIV-prevention" (Holmes et al., 2004).

The three AOE curricula do not support these ideas about condom availability to teens. The Teen-Aid curriculum takes a contrary view citing the following opinion: "*'Condoms don't hack it. Passing them out is futile'—Robert Noble M.D.*" (Potter & Roach, 1998, p. 20; Roach & Benn, 1998, p. 215).

Teaching Examples

The *Why kNOw* and Teen-Aid curricula use a variety of illustrative examples to impart the authors' understanding of condoms and risk for HIV, STIs, and pregnancy. The next two sections illustrate this use of such examples. In each case, we identify informational problems.

Condom Use and Russian Roulette

The Teen-Aid curricula draw an analogy between condom use and playing Russian roulette:

"If condoms and condom usage are not reliable, wouldn't relying on them be like playing the insane "game" of Russian roulette? A cartridge is loaded into one of the six chambers of a revolver. The first "player" spins the cylinder, points the gun to his/her head, and pulls the trigger. He/she has only one in six chances of being killed. But if one continues to perform this act, the chamber with the bullet will ultimately fall into position under the hammer, and the game ends as one of the players dies. Condoms are like Russian roulette. Condoms do not prevent pregnancy, STDs or AIDS; they only delay them. Theoretically, the longer one relies on them, they will fail and the "game" is over." (Roach & Benn, 1998, p. 215)

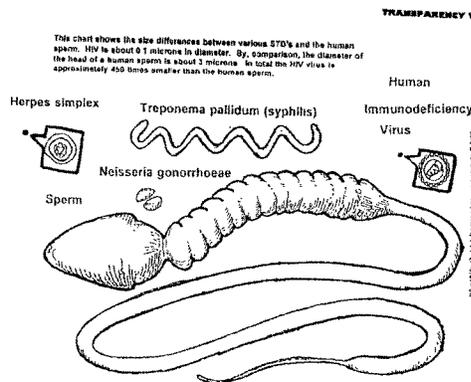
This analogy, which is found under the heading "Are Condoms Effective and Reliable?" in which condoms and HIV risk are discussed, is problematic on several levels. First, it implies that HIV transmission is synonymous with a serious bullet wound and therefore causes imminent death. Second, the analogy implies a 1 in 6 chance of death, much higher than either per coital act or per annum HIV transmission rates among serodiscordant couples who do not use condoms (Weller & Davis, 2002). Third, the

example ignores the fact that most sexual partners among teenagers are not HIV infected. The HIV prevalence in the U.S. teenage population is relatively low, between 0.16% and 0.75% of 15 to 24 years olds (Joint United Nations Programme on HIV/AIDS, 2000). Fourth, this analogy assumes that condoms do not reduce HIV transmission risk.

Condom Permeability and the "Speedy Sperm" activity

The *Why kNOW* Speedy the Sperm lesson attempts to explain HIV and pregnancy risk by focusing on the size of the virus and human sperm and implies that viral particles may be able to pass through the condom. First, the Speedy the Sperm lesson states that "The condom has a 14% failure rate in preventing pregnancy (1998 Contraceptive Technology, p 216) i.e. keeping sperm from entering the woman's body" (Frainie, 2002, p. 96). This implies that pregnancy risk is the same each time sperm enter a woman's body and ignores other factors relating to the fertility.

The Speedy the Sperm lesson uses a cartoon depiction of sperm, HIV, Treponema pallidum, syphilis, and Herpes simplex to illustrate size differentials and suggest transmission risk:



“This chart shows the difference between various STDs and the human sperm. HIV is about 0.1 microns in diameter. By comparison the diameter of the head of a human sperm is about 3 microns. In total the HIV virus is approximately 450 times smaller than the human sperm.” (Frainie, 2002, Transparency 5)

This explanation is problematic. The source of information about this size comparison is a letter to the editor from 1992 in *The Washington Post*. The 2001 NIH Condom Report explicitly states that latex condoms are impermeable to sperm and viruses, such as HIV, regardless of biological size (National Institute of Allergy and Infectious Diseases, 2001). By emphasizing this biological size difference, the curriculum implicitly builds on myths that condoms have holes in them or may be porous.

The Speedy the Sperm lesson also compares pregnancy and HIV infection risk: *“Since the HIV virus is smaller than a sperm and can infect you any day of the month, the failure rate of the condom to prevent AIDS is logically much worse than its failure rate to prevent pregnancy”* (Frainie, 2002, p. 96). This statement is confusing as failure rates for pregnancy and HIV are not calculated in the same ways. The risk of acquiring HIV is dependent on the prevalence in a population and the consistency and correctness of condom use. The risk of pregnancy is dependent on both partners’ fertility during intercourse and contraceptive use, which includes condom use. Thus, statistics for condom failure leading to pregnancy or HIV are not comparable.

Finally, the curriculum asks the instructor to further explain condom failure rates and the size differential between sperm and HIV: *“If the condom has a failure rate of 14% in preventing ‘Speedy’ from getting through to create a new life, what happens if this guy (the penny) [which is used to represent HIV] gets through? You have a death:*

your own” (Frainie, 2002, p. 96). As elaborated previously in the section on the Russian roulette analogy, HIV transmission is dependent on a multitude of factors, such as having sexual intercourse with an HIV infected partner. Even with an infected partner, the risk of HIV transmission per coital act is low.

In 2006 after we had completed our initial review, *Why kNOw* released an updated version of their curriculum which corrected and removed some of the curriculum content from their 2002 edition (Frannie & Ritterbush, 2006). When we requested a copy of the 2006 curriculum through the Department of Health and Human Services, it appeared that the pages of the teacher notebook which included The Speedy the Sperm lesson had been redacted after publication. A letter from the executive director of *Why kNOw* following Santelli’s Declaration stated that “Why Know is in the process of removing this activity from our curriculum. All users of our curriculum will be notified of its removal” (Scarce, 2007)

Discussion and Implications

We found evidence of misinformation about condoms and their ability to prevent HIV and pregnancy in three AOE curricula that are commonly used in federally supported programs. These three curricula explicitly and implicitly convey the message that condoms fail to provide protection against HIV, STIs, and pregnancy. References used to support these assertions in the curricula often were out of date or from non-peer reviewed sources. The curricula often misrepresented studies, for example, only reporting the highest condom failure rates reported within a study. In other instances, the curricula drew conclusions that go beyond the findings from the study cited. The curricula did not explain differences between typical and perfect use contraceptive failure rates associated

with condom use. Curricula often compared statistics for HIV transmission risk and pregnancy risk, even though these are not calculated in the same way. Finally, these curricula use faulty reasoning in explaining risk and promote misinformation about condoms (such as condom permeability) that have been repudiated by scientific consensus bodies. The information about condoms presented in these curricula does not represent complete, current, and accurate medical knowledge about the effectiveness of condoms in preventing sexually transmitted infections, including HIV.

Our findings are consistent with previous reports that document scientific inaccuracies in publications that examined a broader range of AOE curricula. The Waxman report examined a larger group of curricula and identified errors in the content across a range of topics (United States House of Representatives Committee on Government Reform, 2004).

Our study aimed to illuminate the specific reasons that particular statements are incorrect. The inaccuracies identified here presumably reflect legislative restrictions that prohibit AOE programs from teaching about the efficacy of contraceptives in preventing pregnancy, HIV and other STIs except to describe their failure rates (Administration for Children and Families, 2007). Our findings suggest a strong hostility to condoms in all three curricula. Perhaps, the authors of these curricula believe that undermining confidence in condom efficacy will induce students to remain abstinent or stop being sexually active, however, we are not aware of scientific evidence that such misinformation strategies are effective in promoting abstinence. Rather, such strategies may ultimately cause students to reject condom use.

Limitations

The findings from this analysis may not be representative of all AOE curricula nor does it detail the experiences of youth who were taught from these curricula. In this study, we chose to elucidate the types of errors rather than their frequency. The paper offers in depth analysis of selected medical inaccuracies, to detail how they are inaccurate.

Policy Implications

These findings and other research raise serious questions about the efficacy and ethics of AOE promotion (Kantor et al 2008; Kirby, 2008; Miller and Schleifer 2008 in the special issue). One third of ninth graders are sexually active and two thirds of high students are sexually active before graduation (Eaton et al., 2006) and virtually all Americans initiate sexual intercourse outside of marriage (Finer, 2007). Thus, students need access to medically accurate information on condoms and other ways to prevent HIV and other STIs. Comprehensive sexuality education programs which include information about condoms do not increase sexual activity among youth, in fact, many comprehensive programs both increase condom use and help teens delay initiation of sexual intercourse (Kirby, Laris, Rolleri, 2007; Kirby 2008 in this special issue; Smoak et al 2006). AOE curricula do not equip youth with information or skills necessary to use condoms to protect themselves from HIV, other STIs, or unintended pregnancies. Rather, these curricula teach that condoms are not reliable protection against HIV and pregnancy and that teens often fail at using condoms. Such messages may undermine the correct and consistent use of condoms.

Programs that promote abstinence should provide medically accurate information about condoms and other aspects of human sexuality. Federal requirements that restrict

information on contraception and condoms should be repealed and oversight of AOE curricula for scientific accuracy should be provided. The recent movement among states to require medical accuracy in sex education is an important policy development (Santelli, 2008 in press) however the federal government should also require that all federally supported sexuality education programs are medically accurate.

Ultimately the policy debate about abstinence education reduces to how can we best prepare youth for a healthy lifetime and how we best promote sexual and reproductive health in our society. At a minimum, all youth must be given the information they need to protect their health and their lives.

Acknowledgments

We would like to thank Molly Findley for her assistance in reviewing the 2006 *Why kNOW* curriculum and Molly Franks for her comments on the manuscript.

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Appendix: Quotations from Selected Curricula concerning Condoms

Quotations by Theme ¹	Specific Quotations from <i>Me, my world, my future</i> (MMWMF), <i>Sexuality, Commitment and Family</i> (SCF) and <i>Why kNOw</i> (WK) ²
Condom slippage and breakage	
Condom slippage and breakage	The failure rates for condoms (breakage or slippage rate) is higher than most people think. During vaginal intercourse condoms have been reported to break or slip off 14.6 % of the time, and a large family planning clinic found that 52% of respondents had experienced condoms bursting or slipping off in the previous three months. Between male homosexuals, condoms have been shown to fail 7.3%, 8% and 25.5% of the time. (MMWMF p 214; SCF p 19)
Condom slippage and breakage Youth as condom users	Condoms fail to protect when they break or slip off. Failure most often occurs when used by couples who are young, less experienced, or in those who are not cohabitating. <ul style="list-style-type: none"> • Reported failure rates with female prostitutes are 0.6% to 5%. • Failure rates for adults who are experienced and/or mutually monogamous are 1.3%, 1.9%, 6.7%, 7.4%, 8%, 10.1%, 11.7%, 12.9% and 15.1%. • When one partner had limited experience, condoms failed 6.9% and 14.8% of the time. • At the time of publication, only one study was found in non-cohabitating couples ages 13 to 17. Condoms failed 11.5% of the time. (MMWMF p 257)
Condom slippage and breakage	The condom has a 14% failure rate in preventing pregnancy (1998 Contraceptive Technology, page 216) i.e. keeping sperm from entering the woman's body. (WK p 96)
Contraceptive Efficacy of Condoms	
Contraceptive Efficacy and Condoms Youth as condom users	Basically two factors influence the overall effectiveness of a birth control method; (1) method failures and (2) patient failures. Mature married couples experience low failure rates, while single adolescents consistently prove to have higher failure rates, even after extensive training and follow-up (see below). Perhaps there is fundamental difference between post marital family planning and pre-martial birth control. (MMWMF p 215; SCF p 20)
Contraceptive Efficacy of Condoms	<i>Do condoms ever break or slip?</i> Condoms fail 15.7 percent of the time over the course of a year. This is a

¹ The possible themes are Condom breakage and slippage, Contraceptive Efficacy of Condoms, Youth as condom users, Condom availability and distribution programs, Condoms and HIV transmission risk, Teaching Examples (Condom use and Russian roulette, Condom Permeability in Speedy the Sperm) and Other

² Roach, N., & Benn, L. (1998). *Me, my world, my future: Teacher's manual* Spokane, WA: Teen-Aid.
Potter, S., & Roach, N. (1998). *Sexuality, commitment & family. Teacher's manual*. Spokane, WA: Teen-Aid
Frame, K., & Ritterbush, D. (2006). *Why kNOw Abstinence Education programs: Curriculum for sixth grade through high school, teacher's manual*. Chattanooga, TN: Why Know Abstinence Education

Condoms and HIV transmission risk	standardized failure rate—among some groups of women it has gone as high as 36.3 percent and 44.5 percent. This means that at the least, the chances of getting pregnant with a condom are 1 out of 6. (Contracting HIV is easier than getting pregnant because you can only get pregnant several days a month). (MMWMF p 257; SCF p 37)
Contraceptive Efficacy of Condoms Youth as condom users	The condom has a 22.5% failure rate in preventing pregnancy in unmarried women under the age of 20 during the first 12 months of use. (<i>Family Planning Perspectives</i> , March/April 1999). (WK p 90)
Contraceptive Efficacy of Condoms	The typical failure rate for the male condom is 14% in preventing pregnancy (1998 <i>Contraceptive Technology</i> p 216). (WK p 90)
Contraceptive Efficacy of Condoms Other	In view of these “comforting” statistics , consider these additional facts: <ul style="list-style-type: none"> • The human sperm is 450 times larger than the HIV virus • A woman can become pregnant approximately 6 days each cycle (The ovum actually lasts less than one day, but sperm has been known to survive up to five days inside the female genital tract.) • You can acquire an STD any day of the month. (WK p 90)
Condoms and HIV transmission risk	
Condoms and HIV transmission risk	In one study of heterosexual couples where one partner is HIV infected, over an average of two years of sexual exposure if latex condoms were relied upon there was still a 10 to 23% risk of transmission of HIV infection even with training and proper use. (MMWMF p 214 p 256; SCF 19 & 36)
Condoms and HIV transmission risk	A meticulous review of condom effectiveness was reported by Dr. Susan Weller in 1993. She found that condoms were even less likely to protect people from HIV infections. Condoms appear to reduce the risk of heterosexual HIV infection by only 69%. (MMWMF p 214; SCF p 19 & p 36-37)
Condoms and HIV transmission risk	The CDC has highly touted a study from Europe by Dr. de Vincenzi. This was a study of 256 heterosexual relationships where one partner was known to be HIV positive, and continued to have vaginal and anal intercourse. These adults were carefully instructed to use condoms correctly and consistently. Over an average time of 20 months, none became infected in the consistent condom users, while 4.8% of the inconsistent users seroconverted annually. This study has been criticized by three different university groups as being seriously flawed in at least six areas, and therefore the results are questionable and not statistically significant. (MMWMF p 257)
Condoms and HIV transmission risk	In the CDC’s highly touted study Dr. de Vincenzi, 256 heterosexual couples were followed when one partner was known to be HIV positive. Each partner was counseled about HIV infection and about “safe sex.” Only 48% of the adult couples used condoms consistently. (MMWMF p 258)
Condoms and HIV transmission risk	Do HIV positive men and women tell their sexual partners of their infection? In one study, 40% of HIV infected people did <u>not</u> . Of those who did not disclose, 57% did not use condoms consistently. Only 42% of individuals with multiple partners were honest about their HIV status.

	Surprisingly, 21% people did not tell their one and only sexual partner. (MMWMF p 257)
Condoms and HIV transmission risk	In a study performed in Canada, freshman college students knew more about HIV/AIDS than other STD's. In spite of this knowledge, only 25% of the men and 16% of the women always used a condom during sexual intercourse. Incredibly, among those students with ten or more sexual partners , regular condom use was reported by only 21% of the men and 7.5% of all the women! (MMWMF p 216, 258; SCF p 38)
Condoms and HIV transmission risk	The use of latex condoms has been promoted, by some, as a means to reduce the risk of sexual transmission of HIV. Experts from the Centers for Disease Control recommend abstinence and faithful monogamy as the only totally effective prevention strategies for sexually transmitted diseases. They also note that proper use of condoms for each sexual exposure can reduce, but not eliminate , the risk of infection. (MMWMF p 259; SCF p 36)
Condoms and HIV transmission risk	In mid-1988, the National Institute of Health canceled a two-year research project on condom effectiveness in Los Angeles. Officials felt that the study had too much risk and was therefore "unethical." The project was designed to determine how effective condoms are while people are involved in "high-risk" sex. They estimated that 40% of the control group would have become infected with HIV, and if condoms even reduced the risk ten-fold, four percent of condom users would become infected. (SCF p 38)
Condoms and HIV transmission risk	XVI. About Condoms A. The use of condoms does not necessarily prevent infection, but could just _____ it. (SCF p 44).
Condoms and HIV transmission risk	HIV Crossword Puzzle Down 16 Best protection- abstinence and mutually faithful monogamy; less than best protection - _____. [condoms is correct crossword answer]. (SCF p 45)
Condoms and HIV transmission risk	In heterosexual sex, condoms fail to prevent HIV approximately 31% of the time (Dr. Susan Weller, "A meta-analysis of Condom effectiveness in Reducing sexually transmitted HIV," <i>Social Science and Medicine</i> , June 1993). (WK p 90)
Youth as condom users	
Youth as condom users Contraceptive Efficacy and Condoms	Pregnancy Rates during the first year of contraceptive use. <i>Studies show that unmarried adolescents consistently experience higher contraceptive failure rates for pregnancy.</i> Condom: method failure 4%, married adult 14.1%, unmarried adolescent 18.4% (MMWMF p 215; SCF p 20)
Youth as condom users	Cohabiting women under the age of 20 had condom failure rate of 53.4 percent in preventing pregnancy during the first 12 months of use. (<i>Family</i>

Contraceptive Efficacy of Condoms	<i>Planning Perspectives</i> , March/April 1999). (WK p 90)
Youth as Condom users	<p>Studies have been done on sexually active adolescents and condom usage. One was completed in October 1986 in San Francisco. The authors noted:</p> <p>In San Francisco, information about AIDS prevention (including use of condoms) via television, newspapers, billboards, and on buses, some aimed specifically at teenagers, has increased in past years. The San Francisco Unified School District (SFUSD) began teaching a one-class segment on AIDS in the middle and high schools in academic year 1985-86 with teachers free to discuss AIDS in the lesson plans as they chose.</p> <p>After one year of intensive promotion, they notes that only 2.1% of teen girls and 8.2% of teen boys reported that they used condoms every time they had intercourse during the year. Also, paradoxically they learned that, in spite of the knowledge that condoms, “prevent” AIDS and other STD’s, the boys had less intention to use them one year later! (MMWMF p 215; SCF p 20)</p>
Youth as condom users	Is the goal of “correct and consistent” condom use attainable for the majority of teens, or even for the majority of adults? (MMWMF p 259)
Condom availability and distribution programs	
Condom availability and distribution programs	“Condoms don’t hack it. Passing them out is futile.” – Robert Noble, M.D. (MMWMF p 215; SCF p 20)
Teaching Examples	
	Condom use and Russian roulette
Condom slippage and breakage	If condoms and condom usage are not reliable, wouldn’t relying on them be like playing the insane “game” of Russian roulette? A cartridge is loaded into one of the six chambers of a revolver. The first “player” spins the cylinder, points the gun to his/her head, and pulls the trigger. He/she has only one in six chances of being killed. But if one continues to perform this act, the chamber with the bullet will ultimately fall into position under the hammer, and the games ends as one of the players dies. (MMWMF p 215 & 258; SCF 19)
Condom slippage and breakage	Condoms are like Russian roulette. Condoms do not prevent pregnancy, STD’s, or AIDS; they only delay them. Theoretically, the longer one relies on them, they will fail and the “game” is over.
Contraceptive Efficacy of Condoms	(MMWMF p 215; SCF p 19)
Condoms and HIV transmission risk	
Condom slippage and breakage	Relying on condoms is like playing Russian roulette. Condoms do not prevent pregnancy, STD’s, or AIDS. The longer one relied on them, the greater the chance of failure. Even if the method had a 90% chance of success the first time, repeated acts compound the failure rate and a person’s risk. The longer one relies on them, the probability increases that a
Contraceptive Efficacy of Condoms	

Condoms and HIV transmission risk	condom will fail and that the “game” is over. (MMWMF p 258)
	Speedy the Sperm
Condom Permeability in Speedy the Sperm lesson Condoms and HIV transmission risk Contraceptive Efficacy of Condoms	<p>The purpose of this illustration is to show the dangers of trusting your life to a piece of latex (condom). The condom has a 14% failure rate in preventing pregnancy, (1998 Contraceptive Technology, page 216) i.e. keeping sperm from entering the woman’s body. Studies show that the HIV virus is 450 times smaller than a human sperm. (Michael Roland of the Rubber Chemistry and Technology Company, (1992), Letter to the Editor—<i>The Washington Post</i>.) Recent research shows that the actual fertile time for women can last for about 6 days each cycle. Sperm has been known to live up to 5 days inside the female genital tract; the egg lives less than 1 day. Since the HIV virus is smaller than a sperm and can infect you any day of the month, the failure rate of the condom to prevent AIDS is logically much worse than its failure rate to prevent pregnancy.</p> <p>Explain to students the condom failure rate (see page 90) and the size difference between the HIV virus and the human sperm. The HIV virus is so small that it is impossible to see with the naked eye. In fact, you would have to magnify it greatly just to see it under a microscope! So for the sake of illustration, you are going to magnify it to the size of the penny, which is much easier to see. Now the sperm has to be magnified 450x the size of the penny.</p> <p>Hold up the penny and ask them how large we would have to make the sperm if we make the HIV virus the size of the penny. Using their brains, paper, and pencils, or calculators tell them to multiply 450 x .5 (size of penny’s diameter) = 225 inches. Since there are 12 inches in a foot, divide by 12=18.75 ft. That’s a big sperm!</p> <p>Tell them you just happen to have a sperm of that size with you and ask for two volunteers. Introduce “Speedy” and have students stretch him out to his full length. You stand in the middle and hold the penny up for them to see. If the condom has a failure rate of 14% in preventing “Speedy” from getting through to create new life, what happens if this guy (the penny) gets through? You have a death: your own.</p> <p>(WK p 96)</p>
Condom Permeability in Speedy the Sperm lesson Condoms and HIV transmission risk	This chart shows the size differences between various STD’s and the human sperm, HIV is about 0.1, microns in diameter. By comparison, the diameter of the head of a human sperm is about 3 microns. In total the HIV virus is approximately 450 times smaller than the human sperm. (WK Transparency V)
	Safer Than Nothing (activity supplement Sexually Transmitted Diseases)
Condoms and HIV transmission risk Contraceptive Efficacy of Condoms	After a discussion about the failure rate of the condom ask the class, “Since the condom is not 100% safe, it cannot be called “safe sex”; so what could we call it?” After the class has had a few moments to answer, you suggest that “safer than nothing” may be a better name. Ask them if they want to be 100% safe, or just “safer than nothing.” Since there are some people who are satisfied with being “just safer,” we have a little scenario that will help us

	<p>understand exactly what they are settling for when they settle for “just safer.” <i>Invite a student to come to the front of the class to play the part of “Teen.” You plan the part of “Narrator” and “Tempter.”</i></p> <p>[sic] From the plane we are watching this happening. We can't jump because we are not married and don't have a parachute. If we jump without being married, we are going to go “splat,” so all we can do is watch and learn. We watch those who are doing it right and making their marriage work. [sic]</p> <p><i>Ask the students what will happen when they jump [the unmarried couple who is using a baby blanket as a parachute]. They will say that they are going to crash. Yes, they are going to crash, because, although they are doing the same thing that married people are doing, they are not married. A blanket cannot take the place of a parachute, and condom cannot take the place of the protection of a faithful, loving, monogamous relationship. (WK p 98-99)</i></p>
Other	
Other	<p><i>How effective is Teen Contraceptive Use?</i> Encouraging the use of condoms and other contraceptives may even be harmful if it gives a false sense of security. (emphasis added [by Teen Aid]) (MMWMF p 214)</p>
Other	<p><i>Are Condoms Effective and Reliable?</i> [sic] Would you trust a condom, when condoms have been shown to be ineffective in preventing pregnancy or disease, to break, and even with proper usage to allow the transmission of HIV? (MMWMF p 214)</p>
Other	<p>A Rutgers University study found that barrier contraceptives apparently do not afford adequate protection against chlamydia. Infection rates were similar regardless of the contraceptive used. User infection rates were diaphragm -44%, condom-36%, oral contraceptives- 37% and no contraception- 44%. (MMWMF p 214; SCF p 19)</p>
Other	<p>Prevention ...He [former US Surgeon General Dr. C. Everett Koop] advocates condoms only for those who would not be abstinent or monogamous. (MMWF p 256)</p>
Other	<p>In spite of high level of AIDS-specific knowledge among sexually active young people (mean age 16.3 years), more than 66% engaged in sex without correct condom usage, with partners whose sexual history was unknown. These authorities concluded that AIDS knowledge alone is unlikely to reduce sex risk behavior in adolescents. (MMWMF p 257)</p>
Other	<p>A questionnaire of 108 men found that 49% reported removing condoms after beginning intercourse. (MMWMF p 258; SCF p 19)</p>
Other	<p>About Condoms What if condoms were 100% effective in preventing HIV infection, if used “correctly and consistently”? Should we then abandon moral values and advocate that all our children be indoctrinated that they must use condoms</p>

	with every sex act, and be taught how to correctly use them? If so, at what age do we begin instruction? (MMWMF p 258)
Other	Should physical safety from HIV, other STDs, or pregnancy be our paramount concern? Or are there other very important long-term considerations? What effect does condom instruction have on young people spiritually, emotionally, and socially? Does condom instruction result in positive or negative effects on future family stability and economic success? Could it not actually be harmful to young people, or to the rest of us, to follow this course? (MMWMF p 259)
Other	If you knew that someone was infected with the AIDS virus (HIV) would you have sex with that person? Would you recommend that your son or your daughter or your students place their trust in condoms? Would you trust a condom when condoms have been shown to be ineffective in preventing pregnancy or disease, to break, and even with proper usage, to allow the transmission of HIV? (MMWMF p 259; SCF p 19 & 36)
Other	Risky Behavior If abstinence is 100% effective and there is virtually no risk in a mutually faithful, monogamous (marriage) relationship, what level of risk are you willing to take? Condoms use has a risk factor. Are you worth the best? What is the best choice with the least risk? What choice can you live (die) with? (MMWMF p260; SCF p39).
Other	Teens Can Abstain [sic] Medical authorities see a continuing toll of sickness and death by HIV/AIDS, and they are calling for changes in sexual behavior. A popular "solution" one frequently hears is the cry that people must be given more condoms, and condom/AIDS education, an effort that has proven to fall short of expectations. (SCF p 22)
Other	It appears that a condom should reduce one's risk of infection in a single sex act. The more often that the act is repeated, the more opportunity there is for condom failure. The longer people engage in risky behavior and rely on condoms for protection, the greater the risk of becoming infected. (Those married couples who are mutually faithful and don't do IV drugs have no risk of HIV infection, with or without a condom.) (SCF p 38)
Other	Think about the following statistics and consider: "Could condoms be just another stupid idea?" (WK p 90)
Other	Currently there is not a condom made that can protect a person's emotions. (WK p 90)

IN PRESS TO THE AMERICAN JOURNAL OF PUBLIC HEALTH
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Medical Accuracy in Sexuality Education: Ideology and the Scientific Process
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"If medicine is to fulfill her great task, then she must enter the political and social life." Virchow, founder of modern pathology

Abstract

Recently, many states have implemented requirements for scientific or medical accuracy in sexuality education and HIV prevention programs. While seemingly uncontroversial, these requirements respond to the increasing injection of ideology into sexuality education, as represented by abstinence-only programs. This commentary describes the process by which health professionals and government advisory groups within the United States reach scientific consensus and reviews the legal requirements and definitions for medical accuracy. Key elements of this scientific process include the weight of scientific evidence, the importance of scientific theory, peer review, and recognition by mainstream scientific and health organizations. A concise definition of medical accuracy is proposed which may be useful to policy makers, health educators, and other health practitioners.

Introduction

Despite the overwhelming success of science as the foundation for medicine and public health, increasingly science itself is being manipulated or ignored in the debates surrounding public policy. While health professionals implicitly accept this scientific foundation for their work, we have seen political intrusions into scientific policy making normally based on scientific considerations in areas as diverse as FDA approval of emergency contraception, stem cell research, and new vaccines for the Human papillomavirus (HPV). (This interference also reaches into public schools with the teaching of evolution and abstinence education.¹⁻⁴) Tampering with scientific decision-making has included the suppression of data collection and

analysis, the muzzling of federal scientists, the packing of scientific advisory committees, the equating of fringe science with mainstream science, and the manipulation of scientific uncertainty.^{1,2,5} While political interference in public health is not new, many have suggested the Bush administration has politicized science to an unprecedented degree.^{6,7} In this commentary, I explore the collision of science and ideology in recent federal policy designed to promote abstinence to improve adolescent reproductive health, and the recent introduction of federal and state legal requirements for *medical accuracy* as a legislative solution to these ideological debates. [Clearly distinctions can be made between *medical accuracy* and *scientific accuracy*, however, for purposes of this commentary I have generally considered *medical accuracy* to be the application of *scientific accuracy* to health matters. *Scientific accuracy* is the preferable term but *medical accuracy* is more commonly use.] {Note to the editor- this sentence could go into a footnote.}

Since enacting “welfare reform” in 1996, the federal government has spent more than 1 billion dollars on assistance to states, and to community-based, and faith-based organizations for abstinence-only educational programs.^{8,9} These programs are restricted from providing information about condoms and contraception, except to discuss their failure rates.¹⁰ A variety of critiques, based upon scientific and ethical considerations, have been directed toward US government policies that promote abstinence exclusively.^{7,11-20} These critiques of commonly used abstinence education curricula, from leading health professional and human rights organizations, have addressed multiple issues including scientific accuracy, withholding of life-saving information about the Human Immunodeficiency Virus (HIV), failure to delay initiation of sexual intercourse, promotion of gender stereotypes, insensitivity and unresponsiveness to sexually active youth and non-heterosexual youth, harm to comprehensive sexuality education and other domestic public health programs, damage to US foreign aid programs, and inconsistency with ethical imperatives of medicine and public health.^{7,9,11,17,19-21} Underlying ideological assumptions of abstinence-only programs, based on moral and religious beliefs of their authors, are often at odds with current scientific consensus; these beliefs are a critical feature of the “scientific” basis for abstinence-only policies.²²

Medical Accuracy in Abstinence Only Education Programs

A number of analyses have specifically examined the scientific or medical accuracy of commonly-used abstinence programs. In 2004, the minority staff of the Committee on Government Reform of the U.S. House of Representatives reviewed 13 commonly-used, abstinence-only curricula for evidence of scientific accuracy.²³ Their report, commonly referred to as the Waxman report, found that 11 of the 13 curricula contained false, misleading or distorted information about reproductive health including inaccurate information about contraceptive effectiveness and the risks of abortion, as well as other scientific errors. These curricula treat stereotypes about girls and boys as scientific fact and blur religious and scientific viewpoints.²³ Two recent reviews of several abstinence-only curricula found similar problems.^{24,25} In the fall of 2006, the Government Accountability Office (GAO) issued two reports on the federal programs that promote abstinence, both of which faulted the programs on the issue of scientific accuracy.^{26,27} In the first report, the GAO found that the Agency for Children and Families (ACF), which dispenses most of the federal funding for abstinence education through the Community Based Abstinence Education (CBAE) or Title V programs, does not review grantees’ educational materials for scientific accuracy and does not require either CBAE or Title V recipient programs to review their own materials for scientific accuracy.²⁶ The second report

concluded that the federal statutory requirement (section 317P(c)(2) of the Public Health Service Act) to include scientifically accurate information on condom effectiveness would apply to abstinence education materials prepared and used by federal grant recipients.²⁷ The Department of Health and Human Services (DHHS), a parent agency of the ACF, responded that 317P does not apply to abstinence education,²⁷ although the 2007 program guidelines for the CBAE program created a new requirement specifically pertaining to medical accuracy.²⁸

What is meant by “*medical or scientific accuracy?*” Importantly, how do health professions determine medical and scientific accuracy? In answering these questions, it is useful to review the way medical and public health organizations review scientific studies to formulate policy guidance.

Scientific Consensus in Setting Health Policy

The community of scholars within a scientific discipline provides opportunities for vetting and critiquing new ideas: via professional meetings and conferences, peer-reviewed publications, advisory boards, university education, and mentoring of junior scientists. This scientific community operates through a variety of professional organizations - associations of scientists, public health workers, and medical professionals which promote scientific consensus by offering scientific opinions on key policy and practice issues. These professional organizations include the American Medical Association (AMA), the American Public Health Association (APHA), the American Academy of Pediatrics (AAP), and other specialty and subspecialty groups. These opinions are created and reviewed by a series of scientific committees to insure both the scientific accuracy and the clarity of specific recommendations. Likewise, federal government advisory committees such as the Advisory Committee on Immunization Practices (ACIP), the US Preventive Services Task Force, (USPSTF), the Task Force on Community Preventive Services (TFPCS), and the Institute of Medicine (IOM), as well as federal agencies such as the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA) offer scientific opinions on a broad variety of health matters. Taking a hard-nose approach, these bodies separate scientific fact from fallacy to assure policy based on the current scientific understanding.

These consensus statements are authoritative recommendations informed by scientific research. Membership within these advisory groups is based on scientific accomplishment and recognition by members of one’s own profession. Such groups use a variety of methods to reach consensus on scientific matters, including literature reviews, formal meta-analyses, and clinical experience. All scientific disciplines have standards for scholarship that are used to judge the quality of specific studies, although such standards differ among professions and disciplines. The methods for reviewing scientific findings, rating the strength of scientific evidence, and reaching recommendations are often explicitly defined in written documents.^{29,30} These review processes favor research published in peer-reviewed journals, particularly those journals that are held in high regard within the medical and scientific communities. Scientific panels weigh not only the predominance of evidence, but also consistency of specific studies with scientific theory within a particular discipline. These reviews examine key issues of scientific validity, such as the strength of research design, sample size, the generalizability of findings, etc. Policy makers and practitioners alike utilize these consensus statements in their decision making. While this scientific consensus process does not guarantee consensus in policy making, particularly where

strong cultural beliefs or economic forces are at work, this consensus process is often essential in determining scientific accuracy.

The licensure of the first vaccine to prevent HPV infection and cervical cancer is an example of this scientific consensus process at work - particularly when this scientific process is confronted with social and cultural concerns.³¹ Based on research findings provided by the drug company (Merck), FDA advisory committees recommended licensure and the FDA subsequently approved the vaccine for sale in 2006. Following licensure, the ACIP endorsed the vaccine's use among females 9-26 years of age and provided specific recommendations for its use. Medical associations such as the Society for Adolescent Medicine and American College of Obstetricians and Gynecologists (ACOG) have endorsed its widespread use. Despite concerns among social conservatives that the vaccine would lead to increased sexual risk taking among teens and despite conservative political leadership in the White House, the scientific review and consensus process functioned properly and led to approval of a vaccine that appears to be very safe and potentially highly efficacious.³² More than 20 states are currently considering legislation to mandate vaccine coverage. Despite considerable evidence that school mandates improve vaccine coverage for children and adolescents,³⁰ opposition to these mandates has been strong. Opposition from conservatives have been joined by opposition from those who generally oppose childhood vaccinations, those worried about drug company tactics, and physicians who are concerned about costs, long term efficacy, and side effects.^{31,33}

Similar review and consensus processes have been used in determining the efficacy of sexuality education, including AOE.^{19,20,34} Most recently, scientific review has been extended to the content of sexuality education curricula.^{23,24} This extension has often used the term "medical accuracy."

State and Federal Requirements for Medical Accuracy

State governments and the federal government have begun requiring medical accuracy in public health programs such as sexuality education, HIV prevention programs, and condom distribution.³⁵ For example, section 317P(c)(2) of the federal Public Health Service Act (42 U.S.C. § 247b-17(c)(2)), enacted in 2000, (also known as "the federal condom statute") requires medical accuracy when educational materials about sexually transmitted diseases (STDs) are created and distributed by HHS and HHS grantees. Such materials must contain "*medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the STD.*" Notably, the federal statute does not define "medical accuracy."

Based on a WestLaw search of all 50 state statutes, twenty-one states (AZ, CA, CO, IA, IL, IN, LA, ME, MD, MI, MN, MO, NV, NY, NC, OK, OR, RI, UT, WA, WV) have in some way required medical or scientific accuracy (using a variety of terms) in the provision of sexuality and/or HIV/AIDS education, although often without defining the term.³⁵

Among these 21 states, seven states have definitions of medical accuracy in some area of health law; four of these definitions appear in state sexuality education requirements (Table 1). Some states, such as New Mexico, have undertaken specific reviews of abstinence curricula, while other states, such as New Jersey, have rejected the curricula outright and declared they are unable to review each individual curriculum.³⁶

California requires that information presented in "sexual health education" courses "shall be medically accurate and objective" (Cal. Education Code § 51933(b)(2)). Similarly, Utah law requires the state board of education to approve instructional materials used in school health courses (Utah Code § 53A-13-101(1)(c)(i)) and an additional educational regulation mandates

that the board may “approve only medically accurate human sexuality instruction programs” (Utah Administrative Code r. 277-474.4.(D)). Colorado requires and defines medical accuracy with respect to HIV and AIDS prevention and education programs. (Colo. Rev. Stat. § 25-4-1413(5); 6 Colo. Code Regs. § 1009-10(1.1)(G)). A new Colorado statute also requires school human sexuality courses to be “medically accurate according to published authorities upon which medical professionals generally rely” (H.B. 07-1292, 66th Gen. Assem., Reg. Sess. (Colo. 2007) (amending Colo. Rev. Stat. § 22-1-110.5)). Finally, new state laws in Iowa and Washington require sexuality education to be “research-based” and “medically and scientifically accurate,” respectively. New Mexico and New Jersey require (and define) medical accuracy with respect to written and oral information provided to sexual assault survivors (N.M. Code R. §§ 7.7.2.7(KK), 7.7.2.38(B)(6); N.J. Stat. §§ 26:2H-12.6b, 26:2H-12.6c).

The medical accuracy definitions found in the California, Iowa, New Jersey, and Washington statutes and the Utah, New Mexico, and Colorado regulations are nearly identical. In these cases, medical accuracy is defined by three interrelated features:

- verification or support of research conducted under accepted scientific methods;
- publication in peer-reviewed journals; and
- recognition as accurate and objective by mainstream professional organizations such as the AAP, ACOG, APHA, and government agencies such as the CDC.

New Mexico, New Jersey, and Iowa add an important qualifier to peer-reviewed publication:

- supported by the weight of scientific evidence, i.e., “weight of research.” (This weighing of the predominance of evidence is intrinsic in the review by professional organizations and government agencies.)

The Colorado definition includes two additional components:

- linkage to social, behavioral, and biomedical theories; and
- adaptation of programs that are evidence-based.

Iowa adds the important notion of “complete” information.

Are these state definitions of medical accuracy adequate? The short answer is “Yes,” particularly if one considers the features identified by New Mexico, New Jersey, Iowa, and Colorado - which add critical dimensions. These state definitions clearly recognize the process which health professionals and scientists themselves understand and reflect the practical realities by which scientific consensus is produced.

The social/political context for requirements for “medical accuracy” is important to understand. Since the 2004 report of the Waxman Congressional staff, conservative organizations that support abstinence-only programs have attempted to define medical accuracy themselves.^{37, 38} For example, the Medical Institute for Sexual Health, a physicians group based in Texas which promotes sexual abstinence and the National Abstinence Leadership Council, has issued statements on medical accuracy. Such statements provide some insight into the scientific process, e.g., by identifying the importance of correctly quoting scientific research and the importance of peer review and publication in a medical journal. Such statements also undermine the scientific consensus process, for example, by suggesting that “*not all government agency recommendations meet this standard [of medical accuracy].*”³⁷ Moreover, these definitions are incomplete in key respects. Critical missing elements include the failure to acknowledge the positive importance of scientific consensus, the predominance of scientific evidence, and the use of theory in guiding scientific discovery and producing consensus. Theory is critical to the scientific process and in distinguishing science from ideology.

Scientific Theory

"Stand on the shoulders of giants." From the home page of Google Scholar

An unfortunate feature of many current public debates is the manipulation of scientific uncertainty and confusion about scientific theory.⁶ Discovery and debate within the scientific community are critical to the scientific process and scientists are generally acutely aware of the limits to their own understanding. Does this suggest that scientific theories are merely unproven hypothetical constructs? If science is not definitive, is any *scientific fact* as good as any other? This confusion (or perhaps obfuscation) goes to the heart of the processes by which science reviews and reaches consensus on health issues.

Scientific discovery builds theories or paradigms, i.e., all encompassing theoretical constructs that attempt to explain a body of scientific findings.³⁹ In its classic formulation by Kuhn, a paradigm is expected to be consistent with all of the scientific findings within a specific area of scientific investigation and not inconsistent with other theories. Theoretical paradigms are not static, but substantial alternative findings are required to incite a paradigm shift or scientific revolution. An example is Darwin's discovery of natural selection that became the foundation for a new theory of evolution and essential to modern biology and medicine. In contrast to natural selection, some have developed an alternate "theory" so-called *intelligent design* that is not science at all; this "theory" fails to follow the rules of science discovery and collapses under the accumulated body of scientific evidence. It makes little attempt to be encompassing and is rejected by mainstream organizations of biologists.

In the behavioral sciences and health education we are seeing the emergence of consensus theories of behavior change based on several decades of research, particularly AIDS prevention research (Fishbein Report). This emerging paradigm emphasizes key psychosocial factors such as self efficacy and peer norms and stages of behavior change. These factors have become key building blocks in developing comprehensive, effective sexuality curricula, such as Safer Choices.⁴⁰ Likewise, Kirby and others have identified key characteristics of effective programs.⁴¹ These psychosocial factors and characteristics do not appear to have influenced the creation of AOE curricula.

If Information is Incomplete, is it Medically Accurate?

A final issue in debates over medical accuracy involves the withholding of information about the benefits of condoms and contraception in abstinence-only curricula. Federal abstinence programs must have as their "exclusive purpose" the promotion of abstinence outside of marriage and may not in any way advocate contraceptive use or discuss contraceptive methods except to emphasize their failure rates.^{10,42} As such, programs may discuss the risks and failures of contraception but not their benefits or successes in preventing pregnancy or HIV and other STDs. This specific program restriction clearly *requires* programs to provide *biased* information, by withholding positive information about contraception. Thus, it is not surprising that the Waxman report found that commonly-used abstinence programs contained inaccurate information about condom and other contraceptive effectiveness.²³

Withholding potentially life-saving information from sexually active teenagers is ethically troubling.^{15,16,34} The principle of informed consent suggests that persons should be given all the information they need to make informed choices.⁴³ Patients with cancer or other serious illness expect that they will receive complete and accurate information about treatment options from their physicians. Likewise, teenagers at risk of HIV and other STDs and unintended pregnancy need information on ways to prevent these. The American Medical

Association and other medical societies have endorsed annual behavioral screening and counseling for teenagers about sexual health.⁴⁴ Similarly, key medical and public health groups have endorsed comprehensive sexuality education.^{11, 12, 20, 34} If teenagers are sexually active, they need information to protect their health and lives. In school-based health education programs where a significant proportion of students are sexually active or will be shortly, students need access to education that provides accurate information about condoms and contraception. Where there is a need to know, medically incomplete is medically inaccurate.

Conclusions and Implications

Koplan and McPheters have suggested that science should inform public health which in turn should drive public policy.⁴⁵ Unfortunately, they find that often the reverse is true, with politics driving public health decision-making and then seeking scientific justification using faulty science. Such manipulations of public policy-making must be stopped.

In this context, the requirement for *medical accuracy* is a welcome and generally helpful development for sexuality education and potentially useful in other areas of health. Requiring medical accuracy can help in clarifying debates between mainstream scientists and ideologically driven groups who claim the mantle of science in supporting specific social policies. Understanding the scientific consensus process can prevent the manipulation of scientific uncertainty. Health professionals and scientists need to become active in speaking out on the importance of scientific integrity in public policy. This can be done personally via letter writing and community advocacy or more broadly through energizing professional organizations around these issues.

Likewise, a definition of medical accuracy, based upon current practices for developing scientific consensus, would be helpful to state and federal policy-makers and local practitioners. Such a definition of *medical accuracy* should incorporate a comprehensive understanding of the scientific process. As such, medical accuracy should be defined as:

information relevant to informed decision-making based on the weight of scientific evidence, consistent with generally recognized scientific theory, conducted under accepted scientific methods, published in peer-reviewed journals, and recognized as accurate, objective, and complete by mainstream professional organizations such as AMA, ACOG, APHA and AAP, government agencies such as the CDC, FDA and NIH, and scientific advisory groups such as the Institute of Medicine and the Advisory Committee on Immunization Practices. The deliberate withholding of information that is needed to protect life and health (and therefore relevant to informed decision-making) should be considered medically inaccurate.

All states and the federal government should adopt requirements for medical accuracy in health education. At a national level, DHHS should create an independent review process to ensure the accuracy of commonly-used health education curricula supported by the federal government. Likewise, states should convene advisory bodies of knowledgeable medical professionals and public health officials to review local curricula.

Requirements for medical accuracy will not end attempts to manipulate health policy-making. However, such a requirement provides a clear standard in refuting such attempts. Even in the absence of a specific public health mandate or definition, appeals for medical accuracy may be a useful approach in promoting scientifically-grounded health policies.

Table 1. State Definitions of Medical Accuracy			
State	Statute (enacted)	Scope	State Definition
California	Cal. Educ. Code § 51931(f) (2003)	Sexuality education	Verified or supported by research conducted in compliance with scientific methods and published in peer-reviewed journals, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the federal Centers for Disease Control and Prevention, the American Public Health Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.
Utah	Utah Admin. Code r. 277.474.1(G) (2001)	School health education	Verified or supported by a body of research conducted in compliance with scientific methods and published in journals that have received peer review, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the American Medical Association.
New Mexico	N.M. Code R. § 7.7.2.7(KK) (2004)	Sexual assault survivors, information about emergency contraception	Verified or supported by the weight of research conducted in compliance with accepted scientific methods and standards; published in peer-reviewed journals; and recognized as accurate and objective by leading professional organizations and agencies with relevant expertise in the field of obstetrics and gynecology, such as the American College Of Obstetricians And Gynecologists.
New Jersey	N.J. Stat. § 26:2H-12.6b (2005)	Sexual assault survivors, information about emergency contraception and STDs	Verified or supported by the weight of research conducted in compliance with accepted scientific methods and standards, published in peer-reviewed journals, and recognized as accurate and objective by leading professional organizations and agencies with relevant expertise in the field of obstetrics and gynecology.

Colorado	6 Colo. Code Regs. § 1009-10(1.1)(G) (2006)	HIV/AIDS prevention and education programs	<i>Consistent with one or more of the following:</i> 1. Verified or supported by research conducted in compliance with scientific methods;2. Recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the American Public Health Association, American Social Health Association, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the Infectious Disease Society of America, and the American Psychological Association;3. A study published in a peer-reviewed journal;4. Clearly identified link to social, behavioral, and biomedical science theories; or5. A local adaptation of an evidence-based model.
Iowa	H.F. 611, 82nd Leg., 2007 Sess. amending Iowa Code § 279.50 (2007)	Instruction in human growth and development, human sexuality, STDs, and HIV/AIDS	Complete information that is verified or supported by the weight of research conducted in compliance with accepted scientific methods; recognized as medically accurate and objective by leading professional organizations and agencies with relevant expertise in the field, such as the American College of Obstetricians and Gynecologists, the American Public Health Association, the American Academy of Pediatrics, and the National Association of School Nurses; and published in peer-reviewed journals where appropriate.
Washington	S.B. 5297, 60th Leg., 2007 Reg. Sess. (2007)	Sexual health education	Information that is verified or supported by research in compliance with scientific methods, is published in peer-review journals, where appropriate, and is recognized as accurate and objective by professional organizations and agencies with expertise in the field of sexual health including but not limited to the American College of Obstetricians and Gynecologists, the Washington State Department of Health, and the federal Centers for Disease Control and Prevention.

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Explanation of Authors' J.S. Santelli originated the article and wrote the manuscript.

Contributions:

Acknowledgments: I would like to thank Ava Barbour, JD for her invaluable assistance in conducting the legal research for this paper and to Alison Lin and Molly Findley with manuscript preparation. I am pleased to acknowledge the assistance of my colleagues who reviewed various iterations of the manuscript: Ava Barbour, Peter Bearman, Heather Boonstra, Susan Cohn, Debra Haffner, Doug Kirby, Julie Kay, David Landry, Mary Ott, Cory Richards, Amy Schalet, and Rebecca Schleifer.

Human Participant Protection: No human subjects review protocol was needed for this study.

Chairman WAXMAN. Thank you very much.
Dr. Benjamin.

STATEMENT OF GEORGES BENJAMIN

Dr. BENJAMIN. Good morning, Mr. Chairman and members of the committee. Let me just first of all thank you very much for having this hearing and just say that I am here representing the American Public Health Association, and we adopt policies every year looking at very, very important public policy issues. We have addressed this issue in 1990, 2003, 2005, and then again in 2006.

Let me just say the bulk of our policies certainly recognize the critical, critical importance of ensuring abstinence. I think every public policy person and every parent certainly wants to do that. But we have expressed significant concern about abstinence-only programs, and actually would call for their termination in terms of Federal funding in their current form.

We have had three areas of concern. Area of concern No. 1 is fundamentally do they work. We think certainly that the weight of the evidence today, as they are currently constructed they do not work. What I mean by work means that do they create abstinence and do they create the public health outcomes that we really need in the long term. We don't think that they do that.

Second, just to point out that we do believe that the alternative is comprehensive health education, particularly around sexuality issues, and we do think they work. We think that certainly nothing is perfect, but when you compare the two, that the comprehensive approach is much better.

Second, do the abstinence-only programs complicate other public health measures? The answer to that we certainly think is that they do, and they do in a variety of ways. One, they cause a great deal of confusion. One of the things I have learned, both in my time practicing clinical medicine, and, of course, certainly my time as a parent, that our kids are much farther along than we think they are. They know much more and they are a whole lot more curious than we think. So when you give them only a single message, they are going to seek the stuff we don't tell them in other places.

These programs in many cases don't give the kids the tools that they need, the facts that they need to combat inappropriate or inadequate or unscientific information that they may hear or pick up amongst their peers or in other places. We think there are lots of problems with that.

We think that there has been real targeting on the efficacy of condoms as an alternative, again, for those children for which abstinence has now failed. It really doesn't give them the tools to go about that, because of the lack of facts.

We think that certainly the fact that 17 States have now said that they are not going to take funding, having been a health officer in two jurisdictions, here in the District of Columbia and in the State of Maryland, I can tell you for a health department to give up funding is a very, very significant act. That is money that could go for very important public health efforts.

And then I think finally significant ethical concerns. As a clinician, one of the challenges that I have always is figuring out what to tell people, what to tell patients, what to tell the community. I

have discovered the best answer to that is to tell them what I know, tell them what I don't know, to be very clear with them, to tell them at a level, either if I am writing, at a literacy level, or in speaking, in a language that they will understand, that is culturally appropriate, that is age appropriate, and to deal with that in the most honest way that I can.

My real concerns, I think the concerns of APHA, is that, at least as currently constructed, these abstinence-only programs on bulk don't do that, and so we have real significant concerns about their continuation.

With that I will stop. Thank you.

[The prepared statement of Dr. Benjamin follows:]



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Protect, Prevent, Live Well

Testimony of the American Public Health Association
“Domestic Abstinence-Only Programs: Assessing the Evidence”
House Committee on Oversight and Government Reform
April 23, 2008

The American Public Health Association (APHA) is the oldest and most diverse organization of public health professionals in the world. APHA represents a broad array of health officials, educators, environmentalists, policy-makers, and health providers at all levels working both within and outside government organizations and education institutions. We are pleased to present our views on abstinence-only-until-marriage programs.

The Role of Schools in Sexuality Education

The American Public Health Association (APHA) recognizes that youth face considerable risk to their reproductive health. Adolescents have the highest age-specific risk for many sexually-transmitted infections (STIs) and the United States continues to lead the developed world in the rate of adolescent pregnancy. In fact, U.S. teen pregnancy and teen birth rates are the second highest among 46 countries in the developed world (the U.S. is second to Russia in teen pregnancy rates and Armenia in teen birth rates). APHA further recognizes that abstinence from sexual intercourse is an important behavioral strategy for preventing HIV, STIs, and unintended pregnancy. Many adolescents have not initiated sexual intercourse, and many sexually experienced adolescents and young adults are abstinent for varying periods of time. We note that there is broad public support in the U.S. for abstinence as a necessary and appropriate part of sexuality education. APHA also notes that few Americans remain abstinent until marriage, and most initiate sexual intercourse as adolescents. Together, data from the 2002 National Survey of Family Growth and the 2000 U.S. Census indicate a considerable gap between the median age at first intercourse of 17 years, and the median age at first marriage of 25 in women and 27 in men. Such demographic realities raise serious questions about the feasibility of programs that promote abstinence-only-until-marriage (AOUM) as a universal strategy. Moreover, APHA notes that significant ethical and human rights concerns arise when abstinence is presented to adolescents as the sole choice, or when health information regarding other choices is limited or misrepresented.

All young people must be prepared to become sexually healthy adults and provided with the knowledge and skills necessary to avoid HIV, other sexually-transmitted infections, and unintended pregnancy. Parents/guardians and families are the first and most influential sexuality educators of their children, yet many young people report that they need additional guidance. APHA believes that the nation's K-12 schools, in concert with families, religious and community groups, and health care professionals, should implement effective sexuality education programs that are age, gender and culturally-appropriate, support the elimination of health disparities, and are based on sound science and proven principles of instruction.

Currently, there are two contrasting approaches to teaching adolescents about sexuality: 1) comprehensive sexuality education (CSE) programs, which include abstinence-based instruction; and 2) AOUM programs. In 1990, APHA adopted a policy that “Urges that a national policy on reproductive health care for adolescents include comprehensive health and sexuality education in schools extending from kindergarten through high school.” Policies containing the same recommendation were adopted in 2003, 2005 and 2006. The 2006 policy also notes that “significant ethical and human rights concerns arise when abstinence is presented to adolescents as the sole choice, or when health information regarding other choices is limited or misrepresented.”

Youth are at Risk for STIs, Unintended Pregnancy and HIV

Young people in the United States are at persistent risk for STIs, unintended pregnancy and HIV infection. In addition, youth of racial and ethnic minorities are at particular risk, as indicated by the following data. Eliminating such health disparities is a priority for APHA.

According to the 2005 Youth Risk Behavior Surveillance, 46.9 percent of high school students had ever had sexual intercourse. The prevalence of having had sexual intercourse was 63.1 percent of 12th graders, 51.4 percent of 11th graders, 42.8 percent of 10th graders, and 34.3 percent of 9th graders. The prevalence of having had sexual intercourse was higher among black students (67.6 percent) and Hispanic students (51.9 percent) than white students (43.0 percent). Overall, 14.3 percent of students had had sexual intercourse with more than four persons during their lifetime with higher rates among black students (28.2 percent) and Hispanic students (15.9 percent) than white students (11.4 percent). In addition, 33.9 percent of students were sexually active (meaning they had had sexual intercourse with at least one person during the three months preceding the survey) and 37.2 percent of sexually active high school students had not used a condom at last sexual intercourse.

According to the survey, every year there are approximately 831,000 pregnancies among women aged 15 to 19 years, about 9.1 million cases of STIs among persons aged 15 to 24 years, and an estimated 4,842 cases of HIV/AIDS among persons aged 15 to 24 years. This represents almost 13 percent of all pregnancies, half of new STIs, and 13 percent of HIV/AIDS diagnosis. Black and Hispanic adolescents have been disproportionately affected by the HIV/AIDS epidemic. The HIV/AIDS Surveillance Report estimates that from 2001-2005, 60.6 percent of HIV/AIDS diagnosis in 13 to 19 year olds was among blacks, and 17.3 percent was among Hispanics.

Abstinence-Only Programs: Are They Effective?

Since 1996, there have been major expansions in federal support for AOUM programming including Section 510 of Title V of the Social Security Act in 1996 and Community-Based Abstinence Education (CBAE) projects in 2000. Both Title V AOUM and CBAE programs prohibit disseminating information on contraceptive services, sexual orientation and gender identity, and other aspects of human sexuality. Programs must have as their "exclusive purpose" the promotion of abstinence outside of marriage. AOUM programs must teach that "a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity" and that "sexual activity outside of marriage is likely to have harmful psychological and physical effects." Moreover, AOUM programs are not allowed to include information about contraceptives and disease-prevention methods, except to emphasize their failure rates. A congressional report prepared for Rep. Henry A. Waxman in December 2004 on AOUM programs commonly supported by the U.S. federal programs found that 11 of the 13 most frequently used curricula contained false, misleading or distorted information about reproductive health, including inaccurate

information about contraceptive effectiveness, risks of abortion and other scientific errors. In addition, these curricula treat gender stereotypes as scientific fact, impose moral judgments and blur religious with scientific viewpoints. These program requirements have little to do with public health priorities; instead, they reflected a moral and ideological viewpoint.

To date, no AOUM program that conforms to the eight point criteria listed in Section 510(b) of Title V of the Social Security Act and focuses exclusively on promoting abstinence until marriage has shown credible evidence of significantly delaying sexual initiation or reducing the frequency of sexual intercourse. While abstinence from sexual intercourse is theoretically fully protective against pregnancy and disease, in actual practice abstinence often fails. In a nationally representative study of adolescents aged 12-17 years, adolescents who took virginity pledges, a key component of nearly every AOUM program, delayed onset of intercourse an average of 18 months longer than those who did not take a virginity pledge. The effect of pledging virginity is variable. It is effective only in the context of, and in interaction with, other youth similar to those pledging. It provides a means for young people to differentiate themselves from other people (who are non-pledgers). The effect of pledging is dependent on the number of other pledgers in the community. If there are very few, there is no real effect on initiation of intercourse because there is no real community of like-minded young people to interact with and support the pledge. Likewise, if there are too many pledgers (more than 40 percent), there is also no effect because there is no real differentiation of identity. In addition, pledging is more effective for younger teens than older teens. However, 88 percent of adolescents who took virginity pledges within AOUM programs reported engaging in sexual intercourse before marriage. Even more disturbing, the study reported that adolescents who took virginity pledges were less likely to use condoms when they became sexually active, more likely to engage in oral-genital and anogenital sexual behaviors, and less likely to seek and obtain care for STIs than non-pledgers, even though they were as likely to contract an STI as non-pledgers.

AOUM programs are often insensitive to sexually active and sexually abused teenagers, as well as to gay, lesbian, bisexual, transgender, questioning, and intersexed (GLBTQI) youth. Sexually experienced teens need access to complete and medically accurate information about condoms and contraception, their legal rights to health care, and ways to access reproductive health services. AOUM programs do not address these needs. AOUM programs also are unlikely to meet the health needs of GLBTQI youth, as they largely ignore issues surrounding sexual orientation and gender identity and may contribute to stigmatization of these young people and/or their sexual behavior as deviant and unnatural. Homophobia and stigmatization contribute to health problems such as suicide, feelings of isolation and loneliness, HIV infection, alcohol, tobacco and other drug use, and violence among and towards GLBTQI youth.

National organizations that address HIV prevention and sexual health related issues have expressed a concern that a shift in U.S. government policy stressing lack of condom efficacy within educational materials, including within a new Department of Health and Human Services' (HHS) Web site for parents, has caused confusion in the general public about whether condoms should be used and promoted for the prevention of HIV infection. However, numerous studies have demonstrated that latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases, including gonorrhea, chlamydia and trichomoniasis. While the effect of condoms in preventing human papillomavirus (HPV) infection is uncertain, the Centers for Disease Control and Prevention (CDC) has found an association between condom use and a reduced risk of HPV-associated diseases, including genital warts, cervical dysplasia and cervical cancer.

The lack of evidence supporting the effectiveness of AOUM programs, as well as evidence demonstrating the potential harm such programs have on adolescents' sexual health, have led 17 states to withdraw from Title V AOUM funding, including Arizona, California, Colorado, Connecticut, Iowa, Maine, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Ohio, Rhode Island, Virginia, Wisconsin, and Wyoming. The number of adolescents living in the states that have passed up this funding is now substantial, more than 12 million, or 42 percent of young people aged 12–18 nationwide. In contrast, the President's budget continues to increase funding for AOUM programs. As an example of this trend, the fiscal year 2008 appropriation for AOUM programs was \$163 million and the President's fiscal year 2009 proposed budget requests \$191 million, a \$28 million increase.

The Evidence Supporting Comprehensive Sexuality Education

Experts in the fields of adolescent development, health and education recommend CSE programs that assist young people in developing a positive view of their sexuality, provide them with information necessary to protect their sexual health and help them acquire skills to make informed decisions, both now and in the future.

CSE programs emphasize abstinence from all sexual activity as the most effective and reliable method of avoiding STIs, HIV and pregnancy. In addition, CSE programs teach adolescents about contraceptives and barrier methods to reduce their risk of contracting STIs, HIV and/or becoming pregnant. Ideally, CSE programs start in kindergarten and continue through the twelfth grade, are taught by teachers who have completed CSE-related instruction and provide adolescents with developmentally appropriate information regarding a broad range of topics related to sexuality, including sexual development, reproductive health, interpersonal relationships, body image, and gender roles. Furthermore, CSE programs provide opportunities for students to develop communication, decision-making and other interpersonal skills. CSE programs also allow parents to exercise the option of taking their children out of such classes if they do not wish their children to be exposed to this information.

Research has demonstrated that parents strongly and consistently favor age-appropriate and culturally sensitive school-based sexuality education programs that stress abstinence and include information about contraception as part of a CSE program. Moreover, both parents and teens report that such programs do not send teens a mixed or confusing message. Parents also support sexuality instruction about topics such as reproductive anatomy and physiology, physical changes associated with puberty, and body image beginning earlier in school, preferably during the elementary grades. In addition, the National Coalition to Support Sexuality Education, made up of over 155 national organizations including APHA, is committed to medically accurate, age-appropriate comprehensive sexuality education for young people in the United States. These organizations represent a broad constituency of education advocates and professionals, health care professionals, religious leaders, child and health advocates, and policy organizations. Due to the epidemic of overweight and obesity among school-aged children in the United States, such sexuality instruction is particularly warranted, as overweight and obese girls are nearly twice as likely as healthy weight girls to reach sexual maturity at an earlier age and to report greater body dissatisfaction, lower self-esteem and to engage in a variety of health and sexual risk behaviors at an earlier age than healthy weight girls.

Several comprehensive sexuality education programs have demonstrated, through rigorous evaluation, to delay the onset of sexual intercourse, reduce the frequency of sexual intercourse, reduce the number of sex partners, and/or increase the use of condoms and/or other forms of contraception among teens. Some programs have demonstrated sustained positive effects on behavior for as long as three years. In fact, most of the decline in teen birth and pregnancy rates seen in the U.S. between 1991 and 2005 is attributable to

improved contraceptive use. An analysis published in the American Journal of Public Health in 2007 found that 86 percent of the decline in teen pregnancy between 1995 and 2002 was the result of improved contraceptive use and only 14 percent was the result of fewer teens engaging in sexual intercourse. In addition, teaching about contraceptives and barrier methods is not associated with increased risk of adolescent sexual activity or STIs. As reported in the April 2008 issue of the Journal of Adolescent Health, adolescents who received comprehensive sex education had a significantly lower risk of pregnancy than adolescents who received abstinence-only or no sex education.

Unfortunately, schools on average are teaching abstinence at much higher rates than the use of condoms and contraception. CDC's 2006 School Health Policies and Programs Study found that 76 percent of middle school and 87 percent of high school teachers taught abstinence as the best way to avoid STIs, pregnancy and HIV. However, only 42 percent of middle school and 65 percent of high school teachers taught condom efficacy, only 21 percent of middle school and 39 percent of high school teachers taught the correct use of condoms, and only 33 percent of middle school and 58 percent of high school teachers taught methods of contraception. Moreover, the emphasis on abstinence-only has permeated into other domestic and international health programs including family planning and HIV prevention through the incorporation of "ABC" concepts for HIV prevention counseling (that is, "A" for extramarital abstinence, "B" for be faithful in marriage or committed relationships, and "C" the correct and consistent use of condoms). This principle, developed by CDC, can now be found in the Title X of the Public Health Service Act Family Planning program, the Ryan White HIV/AIDS program and the President's Emergency Plan for AIDS Relief. However, whether ABC really represents comprehensive or effective HIV prevention has been widely questioned.

AOUM Programs Are Incompatible With Internationally Recognized Human Rights

While abstinence is often presented as the only moral choice for adolescents, APHA recognizes that the current U.S. government approach focusing on AOUM raises serious ethical and human rights concerns. Access to complete and accurate STI, HIV and sexual and reproductive health information has been recognized internationally as a basic human right and essential to realizing the human right to the highest attainable standard of health. In the context of sexual and reproductive health and rights, APHA adopted a policy in 2003 that calls for "affirming and upholding U.S. commitments under international human rights agreements" including "ensuring that government-supported sexuality education programs include comprehensive, medically-accurate information."

International treaties and human rights statements support the rights of all people to seek and receive information vital to their health. The U.N. Committee on the Rights of the Child in 2003 emphasized that "Consistent with State party obligations in relation to the rights to health and information (Articles 24, 13 and 17), children should have the right to access adequate information related to HIV/AIDS prevention and care, through formal channels (e.g., through educational opportunities and child-targeted media) as well as informal channels...The Committee wishes to emphasize that effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that consistent with their obligations to ensure the survival, life and development of the child (Article 6), States' parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality." In addition, the Programme of Action of the International Conference on Population and Development, adopted in 1994 by 179 countries including the U.S., included the principle that "States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual

health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."

These treaties and human rights statements strongly suggest that governments have an obligation to provide accurate information to their citizens and to eschew the provision of misinformation in government-funded health education and health care services. Likewise, APHA holds that individuals have rights to accurate and complete information from their health care professionals, and that health care providers and health educators have ethical obligations to provide accurate health information. While good patient care is built upon notions of informed consent and free choice, APHA holds that AOUM programs are inherently coercive by withholding information needed to make informed choices. As defined by the U.S. government's own funding requirements, these programs are required to withhold information on contraception and other aspects of human sexuality, and to promote scientifically questionable positions. These requirements, which limit topics for discussion in the classroom, place health educators in an ethical quandary, forcing them to choose either to withhold potentially life-saving information, or to breach federal government guidelines by disclosure of such.

Recommendations

Given these serious concerns about the efficacy and ethics of current U.S. support for abstinence-only education, APHA makes the following recommendations:

1. Efforts to promote abstinence should be provided within public health programs that present adolescents with complete and accurate information about sexual health. Such programs must be scientifically and medically accurate and based on theories and strategies with demonstrated evidence of effectiveness; be consistent with community standards, yet be implemented in a nonjudgmental manner that does not impose religious viewpoints on students; support positive parent-child communication and guidance; be age, developmentally, linguistically, and culturally appropriate; and be taught by well-prepared teachers who have received specialized training in the subject matter. APHA strongly supports CSE that includes information about healthy sexuality; reproductive anatomy and physiology; physiological, psychological and social changes associated with puberty and adolescent development; sexual orientation, gender identity and tolerance; healthy vs. unhealthy relationships; personal responsibility; risks of STIs, unwanted pregnancy and HIV; access to reproductive health care; and benefits and risks of condoms and other contraceptive methods.
2. All States should support school districts and local schools to implement abstinence education as a part of comprehensive sexuality education and as an integral part of comprehensive K-12 school health education. Districts should use multiple sources of data regarding student needs, knowledge and behavior to plan programs that meet the prevention needs of all students, with due attention to those who might be at greater risk for STIs, HIV and pregnancy, such as young men who have sex with men or members of populations with high prevalence rates. Schools should be required to provide this instruction to all students unless a parent or legal guardian has specifically requested that their child be excused from ("opt-out" of) the entirety of the instruction before it begins.
3. Current federal funding for AOUM programs under Section 510 and CBAE should be repealed and replaced with funding for a new federal program to promote and support CSE. The U.S. Congress should authorize and fully fund legislation that promotes CSE programs that include information about both abstinence and contraception; include parent-child communications components; and teach goal-setting,

decision-making, negotiation, and communication skills. To initiate this process, HHS should convene special advisory groups of respected experts in the fields of adolescent health and sexuality education and parents to determine how best to implement this strategy.

4. The U.S. Congress should require that all sexuality education programs supported by the federal government, and all sexual health information disseminated by federal agencies, be medically and scientifically accurate, age and context appropriate, and based on theories and strategies with demonstrated evidence of effectiveness and consistent with international human rights declarations.

5. Governments and school districts should not tolerate censorship of information related to human sexual health within the public schools.

6. Federally supported public health programs should promote social and cultural sensitivity to sexually active youth and GLBTQI youth.

7. Schools of higher education should prepare prospective teachers in the content and pedagogy of effective comprehensive sexuality education. In addition, HHS should develop a technical assistance training program between established trainers in comprehensive sexuality education and teachers in need of this training.

8. CDC's Division of Adolescent and School Health and/or the National Institute for Child Health and Human Development should provide funding for scientific research into the effectiveness of sexuality education programs.

Chairman WAXMAN. Thank you very much, Dr. Benjamin. Dr. Blythe.

STATEMENT OF MARGARET J. BLYTHE

Dr. BLYTHE. Chairman Waxman, Ranking Member Davis, members of the committee, good morning and thank you for inviting me.

As a current Chair for the Committee on Adolescence, I have been asked to give testimony regarding the position of the American Academy of Pediatrics on Abstinence-Only Education and comprehensive sexuality education and the evidence supporting this decision.

The American Academy of Pediatrics supports age-appropriate, comprehensive sexuality education and wants to ensure that our Nation's resources are being allocated toward educational approaches that are science based, emphasize abstinence, but also provide medically accurate information for those teens contemplating or already having sexual experiences. That support for comprehensive education is apparent in the policies that we have written and endorsed and listed in this testimony.

Nearly all teens experience pressure to have sex at some time, and therefore nearly all teens are at risk for having a pregnancy or a sexually transmitted infection. Abstinence-only programs have not been proven to change or impact adolescent sexual behaviors in an effective way, as documented by five reviews, which include the federally funded evaluation. Yet, vast sums of Federal moneys continue to be directed toward these programs.

In fact, there is evidence to suggest that some of these programs are even harmful and have negative consequences by not providing adequate information for those teens who do become sexually active. Comprehensive sexuality education supports abstinence as the best strategy in which a teen can use to decrease the risk of unintended pregnancy and sexually acquired infections. Those adolescents who choose to abstain from sexual intercourse should obviously be encouraged and supported in their decisions by their families, peers, and communities. But abstinence should not be the only strategy that is discussed. Rigorous scientifically valid research supports the effectiveness of comprehensive sexuality education in delaying the initiation of sexual intercourse and reducing risky sexual behaviors.

When the information presented is straightforward, that means real or relevant to their life experiences and specific. That means medically accurate and correct. This means that sex education must include information on contraception and condom use.

Providing information to adolescents about contraception does not result in increased rates of sexual activity, earlier age of first intercourse, or result in a greater number of sexual partners. Emphasizing both abstinence and protection for those who do have sex is a realistic, effective approach that does not appear to confuse young people, only perhaps sometimes the adults around them.

But, despite the encouraging results that have been reported when using comprehensive approaches, there have been no Federal moneys directed specifically toward education programs. Getting teens to delay having sex or to use safer sex practices remains a

challenge, as there are many factors that determine sexual behavior, and estimates suggest that there are over 500 different factors.

The most recent data suggests for the first time in 14 years the birth rate for teens in the United States has increased across virtually all racial and ethnic groups. A recent report by the Center for Disease Control estimates that one in four girls between the ages of 14 to 19 has at least one sexually transmitted infection, and, as already indicated this morning, citing the ineffectiveness of abstinence-only programs, 17 States have opted out of Federal funding.

Adolescence is a time of growth both physically, psycho-socially, and emotionally. Developing a healthy sexuality is a key developmental task for adolescents. As a physician, I spend the majority of my professional time in the trenches. Each week I personally see teens in consultation clinics, three different community sites, a school-based clinic, and the county juvenile detention center. I also serve as the medical director of the clinical program that provided over 40,000 visits to teens last year in these different settings. In every venue teens are trying to figure it out—who they are, where they want to go, and what they want to be.

Adolescence is a time of trial and error, and, frankly, sometimes they get burned even when appropriate information has been offered or given. But we do not want them to get burned just because the information given or offered was inaccurate or distorted or not available at all. We need available to us in the trenches evidence-based approaches that support healthy decisionmaking regarding sexuality, which will benefit not only the health of the teens we work with on a day-to-day basis, but ultimately the health of our society and Nation as a whole.

Thank you.

[The prepared statement of Dr. Blythe follows:]



American Academy of Pediatrics



**TESTIMONY OF
MARGARET J. BLYTHE, MD, FAAP, FSAM
ON BEHALF OF THE
AMERICAN ACADEMY OF PEDIATRICS**

**before the
COMMITTEE ON OVERSIGHT AND
GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES**

APRIL 23, 2008

Endorsed by the Society for Adolescent Medicine

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Chairman Waxman, Ranking Member Davis and members of the committee, good morning and thank you for inviting me. My name is Dr. Margaret Blythe. I am a pediatrician and Professor of Pediatrics at Indiana University School of Medicine and a subspecialist in adolescent medicine. As the current chair for the Committee on Adolescence, I have been asked to give testimony regarding the position of the American Academy of Pediatrics on abstinence education and on age-appropriate comprehensive sexuality education and evidence supporting this position. My testimony is also endorsed by the Society for Adolescent Medicine of which I am also a member.

The American Academy of Pediatrics supports age-appropriate comprehensive sexuality and reproductive health education and wants to ensure that our nation's resources are being allocated toward educational approaches that are science-based. Comprehensive sexuality education *emphasizes* abstinence as the best option for adolescents, and but also provides age-appropriate, medically accurate discussion and information for the prevention of sexually transmitted infections and unintended pregnancies.¹

Abstinence-only programs have not been shown to change adolescent sexual behaviors according to 5 systematic reviews including a federally funded evaluation of Title V programs conducted by an independent research organization.^{2,3,4,5,6} In fact, abstinence-only programs are not only *ineffective* but may cause *harm* by providing inadequate and inaccurate information and resulting in participants' failure to use safer sex practices once intercourse is initiated.^{1,7} Specifically, one systematic review reports that using both self-reported biological and behavioral health outcomes, the abstinence-only programs did not affect incidence of unprotected vaginal sex, frequency of vaginal sex, numbers of partners, age of sexual initiation or condom use.⁵

Two new sets of data recently released by the Centers for Disease Control and Prevention (CDC) bring additional concerns about abstinence-only education programs and really demand a change in policy for funding sexual health education for adolescents. The most recent data indicate that births to teen girls aged 15-19 years increased by 3%; this is the first increase noted in the previous 14 years of decline.⁸ As well in this past month, CDC released new data about the prevalence of sexually transmitted infections (STIs) among adolescents, especially adolescent girls. CDC estimates that one in four girls aged 14-19 has at least one STI. This means as many as 3.2 million adolescent girls are infected with human papilloma virus (HPV), chlamydia, herpes simplex type-2, or trichomoniasis. These numbers are likely to be understated because syphilis, gonorrhea and the human immunodeficiency virus were not included in the data CDC analyzed for the estimate.⁹

Children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behaviors as adults, but also to avoid early, exploitative or risky sexual activity that may lead to health and social problems, such as unintended pregnancy and STIs, including HIV infection and AIDS.¹ This is especially true among gay, lesbian and bisexual youth who are more likely to have had sexual intercourse, to have had more partners, and to have experienced sexual intercourse against their will, putting them at increased risk of STIs including HIV infection.¹⁰ The data is clear that abstinence is the most effective means of birth control and prevention of STIs and needs to be included as part of an individual's strategy to reduce unintended pregnancy and STI rates. But abstinence should not be taught as the *only strategy*. To date, the evidence regarding the efficacy of abstinence-only in the reduction of risky sexual behaviors, including risk for STIs, has not been proven.^{2,3,4,5,6,7} For some adolescents, abstinence may be a difficult choice. And in practice, many adolescents who intend to be abstinent often fail and have sex. A longitudinal analysis of teens and

virginity pledges compared “pledgers” to “nonpledgers” and found at a 6-year follow-up that 88% of pledgers reported experiencing premarital sex and had STI rates that, statistically, were no different from those of nonpledgers.⁷

Evidence suggests that abstinence-only policies of the federal government changed the nature of sexuality education in the United States with many schools adopting abstinence-dominant or abstinence-only education programs for school sexuality curricula. Data comparing 1995 to 2002 showed a decline in young women reporting education about contraception (87% to 70%) and an increase in abstinence-only education (8% to 21%) with a decrease in those receiving both (84% to 65%).¹¹ Citing the ineffectiveness of abstinence-only programs, already 17 states have opted out of Title V funding. Estimates suggest over 40% of youth in the United States between the ages of 12 to 18 years live in these states.¹² The most recent review of abstinence-only programs in 2007 by the National Campaign to Prevent Teen and Unplanned Pregnancy continue to support that such programs are ineffective at reducing risky sexual behaviors. Specifically, these programs “did not delay the initiation of sex, did not increase the return to abstinence, or decrease the number of sexual partners.”¹³

Several published studies and evaluations have suggested that *comprehensive sexuality education* is an effective strategy for helping young people delay initiation of sexual intercourse.^{2,3,4} Comprehensive programs encourage abstinence as the best option but offer discussion and education for those adolescents who are sexually active about protecting against sexually transmitted infections and contraception.¹ Research has shown that these programs do not hasten the onset or frequency of sexual intercourse and do not increase the number of partners that sexually active teens have.¹³

A national study compared sexual health risks of adolescents who received abstinence-only education and those who received comprehensive sex education to those who received none. Adolescents who reported having received comprehensive sex

education before initiating sexual intercourse were significantly less likely to report a teen pregnancy compared to those receiving no sexual education while there was no effect of abstinence-only education.¹⁴ Sexuality education and interventions with some abstinence-base or "abstinence-plus" curriculum components are most effective when targeted at younger adolescents before they become sexually active.¹⁵

Providing information to adolescents about contraception does not result in increased rates of sexual activity, earlier age of first intercourse, or a greater number of partners.¹³ In fact, if adolescents perceive obstacles to obtaining contraception and condoms, they are more likely to experience negative outcomes related to sexual activity.¹⁶

Adolescents who choose to abstain from sexual intercourse should be encouraged and supported by their parents, peers, pediatricians and society, including the media. Adolescents need to know about other contraceptive options before (or if) they decide to have intercourse.¹⁷ Based on the evidence, AAP supports a comprehensive approach to sexuality education for adolescents. Abstinence should play a part in any comprehensive discussion of sexuality, with support and resources available for adolescents who feel pressured, but prefer not, to engage in sexual activity.^{1,17}

From a public health perspective, primary prevention of unintended pregnancy and STIs in adolescents involves a delay in the initiation of sexual activity until psychosocial maturity or marriage, depending on the religious or cultural perspective. Secondary prevention in adolescents involves the use of safer sex practices by those who are sexually active and who do not plan on abstaining from sexual activity.¹⁸ Adolescence is a time of growth and change- physically, psychosocially and emotionally. Developing a healthy sexuality is a key developmental task for adolescents. With these changes and goals come a desire and a need to assert independence and take responsibility for decisions and behaviors that impact health. Evidenced-based

Margaret J. Blythe, MD, FAAP, FSAM
 Testimony before the Committee on Oversight and Government Reform
 April 23, 2008

approaches that support healthy decisions and further these goals benefit not only the adolescent as an individual but the health of our society and nation as a whole.

The Society of Adolescent Medicine summarized its expert review of sexuality education with the following:

Abstinence from sexual intercourse represents a healthy choice for teenagers, as teenagers face considerable risk to their reproductive health from unintended pregnancies and STIs including infection with HIV. Remaining abstinent, at least through high school, is strongly supported by parents and even by adolescents themselves. However, few Americans remain abstinent until marriage, many do not or cannot marry, and most initiate sexual intercourse and other sexual behaviors as adolescents. Abstinence as a behavioral goal is not the same as abstinence-only education programs. Abstinence from sexual intercourse, while theoretically fully protective, often fails to protect against pregnancy and disease in actual practice because abstinence is not maintained.¹⁹

Thank you for the opportunity to provide this testimony. I would be happy to answer any questions you may have.

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Chairman WAXMAN. Thank you very much, Dr. Blythe.
Dr. Weed.

STATEMENT OF STANLEY WEED

Mr. WEED. Thank you, Mr. Chairman, for inviting me here today. I have been working in this field for almost 20 years. I have learned some things about abstinence education programs. I started with a very skeptical attitude thinking how in the world could this work, given the culture and the society that kids live in. Since that time I have learned that it can work. Not all of them do, but many of them do, and we have learned which ones do and why.

I have also seen that there is a lot of misunderstanding and misperceptions. Let me give you two examples.

One young man who was asked about if he was abstinent said, No, sir. I am here every day. Another example, I have heard the phrase abstinence-only maybe 100 times here today, and in the 100 programs that I have evaluated I wouldn't classify any of them as abstinence-only. They are much broader, they are much richer, and they are much deeper than an abstinence-only just say no kind of message.

[Simultaneous slide presentation.]

Mr. WEED. With chart No. 4 I would like to illustrate some examples of programs that work. This is out of Virginia. This program, the comparison group without the program, their initiation rate 12 months later was 16.4 percent. The program kids, their transition rate was 9.2 percent. That is a fairly substantial and significant difference in terms of impact on initiation rates.

Patterns of evidence are critical in terms of understanding program and policy effects. One rigorous study alone is not sufficient. Informed decisions require multiple studies with replication of results across populations, programs, and settings. Our goal should be to look for patterns of research results that can inform best practices for risk avoidance programs.

Here is another example. This one comes from Georgia. Our comparison kids, the transition rate for this group is 20.9 percent, and for our program kids it was 11.1 percent—again, 47 percent is likely to initiate sexual activity, a fairly substantial impact in terms of initiation rates.

The next example, this one comes from South Carolina, a large study of kids where the comparison group initiation rates of sexual activity is 26.5 percent, and in our program group it was 14.5 percent.

Again, in all three cases cutting initiation rates in half in a 1-year time period.

Now, there is a public perception that abstinence education doesn't work and that contraceptive education does work. In fact, there is a brochure out by the national Campaign to Prevent Teen Pregnancy. There is a brochure that says we have strong evidence about what works in preventing teen pregnancy. They list 28 programs, the impression being any 1 of these 28 will reduce teen pregnancy; 20 of those 28 never measured the impact on teen pregnancy. The 8 that did measure it, 3 had results 12 months or beyond; 1 of the 3 was not a sex education program, 1 was retested later and failed to find results, and 1 of 28 reported pregnancy re-

duction beyond 12 months. That does not constitute, in my opinion, strong evidence, nor does it support the public perception that we have mounds of evidence that this works.

Douglas Kirby, a colleague of yours and mine, I think, reviewed 115 programs—released in 2007 called Emerging Answers—108 could be considered, could be categorized as comprehensive in terms of providing contraceptive education to kids. However, only 22 of those 115 measured the most important measure of condom use, which I think we all agree is consistent condom use. Of those 22, 1 reported an increase in consistent condom use, and this occurred in a clinic setting not in a public school education setting. One reported no increase, but it did better than the comparison group; 1 out of 115 does not constitute compelling evidence favoring contraceptive education.

There is an important point here about measurement and impact and effects. This critical measure of consistent condom use is the best indicator of success. Anything less than this standard of effectiveness cannot be considered success. Inconsistent use, according to the CDC, failure to use condoms with every act of intercourse, can lead to STD transmission because transmission can occur with a single act of intercourse.

So when we look at these programs, we are trying to compare them and weigh the evidence—which I think is your goal and I applaud you for it—we have to look at these programs in terms of do they have similar behavioral outcomes, and abstaining from sexual activity is a clear one, and consistent condom use is as close as we can come in comprehensive sex to that behavioral short-term kind of outcome. We have to have similar target populations and appropriate and similar timeframes.

Based on comparability categories—that is, population and program settings are the same, followup is the same, outcome measures are the same—we have only got 8 studies in the abstinence category, we have 34, and not all of them measure CCU.

Here's the bottom line: even when we have comparable programs, the abstinence education in Kirby's review showed 5 out of 7 increased abstinence and 9 out of 34 increased abstinence in the comprehensive program. However, consistent condom use, zero out of 34 in the comprehensive side, zero out of 34 that decreased STD rates. It was three that decreased pregnancy, but one of them was, as I mentioned, not replicated.

I see my time is up. I can hold my last two slides if there are questions. Thank you very much.

[The prepared statement of Mr. Weed follows.]

Testimony Before the U.S. House of
Representatives Committee on
Oversight and Government Reform

Stan E. Weed, Ph.D.

April 23, 2008

Testimony Before the U.S. House of Representatives Committee on Oversight and Government Reform

Stan E. Weed, Ph.D.

Introduction

Thank you for the invitation to participate in this hearing. I look forward to a healthy discussion. We are dealing today with the common perception that abstinence education is *not* effective, and the corollary assumption that comprehensive sex education *is* effective at preventing the problems related to teen sexual activity. My testimony today will address these perceptions.

I started my examination of abstinence education nearly 20 years ago with a very skeptical mind about the likelihood of finding any success. Since that time, I have examined over 100 different abstinence education programs from an empirical standpoint. I have collected data from nearly 500,000 adolescents. I have personally interviewed more than 2,000. I may be the only person on this panel today who has actually been "on the ground" evaluating abstinence education programs. This has given me direct, extensive exposure to young people and their world. I have learned some things from that experience that are very difficult, if not impossible, to replicate through secondhand experience.

Over that same time period, I have also discussed this issue with many opponents of abstinence-centered education. Two camps of critics emerge. One camp would abandon abstinence education as a strategy and policy because they don't believe that it can work. For those, abstinence is a noble idea, but not practical. Their primary concern is *effectiveness*. Were they to see good evidence regarding effectiveness, they would at least consider it as a viable policy.

The second group of critics oppose abstinence education because it goes against their core value system. They believe that our society ought to be more free and open about sex, overcome our inhibitions, and simply enjoy the pleasures of physical intimacy regardless of age or marital status. For this group, effectiveness of abstinence education is not the most important issue. They oppose it because it is counter to their core values. If you are one of those in opposition, you might ask yourself "If it worked, would I still be in opposition?" My testimony today will probably be of more interest and value to those in the first camp.



Establishing Criteria for Program Effectiveness

The Need for Appropriate Criteria

I understand that the primary concern of this hearing is with evidence of effectiveness. Given that, we must first establish the *criteria for effectiveness*. The outcomes of teen pregnancy and STDs are common concerns for both the comprehensive sex education and abstinence-centered approaches to prevention. However, it is surprising how little actual evidence is available on those fundamental outcomes. For example, a recent publication from the National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP) titled "What Works 2008: Curriculum-Based Programs that Prevent Teen Pregnancy" (National Campaign to Prevent Teen and Unplanned Pregnancy, 2008) lists 28 programs that have the "strongest evidence of success." The title of this report implies there is good evidence that these 28 programs actually prevented teen pregnancy. Upon closer examination, however, we see that 20 of those 28 programs did not measure rates of teen pregnancy as an outcome. Of the 8 programs that did, 2 did not reduce teen pregnancy, only 3 reduced pregnancy for 12 months or longer. Of those 3, one was not a sex education program—it did not include any sex education or discussion of sex (Lonczak, et al., 2002)—and one of the remaining 2 was found to be ineffective in a second evaluation study by Dr. Doug Kirby (Kirby, et al., 2005). This leaves only one comprehensive sex education program that reduced teen pregnancy rates for at least one year, out of 28 supposedly effective programs. This does not constitute "strong evidence for success" as the brochure claims (see Table 1).

Table 1. Evidence of Success in 28 Programs that "Prevent Teen Pregnancy"	
↳	Yes, 8 Programs DID Measure It
↳	No, 20 Programs DID NOT Measure It
↳	2 Had NO Impact
↳	3 Had Impact on Teen Pregnancy for Less Than 12 Months
↳	3 Reduced Teen Pregnancy for 12 Months or More
↳	1 Was Actually Not a Sex Education Program (Did not Teach About Sex at All)
↳	1 Was Found Ineffective by a Later Study
↳	1 Sex Education Program had a Lasting Impact

**Published by The National Campaign To Prevent Teen and Unplanned Pregnancy in 2008.*

Another common concern, that of STD transmission, is also lacking adequate measurement history in program evaluation. In a recent and thorough review of 115 of the best sex education research of the past 15 years by Kirby (Kirby, 2007) only 22 evaluation studies measured reduction of STDs as a program outcome. Twenty of those found no reduction in STDs. The two that did find a reduction both occurred with self-selected patients in a clinic setting, not part of a curriculum based comprehensive sex ed program. If you read the report carefully, you will be surprised to find that there were no school- or community-based comprehensive sex education programs that reduced STDs.

Comparable Measurement Criteria

Stan E. Weed, Ph.D. Testimony—April 23, 2008



Given this lack of evidence regarding program impacts on the very outcomes that these efforts are designed to address, we are left with the challenge of establishing other criteria for determining "effectiveness." The impact of prevention programs is often assessed by examining shorter-term behavioral outcomes such as sexual activity (initiation and discontinuation), condom use, and a host of attitude, knowledge, and intention questions. The idea is that if programs can change these outcomes, we should also see reductions in the primary outcomes of interest, namely pregnancy and STDs. Using such evidence can be valuable, but will be useful in decision-making and policy-crafting only when the same criteria are used to measure outcomes for the various programs being compared—"apples to apples". Let me suggest three categories that can help establish comparability of evidence across different programs.

1. Time Frame. The first category for comparable evidence is the time frame for the outcome measure. For example, the widely cited Mathematica report, which evaluated 4 abstinence-centered education programs, measured outcomes 4 to 6 years after the program's end, with no interim support or reinforcement of the message (Trenholm, et al., 2007). Not surprisingly, none of the 4 programs showed decreased sexual activity 4 to 6 years after the program. Several news reports touted this study as the final proof that abstinence education does not work (Guttmacher Institute, 2007). However, when the 107 comprehensive or condom-centered programs in the Kirby review are held to this same time frame (Kirby, 2007), not one of them reported an increase in consistent condom use (CCU), nor did any of them report a decrease in STDs over that time period (see Table 2). And only one program reported a decrease in pregnancy rates (Vincent, et al., 2004). This lack of program impact was not similarly reported in the news as evidence that comprehensive sex education programs do not work.

Table 2. Comparing Program Results Using Similar Criteria
(Based on Similar Outcomes, Populations, & Timeframes out of 113 Reported Studies from 1990-2007)

Outcomes ³	Number of Studies with 4+ Years Follow-up	
	Abstinence (n=1)	Comprehensive (n=11)
	0	0
	0	0
	0	0
	0	1

- NOTES:
 1. Kirby, D. *Emerging Answers 2007*, published by *The National Campaign to Prevent Teen and Unplanned Pregnancy*.
 2. All programs studied employed quasi-experimental design or random assignment and were peer reviewed.
 3. Some programs did not measure all outcomes.
 4. These numbers represent raw counts of studies and not rates of effectiveness.
 5. The 4-year time frame is used for comparability to the Mathematica study's time frame.

Clearly, using equivalent time frames is an important factor in assessing outcomes. When we set up a race in a track meet, everybody in the same race runs the same distance. Our institute uses a minimum one-year follow-up time interval for measuring behavioral outcomes, for the following reasons: 1) a shorter interval is not adequate to detect changes in sexual behavior for young teens, 2) 12 months is the typical interval between school-based program installments (once per school year), and 3) an impact that lasts one year

Stan E. Weed, Ph.D. | Testimony—April 23, 2008



should be considered a minimum standard for a program to be called effective; program effects lasting less are only providing temporary impact.

2. Setting and Population. The second category for comparable evidence has to do with the setting and population where the intervention occurred. Most abstinence-centered education programs, including those funded under Title V, Title XX, and CBAE, are primarily offered in a school setting, either during or after school. Some are based in community settings such as recreation facilities. These are population-based strategies offered to *all* youth in the setting as a group, not to be confused with *clinical intervention* strategies where self-selected youth seek health services, often on a one-on-one basis. A comprehensive or condom-centered strategy that might work in a clinic setting with clients seeking STD diagnosis or treatment would not necessarily work in the school setting with school children. Results of programs in these two categories should not be compared against each other, nor can we expect that approaches found effective in one setting would necessarily work well in the other, or that the findings from the clinical interventions could be generalized to population-based strategies.

3. Outcome Measure. The third category for comparable evidence is the outcome measure itself. In abstinence education, there is a fairly high behavioral standard of success: to reduce sexual initiation rates, and to promote discontinuation for those that have already started. In comprehensive or condom-centered sex education the outcome measures often use a lower behavioral standard—including condom use at first or last intercourse, or frequency of condom use. This might be comparable to abstaining at first or last sexual opportunity. I don't think anybody here would accept the outcome of "abstinent on the first date," "abstinent on the last date," or "abstinent most of the time" as good evidence for program success in abstinence programs. Consistent condom use (CCU)—using a condom for every act of intercourse—is behaviorally a more equivalent measure to abstinence and is the standard by which the condom's capacity for partial prevention of STDs is measured. According to the Centers for Disease Control (CDC), it is *consistent use* that provides the partial protection that condoms are capable of: "inconsistent use, e.g., failure to use condoms with every act of intercourse, can lead to STD transmission because transmission can occur with a single act of intercourse" (CDC, 2003). According to a study in the journal *AIDS* (Ahmed, et al., 2001), for example, "Irregular condom use was not protective against HIV or STD and was associated with increased gonorrhea/Chlamydia risk." A Denver study (Shlay, et al, 2004) reported that "when all condom users were compared with non-users (N=126,220), there was limited evidence of protection against specific STD." But when consistent vs. inconsistent users were compared, the consistent users had significantly lower infection rates.

Measures such as condom use at first or last intercourse might serve as preliminary indicators of some program impact, but the gap between such measures and consistent use for American teens is often wide, suggesting that such measures are as likely to indicate inconsistent use as consistent use. (For example, in 2002, 68% of sexually active teen girls reported condom use at first sex, compared to 28% who said they always use a condom. See Franzetta, et al., 2006.) For a program to be deemed one that "works," promoted to the public and school officials, and implemented widely, surely the basic standard—abstinence or CCU—should be employed. Clearly, the effectiveness of different programs should only be assessed using comparable criteria. For example, comparing the effectiveness of abstinence-centered education on abstinent outcomes to comprehensive programs' effects on condom use at first intercourse would be inappropriate. For these reasons, any measure less than "consistent condom use" would be an unacceptable standard of success for comprehensive sex education.

Even the *consistent condom use* measure is not equal to the abstinence standard in terms of effectiveness, since even with consistent use, 20% to 30% of those exposed to an STD will acquire it, though they are assumed to be protected (Crosby, et al., 2003 and Winer, et al., 2006). However, it is as close as we can come to similar outcomes for comparing abstinence-centered and condom-centered programs and policies. Unfortunately, this more appropriate and comparable measure was used in only 6 of the 72 studies reviewed by Kirby that had a minimum follow-up time of 1 year (Kirby, 2007). This leaves scant evidence upon which to judge the relative success of abstinence versus comprehensive sex education. The 3 categories of comparable evidence are summarized in Table 3.

Table 3. Comparable Evidence-Based Criteria: Categories that Define Program Effectiveness	
Behavioral Outcomes	
↳	Abstinence
↳	Consistent Condom Use (CCU)
↳	Sexually Transmitted Disease (STD)
↳	Pregnancy
Common	
↳	School- or Community-Based
↳	Not Clinic-Based
Appropriate Time Frame (Duration of Follow-Up)	
↳	12-month Minimum
↳	4 Years: Seldom Measured or Achieved by Any Sex Education Program

Evidence for Abstinence and Comprehensive Sexuality Education

Evidence from 17 Years of Sexuality Education Studies

After establishing comparable measurement standards for effectiveness, we can look at Kirby's list of 115 credible studies and identify the abstinence-centered and comprehensive sex education programs that meet these criteria. We can then do a side-by-side comparison of the results of these two types of programs, given that they have 1) a common setting and population (school- or community-based), 2) an appropriate and similar time frame (1 to 3 years), and 3) comparable outcome measures (either abstinent behavior, CCU, STDs, or pregnancy). Out of the 115 studies reviewed, we found 34 studies of comprehensive sex education and 7 studies of abstinence-centered programs that met these criteria.

For the 34 comprehensive sex education studies that are comparable to the abstinence education studies on these three categories, none of the published studies reported an increase in consistent condom use (CCU) after one year (many did not even measure it). In addition, as shown in Table 4, none of the 34 studies reported reductions in STD rates (either not significantly different after at least one year or not measured). And, there were only 3 studies that reported decreases in pregnancy rates (Philliber, et al., 2002; Stanton, et al., 2004; and Vincent, et al., 2004), one of which was not replicated by another study 3 years later (Kirby, et al., 2005). Most of these studies measured sexual initiation (33) and 9 found significant

Stan E. Weed, Ph.D., Testimony—April 23, 2008



reductions (Coyle, et al., 2004; Hubbard & Rainey, 1998; Kirby, et al., 1991; Philliber, et al., 2002; Sellers, et al., 1994; Aten, et al., 2002; Sikkema, et al., 2005; Zimmerman, et al., *in press*; and Zimmerman, et al., *in press*), one of which was not replicated 3 years later (Kirby, 2005). As can be seen, the actual evidence regarding comprehensive sex education as a prevention strategy is far less compelling than what the public perception and conventional wisdom would suggest. Using these same three categories to make the evidence more comparable, we look at the 7 abstinence education studies from Kirby's list that meet the criteria. Of these, 5 of the 7 reported a significant reduction in initiation rates (Clark, et al., 2005; Denny & Young, 2006; Doniger, et al., 2001; Howard & McCabe, 1990; Weed, et al., 1992). It is interesting to note that the comprehensive sex education programs appeared to be more effective at achieving teen abstinence than achieving the other outcomes, although not as effective proportionately as the abstinence-centered programs (5 out of 7 versus 9 out of 33).

Table 4. Comparing Program Results Using Similar Criteria
(Those with Similar Outcomes, Populations, & Conditions out of 113 Reviewed Studies from 1991-2007)

Outcomes ²	Number of Studies with 1-3 Year Follow-up ³	
	Abstinence-Only (n=7)	Comprehensive (n=33)
Significant reduction in initiation rates	5	9
Significant reduction in pregnancy rates	0	0
Significant reduction in STD rates	0	0
Significant reduction in any sexual activity	1	3

- NOTES
 1. Kirby, D. *Emerging Answers 2007*, published by *The National Campaign to Prevent Teen and Unplanned Pregnancy*
 2. All programs studied employed quasi-experimental design or random assignment and were peer-reviewed.
 3. Some programs did not measure all outcomes.
 4. These numbers represent raw counts of studies and not rates of effectiveness.

New Evidence regarding Abstinence-Centered Education

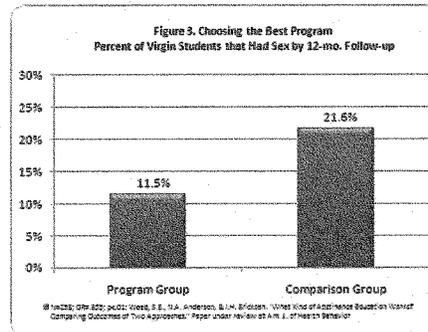
While program and policy evaluation is relatively new to abstinence education, we are now seeing a pattern of evidence indicating that well-designed and well-implemented programs can be effective. Let me share some additional, recent studies that have been published in peer-reviewed venues but were not included in Kirby's list or in any of the recent reviews of abstinence-only evaluation:

Heritage Keepers. The *Heritage Keepers Abstinence Education* study used a large sample size (n=1,535), matched comparison group, and 12-month follow-up (Weed, et al., 2005). It found that program students were about one-half as likely to initiate sexual intercourse after one year as were the comparison students, after controlling for pretest differences (odds ratio=.539, p<.001). Program students also had significant improvement on cognitive factors that appeared to mediate teen abstinence (see Figure 1).

Reasons of the Heart. An evaluation of the *Reasons of the Heart* abstinence curriculum (Weed, et al., 2008) found that adolescent virgins who received the program were less than one-half as likely as the matched comparison group to initiate sexual activity after one year (odds ratio=.413, p<.05). This program



month follow-up period. The 3 studies provide new and more rigorous evidence that abstinence education programs can be effective. Two more studies that are in the publication pipeline show similar patterns of effectiveness (see Figure 3 for one of them). Taken together, a pattern of scientific evidence is emerging that indicates abstinence-centered sex education programs, if properly designed and implemented, can cut rates of teen sexual activity by as much as half for significant periods of time, without reducing condom use by the sexually active. (Condom use was measured by the Jemmott, et al., 2006 and Trenholm, et al., 2007 studies of abstinence programs and no adverse effect was found.) This suggests that teaching adolescents to avoid sexual activity is a viable primary prevention strategy, one that can fully prevent the harmful and costly consequences of teen sex.



It should be noted here that critics of abstinence education cite several recent reviews of abstinence education studies that found no positive impact on teen sexual behavior (Kirby, 2007, Kohler, et al., 2008, and Underhill, et al., 2007). Most of the studies included in those reviews occurred during the first decade of federal abstinence funding at a time when abstinence education programs and program evaluation was still in its infancy. There was a lack of research—both quality and quantity—in this first decade of abstinence funding. This trend is changing, and unfortunately none of those cited reviews included the recent abstinence evaluations we refer to in the preceding paragraphs. These recent studies render the previous reviews and their findings somewhat outdated and not representative of the state of the science of abstinence research.

Characteristics of Successful Programs

Do *all* abstinence programs work? Of course not. We have also evaluated programs that do not work, or do not work well, or that do not work for all of the program participants. (This is more common for programs in the early stages of development and implementation, when they have not had the value of data to provide direction for program modification and improvement.) The real question we need to be asking then is not "Do they work?" but rather "Which ones work, for whom, and under what conditions?" Answers to these questions will move us further down an effective policy road than the simplistic "Do they work?" In our studies of abstinence-centered interventions for teens, clear patterns of program effectiveness have emerged. Successful programs usually share the following characteristics:

1. **Adequate Dosage.** Successful programs attend to the critical factor of adequate "dosage," and deliver that dosage on an effective schedule.
2. **Mediating Factors.** They go beyond the simplistic notion of "providing information" (even if it is medically accurate) and effectively address the key predictors of adolescent sexual risk behavior that are amenable to intervention.
3. **Messenger.** They give as much attention to the messenger as they do to the message. Effective teachers make more of a difference in program outcomes than do printed materials. These teachers engage students in the learning process, gain their respect, model their message, and believe in their ability to impact students.
4. **Evaluation.** Effective programs conduct quality program evaluation, and take seriously the lessons learned, especially those that identify program shortcomings.

Medical Accuracy

Medical accuracy is a reasonable standard, and it ought to be applied to *all* sex education material. If we were to scrutinize all curricula in the broad field of sex education, we would find a plethora of outdated, inaccurate, or misleading information. An example of the latter comes from the research vs. public policy on human papillomavirus (HPV), the STD that is responsible for more than 90% of all cervical cancer in women (Bosch, 1995). More women die annually in the U.S. from cervical cancer than die of AIDS spread through sexual contact (American Cancer Society, 2002 and CDC, 2003a). As early as 1999, the CDC knew that HPV was directly linked to cancer, and that condom use was not an effective barrier to transmission of the virus, but chose not to warn the public about this because they felt it would be counterproductive to condom use that could still provide some protection for other STDs. At the same time some abstinence education programs were criticized for stressing these facts about HPV. I think all would agree that adolescents and their parents should be given accurate information about sexuality and that programs should use the latest and best scientific information available.

Equally important, however, is this well established fact: *adolescent behavior is not primarily driven by their information system.* There are several factors that drive behavior that are far more important and potent than information—no matter how accurate it is. The key predictors of risk behavior do not include medical facts about physiology, biology, and the risks of unprotected sex. These of course can be covered, and should be covered accurately. But we cannot count on medical information and risk assessment to have a major impact on adolescent risk behavior. The recent research on the adolescent brain and its development has helped explain this phenomenon, which flies in the face of conventional wisdom. It is important for program

developers to realize that an emphasis on information is not an effective strategy for changing adolescent behavior.

Changing Behavior—Consistent Condom Use and Abstinence

The National Center for Health Statistics reported that only about 28% of sexually active female teens report consistent condom use over a one-year period. For sexually active boys the number is 47% (Franzetta, et al., 2006). As has been illustrated above, programmatic attempts to increase CCU and maintain it among teens have shown little evidence of success, causing us to look for reasons why.

Medical and social science research may suggest some causes. At least three factors seem plausible. First, there appears to be a disconnect between the sex education strategy of providing teens with contraceptive and STD information for responsible decision making (even if it is medically accurate), and the developmental capacity of the teen brain. According to the latest medical research, the areas of the brain responsible for impulse control, risk assessment, anticipation of consequences, forward planning, and reasoned judgment—all of which are important for consistent correct condom use—are not fully developed until after the teen years, in the early twenties (Giedd, et al., 1999; Romanczyk, et al., 2002; and Thompson, 2001). In other words, as our legal system recognizes, adolescents are not fully capable of responsible decision-making. Those of us who have raised teenagers can relate to this fact. Their developmental schedule mitigates against consistent condom use. As one frustrated condom-centered sex education high school teacher told me “They can’t even remember to bring a pencil to class. How will they be good condom users?” Moreover, logical, foresighted thinking is even less likely to occur in the moment of passion. This is illustrated by two studies of teen girls, one which found that being diagnosed with an STD did not lower their sexual risk-taking behavior (Morrison-Beady, et al., 2003) and the other that reported that those who were *inconsistent* condom users actually had better knowledge about HIV risk than those who were consistent condom users (Kershaw, et al., 2003).

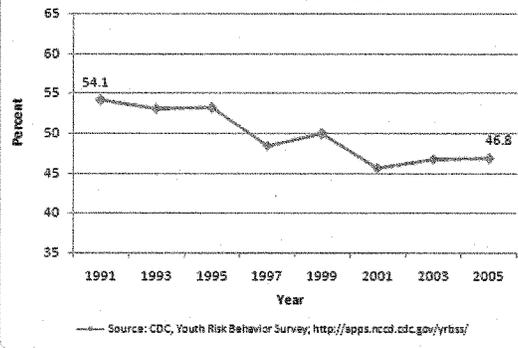
Second, it seems likely that the nature of teen relationships affects condom use. Several studies have shown that requesting condom use is sometimes interpreted as a lack of love, intimacy, commitment, and trust in a relationship, especially by females (Gebhardt et al, 2003; Ackermann & de Klerk, 2003; Hebling & Guimaraes, 2004). Given teen’s inherent need to be accepted and to be loved, it may be difficult to pull out a condom and give the implicit message that “I don’t trust you to be free of disease, nor can you trust me. But since this is just a casual hook-up with no commitment or loyalty expected, let’s just enjoy the moment and do it more safely.” Teen relationships *can* be shallow, but most are not, and most are looking for something more meaningful. Thus, sex *without* a condom may be more compatible with teens’ social and emotional needs, outweighing the risks it presents.

A third obstacle to teen condom use may be that those who are at greatest risk (teen girls), are often those with the least amount of control in the relationship. And, relationship control/power has been shown to be related to condom use (Pettifor, 2004). Teen girls are often outweighed and easily overpowered by their male counterparts, and may be more likely to be seeking love and closeness. Boys are typically more assertive and driven to seek physical pleasure, and may see condom use as an obstacle to that goal.

Admittedly, there are also barriers to promoting abstinence as a lifestyle, especially given the cultural context in which adolescents live. Movies, music, peers, Internet pornography, and other influences are constantly pushing a sexual message. Many teens have and will succumb to that influence. Abstinence education clearly faces an uphill battle. In spite of that, the studies reviewed here today (see Table 4)

showed more positive outcomes for increased abstinence (14 total) than for all of the other outcomes combined (4 total). Recall that of the 34 comprehensive sex education programs that fit the comparability categories, 9 reported significant improvement in abstinence, while none reported an increase in consistent condom use. And, this was in programs where abstinence was not the central message. The national trends in teen sexual activity show a consistent decline in sexual intercourse over the past ten years (see Figure 4). Apparently, this is a behavior that is amenable to change. Dr. Kirby's (1991) statement that "it may actually be easier to delay the onset of intercourse than to increase contraceptive practice" is bearing out. That change in behavior corresponds with the decline in teen pregnancy, teen births, and teen abortions—an encouraging trend by anyone's standards. Although not easy to achieve, it appears that abstinence-centered programs that are well designed and implemented can affect that behavior.

Figure 4. Percent of 9th–12th Graders That Have Had Sex: 1991–2005



Why Not "Abstinence-Plus"?

Why not have abstinence-centered and condom-centered education in the same program? This is the argument made by proponents of what is called "abstinence-plus" sex education programs, suggesting that both abstinence and condom education should occur in the same program. There are several reasons why this is problematic.

1. **Diluted Message.** A strong abstinence message that is not diluted with lessons about condom use and negotiation is necessary to provide teens the strong support they need to "say no" to the pervasive cultural message that teen sex is normal, acceptable, and admirable behavior. Most "comprehensive" or "abstinence-plus" programs are condom-driven, with abstinence as a minor part of the message. The proponents of this approach often are not committed to abstinence and give it only passing coverage in the curriculum, with most content focused on condom acquisition, condom negotiation with partners, and proper condom use. For example, the SIECUS website



recommends 37 topics for sexuality education curriculum content—abstinence is only one of the topics. And, an analysis of 10 popular comprehensive programs found condom use was mentioned 9 times as often as abstinence (see Table 5). These two strategies are based on very different assumptions and premises about human sexuality, healthy relationships, and family formation. It is difficult to see how these two different ideologies and philosophies could be combined.

2. **Separation of Messages.** Separating these approaches is consistent with the wishes of most American parents. In 3 national polls (NPR/Kaiser Foundation, 2004; Zogby, 2003; Zogby, 2004), a majority of American parents (70% to 90%) want a strong abstinence message given to teens. More than 90% believe that adolescents should not become sexually active and 67% say it is morally wrong for them to do so. In fact, 67% of teens who had already initiated sex expressed regret for doing so and the number was even higher for girls (77%). Most parents also favor the separation of abstinence education from information about sexual biology and risk prevention. Fewer than half (40%) think that abstinence and contraception should be taught in the same classroom. Most parents prefer that biological facts about contraception either be taught in a health curriculum separate from the abstinence program (56%) and some prefer it not be taught at all (22%).
3. **Withholding Information.** Comprehensive sex education programs are reluctant to give teens accurate information about the limitations of condom protection. This is an important part of abstinence education and consistent with the wishes of American parents. While a majority of parents believe teens should have information about risk reduction, 76% oppose withholding from teens medically accurate information about the limits of condoms in preventing STDs (Zogby, 2003; Zogby, 2004).
4. **Explicit Content.** Many parents oppose the explicit content found in many comprehensive sexuality programs. It is true that many parents respond favorably when asked whether teens should be given information about how to obtain and use condoms—39% and 58% in one poll (NPR/Kaiser Foundation, 2004), and 78% and 81% in another (Zogby, 2004). However, when asked to respond to the actual content of popular comprehensive sex education curriculum materials, the large majority of parents (70% to 90%) opposed the explicit information they contained about sexual practices, condom application and use, and masturbation. Most importantly, only 7% of parents want sex education to convey the message that “it’s okay for teens...to engage in sexual intercourse as long as they use a condom.” Parents should be able to have their children “opt out” of this kind of program content without also having to forego the abstinence message imbedded somewhere in it. (See NPR/Kaiser Foundation, 2004; Zogby, 2003; Zogby, 2004.)

Table 5. References to Condoms and Abstinence in "Abstinence Plus" Curricula*

Curriculum	condom/condoms	abstinence/abstain	Ratio
	183	90	2:1
	495	50	10:1
	383	5	77:1
	389	5	78:1
	136	0	infinite
	262	19	14:1
	22	32	1:1
	8	15	1:1
	650	18	36:1
	235	87	3:1
TOTALS	2763	321	9:1

*The Administration for Children and Families (ACF), Department of Health and Human Services (HHS). "Review of Comprehensive Sex Education Curricula." May, 2007.

- "Plus" is Not Effective.** Comprehensive or abstinence-plus education has not been shown to be effective at increasing teen CCU, which is the means through which condoms provide teens with partial protection from STDs. We might ask the opponents of abstinence-centered education why, if abstinence does not work, do they want to add it to a condom-centered education? And conversely, if abstinence education does work, why should abstinence programs add the thing that is not working? Recall that in the context of the three categories for comparability of evidence, there were no programs that had an increase in consistent condom use. Until that outcome is attained in risk reduction prevention programs, considering it as a supplement to abstinence would be a flawed strategy.
- Contraceptive Availability Elsewhere.** Risk reduction methods for sexually active teens, such as condom application, may best be taught in a separate health class, apart from the abstinence message. It is there, that sexually active teens can be referred to nearby clinics for one-on-one health care and prevention counseling. An estimated 68% of schools in the U.S. already have some form of comprehensive sex education, while only one-fourth receive an abstinence-centered program of some type. Abstinence education funding has not depleted the funding for comprehensive sex education, on the contrary, its' funding streams are smaller than what is available for comprehensive sex.

Stan E. Weed, Ph.D. Testimony—April 23, 2008



CONCLUSION

The research results presented here indicate that risk avoidance can be a viable strategy for protecting youth from all of the negative consequences of teen sexual activity. That is, emerging evidence supports the notion that abstinence-centered strategies, if well-designed and implemented, can significantly and substantially reduce teen sexual initiation for periods of 1 to 2 years and thereby may positively impact the health of American adolescents. When measured using comparable criteria, comprehensive sexuality education strategies (risk reduction) show little evidence for success at achieving the crucial outcomes of consistent condom use, reduced pregnancy, and STD rates. This pattern of data argues for continued support and expansion of abstinence-centered education, especially considering the regret that most sexually active teens express for becoming sexually active and the support that most parents show for programs that help their teens avoid sexual activity and its hazards.

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Chairman WAXMAN. OK. Thank you very much, Dr. Weed.
Dr. Fineberg, good to see you again.

STATEMENT OF HARVEY FINEBERG

Dr. FINEBERG. Thank you very much, Mr. Chairman, members of the committee. I am Harvey Fineberg. I am the president of the Institute of Medicine. Prior to becoming the president of the organization, I did serve as the chair of the committee that was looking into ways to reduce the risk of HIV infection, produced a report in 1999, *No Time to Lose*. Before that I served as dean at the Harvard School of Public Health, and prior to that practiced part time in neighborhood health centers in Boston. I have seen this issue from a variety of perspectives.

I would like to make five points in my oral presentation to supplement the written testimony that I have submitted.

First point I would like to make is that we are dealing with very complicated and variable interventions when we talk about sex education. Even though we are lumping them in two big categories of abstinence-only or abstinence-plus, the variety of elements in these programs should be a cautionary note to us in trying to interpret their effects. Exactly what is included? Exactly who is taught? Exactly how often? Exactly by whom? Over what timeframe? What exactly is being measured as the outcome that you are interested in? And how are you deciding whether or not the program is successful? These are all highly variable enterprises.

My second point: if you are looking for penicillin to treat pneumonia, something that has proven to work and is demonstrably successful almost all the time, no one has yet found that magic formula for sex education. Programs can be variably successful for variable times on variable outcomes, but fundamentally the dominant problems that we have in sexually transmitted infections in our young people and the continued risks of exposure to infection, as well as these other problems, are still very significant and still the most important problem that I believe you, as Members of the Congress, should be concerned with and attempting to help our Nation do better with.

My third point: because of all the variability and because of the emotionality and the prefixed positions about what works or should work, what do we want to work, one has to be especially scrupulous in examining the evidence in order to try to discern what does it tell us to date beyond this fundamental conclusion that there is no dominant, clearly victorious, magic strategy that will solve all of these problems.

And if you look at the studies that have tried to separate out the most rigorous evaluations and combine them in these broad clusters of abstinence-only or abstinence-plus and ask them, when they have looked at behavioral interventions, that is behavioral outcome reports by individuals in the studies—are they having sex earlier, are they having more or less sex, are they using protection—when you apply those standards and look at the studies in that light, two very significant reviews from the Cochrane Collaborative give us the following bottom-line information: If you look at the abstinence-only studies of the 13 that they included, none of those studies that passed this rigorous methodologic standard demonstrated to have

enduring behavioral affects. If you look at the 39 studies that they classified as abstinence-plus—and there is a lot of variability of what counts as abstinence-plus—23 of the 39 of those studies in this rigorous review found at least some benefit reported on one or another measure of behavior as a result of exposure to the programs.

Now, that doesn't mean they worked very, very well, and it doesn't mean that it is impossible that other programs could be constructed that would work better. In fact, my hope is and my urging is that we will look for those.

So my fourth point is: if you want to base your judgment on the evidence and where your dollars will go the furthest, to hamstring the interventions and the assessments, to limit them to abstinence-only education does not, in my judgment, comport with the evidence. It does not seem wise.

And my final point is that it is incumbent, I believe, to have a more flexible, substantive, careful, evaluative approach, allowing more different strategies to be tried that are built upon the evidence to date so that we can learn better what works over time, and in another 10 years, when another committee is looking at the question of sex education, we will not be in the same position that we are today.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Fineberg follows:]

Statement of

Harvey V. Fineberg, M.D., Ph.D.
President, Institute of Medicine
of The National Academies

before the
Committee on Oversight and Government Reform
U.S. House of Representatives

April 23, 2008

Good morning, Mr. Chairman and members of the Committee. I am Harvey Fineberg, president of the Institute of Medicine in Washington, DC. The Institute of Medicine is the health arm of the National Academies, which also include the National Academy of Sciences, the National Academy of Engineering, and the National Research Council. The Institute of Medicine serves as adviser to the nation to improve health, acting under the charter originally granted by Congress to establish the National Academy of Sciences in 1863.

I welcome this opportunity to discuss the effectiveness of sex education programs to prevent the sexual spread of HIV infection among youth in the United States. I will briefly summarize recent data on HIV infection and risk behaviors among youth in the U.S., discuss different types of sex education programs, and highlight findings from the 2001 Institute of Medicine report *No Time to Lose* (IOM, 2001) which examined this issue, as well as more recent research findings.

Risk of HIV Infection among Youth in the United States

Many young persons who contract HIV are infected through sexual exposure. In 2006, persons aged 13-24 accounted for 15% of newly diagnosed HIV/AIDS cases in the United States in the 33 states with confidential, name-based HIV reporting (CDC, 2008). An estimated 85% of U.S. females aged 13-19 with a diagnosis of HIV/AIDS during 2001-2005 in the 33 states with name-based HIV acquired HIV through high-risk heterosexual contact (CDC, 2007). Among U.S. adolescent males of the same age, approximately 77% with a new diagnosis of HIV/AIDS during the same time period and areas acquired the virus through male-to-male sexual contact, and an additional 11% were infected through high-risk heterosexual contact (CDC, 2007). In the decade between 1994 and 2003, new HIV/AIDS diagnoses declined by nearly 50% among people aged 25-34; however, new HIV/AIDS diagnoses among individuals aged 13-24 remained stable during that same period (CDC, 2006).

Sexual activity among teenagers is common and can lead to infections and unwanted pregnancy. In a 2005 survey, 47% of all U.S. high school students and 62% of high school seniors reported having had sexual intercourse (Kaiser Family Foundation, 2005). A recent national survey found that 1 in 4 teenage females—3.2 million—were infected with at least one sexually transmitted infection (STI) (Forhan et al., 2008). Nearly half of all African-American female teenagers in this study were infected with at least one STI. The STIs measured in this study were chlamydia, herpes simplex virus type 2 (HSV-2) (which causes genital herpes), trichomoniasis, and human papillomavirus (HPV). These STIs can be dangerous in their own right, including increased risk of cervical cancer associated with HPV infection, and the ulceration and inflammation caused by some infections can increase the risk of acquiring and transmitting HIV. Although teen pregnancy and birth rates in the U.S. have declined by approximately one-third since 1990, these rates remain high when compared to other developed countries. One worrying sign is that the teen birth rate increased between 2005 and 2006, the first rise since 1990 (NCHS, 2007).

These sober findings underscore the need for more effective deterrence of unsafe sexual practices among young persons that put them at risk for HIV, as well as other STIs, and unintended pregnancy.

Sex Education Programs in the United States

Sex education programs for adolescents in the U.S. vary considerably in their goals, content, duration and intensity, implementation setting, target age and population, the training and skill of the program facilitator, and other factors. Recognizing these variations, it will be convenient for our purposes to consider sex education curricula in two broad categories: abstinence-only programs and comprehensive programs. Abstinence-only programs (also referred to as “abstinence-until marriage” programs) teach and encourage young people to remain abstinent from sexual activity as the exclusive method to reduce their risks of HIV, other sexually transmitted infections, and unintended pregnancy. These programs provide little or no information about safer sex practices or contraception or emphasize their failure rates. Most comprehensive programs for youth (also sometimes referred to as “abstinence plus” programs) promote abstinence as the best means of preventing HIV, but also educate youth about correct and consistent use of condoms and other contraception to reduce unintended pregnancy, and to decrease the risk of contracting HIV or other infections (Underhill et al., 2007a,b).

Funding for abstinence-only programs has increased significantly in the past decade since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (“welfare reform act”) in 1996 (Pub. L. No. 104-193). This legislation created a new State Abstinence Education Program, funded through section 510 of the Social Security Act for abstinence-only education, appropriating \$50 million per year for five years (FY98-FY02). The program has been reauthorized under extensions of the welfare reform act. Other significant sources of federal funding for abstinence-only education include the Community Based Abstinence Education (CBAE) program and the Adolescent and Family Life (AFL) Program. Together, these three programs (Title V, CBAE, and AFL) totaled \$176 million in federal funding for abstinence-only education in FY2007 (state funding excluded)—compared to the \$9 million in federal funding in FY1997 prior to the enactment of the welfare reform act. Obtaining comparable estimates of expenditures on comprehensive sex education programs is difficult because funding for these programs comes from multiple state, local, federal and private funding streams that are mixed with funding for other services. In light of what are surely substantial expenditures for both types of programs, it is reasonable to ask how well they achieve their goals.

Effectiveness of Sex-Education Programs in Preventing HIV infection

In the 2001 IOM report *No Time to Lose: Getting More from HIV Prevention*, an expert committee reviewed the scientific evidence on the effectiveness of abstinence-only and comprehensive sex education programs targeting youth in preventing HIV infection. At the time, the committee concluded that evidence was insufficient to determine whether abstinence programs were effective in reducing sexual activity, in part because many programs had yet to be rigorously evaluated (Kirby 2000, Maynard, 2000). In contrast, multiple reviews concluded that comprehensive sex education programs were effective in reducing self-reported high-risk sexual behaviors among adolescents and that they did not increase self-reported sexual activity (Kirby, 2000; IOM, 1997; IOM, 1995; Kirby, 1995).

Today we have an opportunity to assess what the cumulative evidence in 2008 tells us about the effectiveness of these programs in preventing HIV transmission. I want to stress the high degree

of variability that exists in the research methods, outcomes, populations, control groups, and quality of evaluations of these programs. This heterogeneity limits our ability to draw comparative conclusions about the effectiveness of different programs.

The discussion below highlights findings from two recent, published, systematic reviews of studies evaluating the impact of abstinence-only and comprehensive (“abstinence-plus”) programs on biological and behavioral outcomes related to HIV prevention (Underhill et al., 2007a,b). Researchers from the Cochrane Collaboration conducted these reviews using established methodological and review guidelines to assess the strength of the body of evidence. The reviews include only randomized or quasi-randomized controlled trials which provide the strongest evidence about the effectiveness of a program. Trials were excluded from the review if they did not list HIV prevention as a specific goal of the program. While there may be other studies that could be referenced, the advantage of relying on these reviews is that they used reasonable inclusion criteria to reveal the overall pattern of results.

Relatively few rigorous scientific studies have evaluated the effectiveness of abstinence-only sex education programs. In 2006, the U.S. Government Accountability Office (GAO) issued a report on efforts to assess the accuracy and effectiveness of three major federally-funded abstinence education programs administered by the U.S. Department of Health and Human Services (DHHS). They found that while efforts had been made to evaluate abstinence-only sex education programs, most evaluation studies failed to meet minimum scientific criteria—such as randomization and use of control groups, sufficient follow-up time, or adequate sample sizes—that are necessary to support scientifically valid conclusions about a program’s effectiveness. Another recently completed, methodologically rigorous evaluation by Mathematica Policy Research of four federally funded abstinence-only studies provides additional insight into the effectiveness of these programs (Trenholm et al., 2007).

Impact of programs on biological outcome measures

Incidence of HIV

To date, no studies have directly measured the impact of abstinence-only or comprehensive sex education programs on HIV incidence (Underhill et al., 2007a,b). This is in part due to the fact that the incidence of HIV in the United States is relatively low compared to other diseases, and very large sample sizes or very long follow-up periods would be required to be able to detect the impact of a prevention program on HIV incidence, making trials more complicated and costly. The impact of these programs on HIV disease is thus undemonstrated.

Incidence of other STIs

The goals of sex education programs generally include reducing the occurrence of STIs. This is important in its own right and as a surrogate biological outcome measure for HIV infection. Still, few evaluations of abstinence-only or comprehensive programs have examined the incidence of non-HIV STIs as outcome measures. All studies in the Cochrane reviews relied on self-reported incidence of STI diagnoses or treatment rather than biologically confirmed disease incidence (Underhill et al., 2007a,b). Self-reported STIs do not necessarily reflect STI incidence accurately because self reports depend in the first instance on a person’s access to and willingness to seek STI screening, and self reports are susceptible to recall and other biases.

In the Cochrane review of abstinence-only programs in the U.S. to prevent HIV infection, 7 of 13 trials assessed participants' reports of STI diagnosis by a doctor or nurse (Underhill, 2007a). None of the trials found a significant short term or long term benefit of the programs compared to usual care, and one trial found significant adverse effects of the adult-led program on reported STI incidence after three- and 17- months of follow-up. However, the authors point out that the higher incidence of reported diagnosed infection in this study could have been due to differences in reporting, frequency of testing, or actual risk.

In the second Cochrane review of comprehensive (abstinence plus) programs in North American countries (primarily the U.S.) to prevent HIV infection, only three trials (of 39 included in the review) examined the impact of programs on STI-related outcomes (Underhill et al., 2007b). Two trials measured self-reported STI diagnosis by a doctor or nurse and one trial measured self-reported receipt of STI treatment. None of the three trials found significantly protective effects compared to control groups.

In reporting that neither abstinence-only nor comprehensive programs demonstrably reduce the incidence of STIs, the authors note that the trials may have been too small or too brief to detect a positive effect.

Incidence of Pregnancy

Pregnancy is an indicator of unprotected vaginal sex—an important risk behavior for HIV infection. Reduction in unintended pregnancies is a desirable outcome in itself, though it does not reflect all the risk behaviors that can lead to HIV, including, of course, the homosexual risk behaviors that account for three out of four newly infected males age 13 to 19 years. While pregnancy can be reduced through abstinence or correct and consistent use of effective birth control, reductions in HIV and STIs require other behavioral changes such as consistent use of condoms, reduction in number of partners, and screening and treatment for STIs, among others.

The Cochrane reviews included only those studies that explicitly listed HIV prevention as a goal—programs focusing exclusively on pregnancy prevention were not included. Studies in the reviews measured self-reported occurrence of pregnancy (females) or causing a pregnancy (males) rather than actual pregnancy incidence among teens (Underhill et al., 2007a,b).

In the Cochrane review of abstinence-only programs, 8 of 13 studies measured the impact of the programs on self-reported pregnancy rates (Underhill et al., 2007a). None found a significant benefit compared to either usual care or no treatment. One trial of a peer-led program found harm when compared to usual care at a 17-month follow up, but this result was isolated to a subset of males at a particular school and was not reflected in long-term behavioral measures.

In the Cochrane review of comprehensive programs, 7 of 39 trials measured the impact of programs on self-reports of becoming pregnant (females) or getting someone pregnant (males) (Underhill et al., 2007b). One unpublished study found a significantly protective effect of the program on female participants. Three studies suggested a positive outcome, but the studies had methodological flaws (e.g., limited statistical analyses or high rate of participant attrition) that limit their utility.

In sum, there is no good basis from these systematic reviews to conclude that abstinence-only programs have a positive effect on self-reported pregnancy. The reviews found limited evidence from a single unpublished study that comprehensive programs may reduce self-reported pregnancy incidence.

Impact of programs on behavioral outcome measures

The majority of studies on the effectiveness of abstinence-only and comprehensive programs examine self-reported measures of behavior rather than attempting to measure reductions in the incidence of disease or pregnancy. Self-reported behavioral outcome measures are not as strong as objective biological measures because they are an imperfect reflection of actual behavior and subject to bias.

Relevant behavioral outcome measures for programs to prevent HIV include: abstinence (or return to abstinence) from sex; reductions in the frequency of unprotected vaginal, anal, and oral sex or increases in condom use; reductions in the number of sexual partners and avoidance of concurrent partners; regular screening and treatment for STIs; and vaccination for certain STIs (HPV and hepatitis B).

Abstinence-Only Sex Education Programs

In the Cochrane review of abstinence-only programs, no program showed an effect on incidence of unprotected vaginal sex, number of sex partners, condom use or sexual initiation compared to controls. One trial favored an abstinence-only program over usual care for incidence of vaginal sex, but this was limited to two-month follow-up and was offset by measurement error and six other studies with non-significant effects. One evaluation found several significant adverse program effects: abstinence-only participants in this program were more likely than usual-care controls to report sexually transmitted infections, pregnancy and increased frequency of vaginal sex. Overall, the authors concluded that abstinence-only programs neither reduced nor exacerbated HIV risk among participants in the U.S. (Underhill et al., 2007a).

One of the most rigorous recent evaluations of federally funded abstinence-only programs was completed in 2007 by Mathematica Policy Research, Inc. (Trenholm et al., 2007). This was a multi-year, experimentally-based impact evaluation of four federally-funded abstinence-only sex education programs funded under from Title V, Section 510 of Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. No.104-193). These four programs vary in their strategies, settings, and population characteristics. Participants in these programs were randomized to abstinence-only program or control conditions. Based on follow-up data collected 4-6 years after enrollment, youth in the abstinence-only program group were no more likely to have abstained from sex compared to those enrolled in the control group. Among those who reported having had sex, the group receiving abstinence-only education reported having similar numbers of sexual partners and similar timing of onset of sexual debut to those in the control group. The abstinence-only program participants were no more likely to have engaged in unprotected sex than youth in the control group.

Comprehensive Programs

In the Cochrane review of comprehensive sex education programs for youth in high-income countries, 23 of the 39 trials found a positive effect on at least one self-reported behavioral outcome including sexual abstinence, condom use, and unprotected sex (Underhill et al., 2007b). While the specific features that contribute most to success are difficult to discern because of the variable design in these programs, the review found many comprehensive sex education programs appear to reduce self-reported short-term and long-term HIV-risk behaviors among young people in high income countries. These findings of positive behavioral outcomes are consistent with a prior independent review of the same body of literature (Kirby, 2007).

Conclusions and Observations

In the seven years since *No Time To Lose* was published, there is little additional evidence about the impact of sex-education programs that rely on biologically verified reductions in the incidence of HIV and other STIs. The growing body of literature on the impact of sex education programs on behavioral outcomes, however, provides more information.

Based on the relatively small number of rigorous evaluations, abstinence-only programs do not reduce the risk of HIV as measured by self-reported behavioral outcomes. Studies indicate that abstinence-only programs do not result in a delay in the initiation of sexual activity, a reduction in the frequency of unprotected vaginal sex, or a reduction in the number of sexual partners. Among sexually active teens, abstinence-only programs have not been shown to increase the return to sexual abstinence nor to affect condom use.

Comprehensive sex-education programs appear more promising. Several studies found a positive effect on a number of behavioral outcomes. Comprehensive programs have reduced the self-reported incidence and frequency of unprotected sex and the number of sex partners. These programs have also been demonstrated to increase reported condom use and to delay initiation of sexual activity.

The available evidence on the impact of sex education programs is limited to a relatively small number of well-executed, controlled studies. Future evaluations should endeavor to improve study quality in such areas as program specification, outcome measures, length of follow-up, and retention of study participants. Studies that validated behavioral measures against biological outcomes would be a valuable addition. Especially useful would be studies that compared abstinence-only and comprehensive programs head-to-head in the same target population at the same time.

I believe public funds should support programs that are well grounded in evidence. By this standard, public financing and wide deployment of abstinence-only programs does not constitute sound fiscal or public health policy. Comprehensive sex education programs appear to be more effective, although this conclusion is based mainly on self-reported behavior change rather than on direct biological measures of outcome. Encouraging innovation and flexibility in the design of future sex education programs coupled to a systematic evaluation strategy is the most promising path to reducing HIV and other sexually transmitted infections among adolescents.

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Mr. SARBANES [presiding]. Thank you.

STATEMENT OF MAX SIEGEL

Mr. SIEGEL. Good morning. My name is Max Siegel. Thank you for the chance to address abstinence-only until-marriage, a policy that has transformed my life.

I share my recommendations on how to improve sexuality education programs as a 23-year-old living with HIV who has spent the entirety of his young adulthood working to prevent new infections. My goal is to portray the personal impact of this flawed policy, while explaining how the lessons I have learned may apply to other young people who today make up 15 percent of all new HIV infections.

Thank you to Chairman Waxman and the Committee on Oversight and Government Reform for including HIV-positive young people in today's hearing.

I experienced abstinence-only until-marriage education taught by my junior high school gym teacher. In his class he told me and my male classmates that sex is dangerous and that we should think more seriously about it when we grow up and marry. He made clear that only one kind of sexuality, heterosexuality, ending in marriage was acceptable to talk about. Already aware of my sexual orientation, I found no value in his speech. It did not speak to me in my life. It might as well not have happened.

While most formal abstinence-only programs are more extensive than the class I experienced, they rely on similarly exclusive and stigmatizing messages that lack basic information about sexual health. Multiple studies, including a recent Federal evaluation, have found that the more expansive abstinence-only programs do not work either.

When I was 17 I began seeing someone 6 years older than me. The first time we had sex I took out a condom but he ignored it. I did not know how to assert myself further. I knew enough to suggest a condom, but I didn't adequately understand the importance of using one. And even if I did, I had no idea how to discuss condoms with my partner. The abstinence-only message did not prepare me for life, and I contracted HIV from the first person with whom I consented to having unprotected sex. I was still in high school.

I was diagnosed with HIV a few months after becoming infected. My friends and family were devastated. We didn't know about HIV, and we quickly developed false and damaging beliefs about my situation. It seemed as though I had done something particularly wrong, but it never occurred to us that I, in fact, engaged in fewer risk behaviors for HIV infection than most of my peers.

My parents were in no position to dispel these beliefs or otherwise educate me about HIV or AIDS because they, too, lacked sufficient knowledge of sexual health. Instead, they mourned the loss of their child.

I decided to pursue a career in the prevention and treatment of the virus, and one role I assumed was the role of an HIV test counselor. Over 3 years I gained a great deal of insight into the shared experiences of individuals living with HIV. I have not allowed discomfort to prevent me from addressing the needs of those around

me, and as an educator from reacting in ways that are proven to be helpful. Sexuality education shouldn't be different. Adults should not allow their moments of discomfort to trump the needs of youth for complete and accurate information.

Sexuality education programs must be as focused as my counseling sessions. Programs must be designed to meet the needs of individual students, most of whom will be sexually active before high school graduation. Students of all ages should know abstinence as the primary method to maintain one's sexual health, but they must be given additional tools to equip them for later life. Those tools should be discussed in a way that is age appropriate by educators with whom students can identify and communicate openly. We must facilitate critical thought about sexuality in terms of keeping students healthy and ultimately alive.

Today's hearing is not about abstinence being a prevention tool—I think we all agree it is—but rather whether abstinence-only programs are deserving of Federal resources, and the answer is no.

More individuals have this virus now than ever before in history. Most children born with HIV no longer die, they go into adolescence and adulthood. Within and outside of marriage, these young people must know how to prevent transmission of HIV to their sexual partners and how to protect themselves from further co-infection, other infections, and unintended pregnancy.

Abstinence-only curricula fail to meet the needs of individuals who are living with HIV. They further disparage HIV-positive youth by suggesting that they are dirty, dying, and unfit to be loved.

What I experienced in junior high gym class is a routine example of the messages of abstinence-only until-marriage programs that children across the country still experience today. These programs ignore the needs of lesbian, gay, bisexual, and trans-gender youth who are at particularly high risk for HIV infection, and use Government dollars to condemn them. They also compromise young women's safety by portraying sexually active females as scarred and untrustworthy.

From the health care perspective, it is essential that congressional scrutiny of these programs focus on the consequences of abstinence-only's condemnation of young people.

HIV prevention must respond to the state of our domestic epidemic now. I have worked with many women who contracted HIV within marriage. A woman asking her husband to respect her decision to abstain from sex or to use a condom is not supported by abstinence-only's teaching that sex is an expectation within marriage and that condoms do not work. There is no sufficient reason why this completely preventable infectious disease should have impacted any of our lives.

After 6 years of living with HIV and striving to prevent this virus in others, I strongly believe that it is society's responsibility to give young people all the tools they will need to lead healthy lives. Any American infected with HIV is a societal failure. I see no room for abstinence-only in this time of shrinking public health budgets and increased accountability. Please end the failed experiment of abstinence-only until-marriage education.

[The prepared statement of Mr. Siegel follows:]

Testimony of Max Siegel
Policy Associate, AIDS Alliance for Children, Youth & Families
Before the
U.S. House Committee on Oversight and Government Reform
April 23, 2008

Good morning. I am grateful for this opportunity to address abstinence-only-until-marriage education, a policy that has transformed my life. I share my recommendations on how to improve sexuality education programs as a person living with HIV who has spent the entirety of his young adulthood working to prevent new infections. My goal is to accurately portray the personal impact of this policy while explaining how the lessons I have learned may apply to other young people, who comprise 15 percent of all new HIV infections in this country every year (CDC, 2008). Thank you to Chairman Waxman and the Committee on Oversight and Government Reform for including an HIV-positive young person in today's hearings.

Abstinence-only programs do not work. Beyond the responsibility we have to provide young people with accurate, complete, and lifesaving education about their sexuality, I see no room for failed programs such as abstinence-only education in this time of shrinking public health budgets and increased accountability. Please end this horrible experiment so we can begin the work of saving young people's lives.

I experienced abstinence-only-until-marriage education taught by my junior high school gym teacher. In a session, he told me and my male classmates that sex is dangerous and that we should think more seriously about it when we “grow up and marry.” He was clear that sex was something only for married people. He was visibly uncomfortable, and he conveyed to us that sexuality was not to be discussed extensively in an educational setting. Even if it were, my gym teacher made it clear that only one kind of sexuality—heterosexuality ending in marriage—was acceptable to talk about. Already aware of my sexual orientation, I found no value in his speech. It did not speak to me and my life. It might as well not have happened.

While most formal abstinence-only education programs in this country are more extensive than the class I experienced, they rely on similarly exclusive and stigmatizing messages that lack basic information about sexual health. My classmates and I required nonjudgmental, practical information that was tailored to our individual needs. I am evidence that the basic abstinence-only lesson I received was ineffective. Multiple studies, including a 10-year federal evaluation, have found that the more expansive abstinence-only programs do not work either.

Unfortunately, this abstinence-only lecture was the only education I received on the subject. As such, I was ill-equipped to make responsible decisions about my sexual health. When I was 17, I began seeing someone six years older than me. The first time we had sex, I took out a condom but he ignored it. I did not know how to assert myself further. I knew enough to suggest a condom, but I did not have an adequate

understanding of the importance of using one, and even if I had more reasons to use a condom, I had no idea how to discuss condoms with my partner. The abstinence-only message did not prepare me for life, and I contracted HIV from the first person with whom I consented to having unprotected sex. I was still in high school.

Did the abstinence-only message make me HIV positive? It did not force me to forgo the condom. But, it did nothing to prevent me from contracting the virus. My coach could have told me that gay people had value and that delaying sex could benefit me too. He could have told me that I could still take actions toward healthy sexual relations even though I could not get married. He could have talked to me about how essential condoms were to stopping the spread of infection among sexually active people, and he could have taught me how to navigate weighty topics such as emotions, love, and condom use within a relationship. These topics also are absent from abstinence-only programs operating today, which puts thousands of young people across the country at risk for disease and teen pregnancy.

I met with a healthcare provider a few months later. Before informing me of my HIV status, the provider asked me about my plans for college. An idealistic teenager, I had a great deal to say about one day earning an advanced degree in a helping profession. The provider responded simply: “Well, after today, you can still *try* to do those things.” I knew then that I had HIV. Unfortunately, I had no preexisting knowledge of what my prognosis could be or any of my healthcare options, which is information that should

have been provided for me during my school's sexuality education program. Beyond shock and hopelessness, my initial reaction was extreme guilt.

My friends and family were devastated upon my new disclosure. We had no substantial knowledge about HIV and we quickly developed false and damaging beliefs about my situation. I came to consider it unfair for me to confide in my loved ones for support because, through having unprotected sex with a single individual, I had committed a heinous crime that brought suffering into their lives. I thought that while a single HIV-infected person adversely impacts an entire community, it is this person's lone undertaking no matter their age or circumstance to reconcile the consequences of this disgraceful infection.

It seemed as though I had done something particularly disgraceful, but it never occurred to any of us that I in fact had engaged in fewer behaviors that could put me at risk for HIV infection than the majority of my peers. I wish I could say that my parents did not reinforce such notions. Like many young people's, my parents were in no position to educate me about HIV or AIDS because, although otherwise extremely well-educated, they did not have a comprehensive understanding or knowledge of sexuality and sexually transmitted infections. Instead, they mourned the loss of their child. As a community, we identified contracting HIV as someone's fault. We had no examples for how one might live well with the virus or any other chronic, sexually transmitted infection. None of us had received adequate education around these issues and what arose from my diagnosis was a widespread crisis. This crisis could have resulted in my absence from the medical

continuum, a refusal to disclose my status to future sexual partners, and suicide among other all-too-common occurrences in the lives of people living with HIV. It fortunately did not.

Soon after diagnosis, I decided to pursue a career in the prevention and treatment of the virus. I thought I had little time on this planet and that I was automatically in a unique position to help people because of my status. I have gone on to earn national recognition for my HIV-related endeavors. I hope I have demonstrated that those living with HIV can be relevant, meaningful members of society—even though the abstinence-only messages I received failed to teach me otherwise. The most personal career choice I made was to assume the role of an HIV counselor and to provide rapid HIV antibody testing to the general public. Working in HIV counseling and testing for three years, I gained a great deal of insight into the shared experiences of individuals living with HIV. These experiences cut across gender, race, and class, and I learned to pay particularly close attention to individuals' unique needs and perspectives.

That which makes me proudest in my life has been my willingness to be present for those who were otherwise alone. I have never averted my eyes from a client's suffering. I have not allowed discomfort to prevent me from addressing the needs of those around me and, as an educator, from reacting in ways that are proven to be helpful. Sexuality education should be no different. Adults should not allow their moments of discomfort to supercede the needs of youth for complete and accurate information.

Sexuality education programs must be as specifically focused as my counseling sessions. Programs must be tailored to meet the needs of individual students, the majority of whom will be sexually active before high school graduation. They should encourage abstinence while providing useful information about the potential consequences of sexual activity. Students of all ages should recognize abstinence as a primary mode of maintaining one's sexual health, but they must be given tools in addition to abstinence that will equip them for later life. These tools should be discussed in language that is accessible to students' particular ages by educators with whom students can identify and communicate openly. We must facilitate critical thought about sexuality in terms of keeping students healthy and, ultimately, alive.

Sexuality education programs should promote skills related to self-esteem, condom use and negotiation in terms of maintaining health as a priority, and self-efficacy while being inclusive of varying sexual orientations and gender identities. They must instill knowledge of local healthcare services, including the availability of HIV counseling and testing, and they should contribute to peer-led dialogue about healthy sexual behaviors, including abstinence. These programs must acknowledge relationship violence, which increases one's risk for HIV infection and is most commonly reported among married women (Lichtenstein, 2005). One's decision to abstain will not be honored in the presence of violence and coercion. Young people should be prepared for the wide array of emotions, not all of which will be bad, that result from engaging in sex. Age-appropriate and comprehensive sexuality education should be built into each grade level as sexuality is an issue of daily life. Effective sexuality education requires well-informed

educators who possess the professional skills to be able to deliver this important information in a confident and understanding way.

Students should leave sexuality education programs equipped and inspired to discuss HIV in terms of risk and transmission. Sexuality education should help individuals who are not living with HIV better understand the realities of a positive status for the purpose of preparing individuals who test positive later or have peers who are diagnosed for the medical and psychosocial ramifications of the virus. This requires a well-rounded portrayal of the lives of HIV-positive individuals. Students should have increased awareness about HIV and the bidirectional relationship between HIV and society. These programs should assume that many lessons arise from the AIDS pandemic. Themes such as stigma, isolation, discrimination, and unequal access to education and healthcare services are global and worthy of examination. Educators and policymakers must ask themselves: What effect does cultural legacy have on the marginalized communities most impacted by AIDS? Is it important to consider others' contexts in a holistic sense, including a history of sexual violence and family abuse, while striving to instill healthy sexual behaviors? Our leaders and role models are sacrificing young people's long-term survival in order to avoid momentary discomfort.

What I experienced in my junior high gym class is a routine example of the messages of abstinence-only-until-marriage programs that children across our country are still experiencing every day. On top of being proven ineffective for students (most of whom identify with traditionally heterosexual views of sex and gender), these programs also

ignore the needs of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, and even condemn them. The message I received in junior high was essentially that deviant life choices such as homosexuality or sex outside of marriage are not to be acknowledged. Furthermore, my educator implied that said deviants could never engage in sex in a healthy manner since non-heterosexual couples cannot “grow up and marry.”

Acknowledging that sexual minorities may be as healthy as anyone else is by no means an endorsement of their behaviors; however, abstinence-only programs utilize government dollars to actually lash out against LGBTQ young people. From a healthcare perspective, it is important for the scrutiny of abstinence-only programs to concentrate on the consequences of abstinence-only programs' condemnation of sexual minorities, including men who have sex with men, who are at high-risk for HIV infection. This government-funded condemnation impacts majority-identified community members as well. Many men who have sex with men, especially young men and men of color, will not disclose their sexual interactions with other men due to the negative social consequences of acknowledging their behaviors (CDC, 2003). Nondisclosers are more likely to contract HIV, less likely to receive HIV testing, and more likely to have sexual contact with women (CDC, 2003). Even if one does not place value on educating LGBTQ individuals about reducing their risk for HIV infection, these individuals inexorably overlap with heterosexual-identified community members. The diversity of sexual orientations and gender identities in our world is irreversible. For everyone's survival, we must realize that a failure to attend to the needs of these individuals is a

failure to perceive the risk that befalls anyone who might be deserving of life-saving education.

Young, straight women also are in need of education that includes, but is not limited to, abstinence. I have worked with various individuals who contracted HIV within marriage. Many of these individuals were women who had children, and some of these children were infected at birth. Women of color are at particular risk. According to the Centers for Disease Control & Prevention, Latina women have nearly the same HIV/AIDS rate (15.1) as white men (16.7) (CDC, 2008). Among African American women, the rate (56.2) is almost four times as high (CDC, 2008). Abstinence-only programs neglect the needs of women of color through curricula that reinforce gender roles and emerge from a context of ethnocentrism. Abstinence-only programs frequently portray sexually active young women as dirty, scarred, and inferior. Regardless, staying faithful to one's partner will not protect a woman whose husband or boyfriend has been incarcerated when rates of HIV infection among inmates is exponentially higher than in the general population. And a woman asking her husband to respect her decision to abstain from sex or to use a condom is not consistent with abstinence-only programs teaching sex as an expectation within marriage or that condoms do not work.

Sex education must be appropriate for as many populations as it plans on helping, and HIV prevention must respond to the state of our domestic epidemic. I have assumed the responsibility of trying to help the women and children with whom I have worked to the best of my abilities, but there is no sufficient reason why this completely preventable

infectious disease should have impacted any of our lives. After six years of living with HIV and striving to prevent sexually transmitted infections in others, I strongly believe that it is society's responsibility to provide young people with all the tools they will need in order to lead healthy lives. Any American infected with HIV is a societal failure.

More individuals have this virus now than ever before in history. Most children born with HIV no longer die; they are growing into adolescence and adulthood. Within and outside of marriage, these young people must know how to prevent transmission of HIV to their sexual partners and how to protect themselves from further co-infection, other sexually transmitted infections, and unintended pregnancy. Understanding proper condom use is imperative to their wellness and to that of others'. Abstinence-only programs stigmatize individuals living with HIV through conveying inaccuracies about the virus' transmission, such as by stating that HIV may be transmitted through skin-to-skin contact (Duran, 2003, p.19). Rarely have I encountered a sexual health forum in which youth *or* older adults in the audience could collectively identify the four fluids that are known to transmit HIV. If asked, would you be able to do so?

Popular abstinence-only curricula rely on scare tactics, which do not work and adversely impact individuals who are diagnosed with HIV or even other sexually transmitted infections. One abstinence-only program has utilized an in-class exercise in which students roll a die to represent the risks they take by having sex and, in the case of the die landing on four, the leader of the exercise told students that they have AIDS and, "You're heading to the grave. No cure" (Hughes, 1998). What does this do for adolescents who

are already living with HIV, or whose parents may be HIV positive, except cause fear? HIV-positive young people could be harnessed as powerful peer educators as they are more frequently in other countries. Instead, fear of them further discourages all individuals from discovering their status and fails to encourage individuals to follow the Centers for Disease Control & Prevention's recommendation that everyone ages 13 to 64 receive routine HIV testing (CDC, 2006). Abstinence-only curricula do not meet the needs of individuals who are living with HIV, whether they are aware of their status or not.

One of the most common barriers to effective HIV prevention among youth that I have encountered is apathy toward one's risk for infection. How are we to expect young people to recognize HIV as a legitimate concern when our policymakers and educators ignore overarching evidence that HIV prevention interventions must be administered in a comprehensive manner? The claim that comprehensive sexuality education encourages sexual activity among youth – despite evidence to the contrary – is an indication that policymakers are not aware of young people's willingness and capacity to make responsible decisions about their sexual health. This claim is counterintuitive to the numerous HIV-negative client success stories that I might tell, and it has not been proven in research. Comprehensive sexuality education programs are shown to increase the use of condoms and contraception while reducing a young person's number of sexual partners and pushing back the age of sexual debut (Kirby, 2007; U.S. Department of Health and Human Services, 2001).

I came to recognize the importance of condoms from my personal and professional experiences. Although condoms are not 100% effective at preventing HIV, they do come close. I have never screened a client HIV-positive who used condoms correctly and consistently. Unfortunately, abstinence-only programs are only allowed to note contraception or condom use in terms of failure rates. Research shows that abstinence-only students are less likely to use condoms or contraception when they do have sex (Bearman & Bruckner, 2001) and are less likely to seek medical attention in the presence of a sexually transmitted infection (Bearman & Bruckner, 2005). The Mathematica Policy Research conducted a large, comprehensive study of students in abstinence-only programs that showed these students to be no more likely to stay abstinent than individuals who do not undergo any sexuality education whatsoever (Mathematica Policy Research, 2007). The evidence shows that comprehensive sexuality education is more effective at keeping our young people abstinent than abstinence-only.

In summary, please stop funding abstinence-only programs and start funding comprehensive sexuality education. As a tax-paying young person living with HIV, I urge you to use our federal dollars for programs that actually do protect our sexual health.

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Mr. SARBANES. Thank you very much, Mr. Siegel.
Ms. Knox, please, 5 minutes.

STATEMENT OF SHELBY KNOX

Ms. KNOX. Thank you.

Good morning distinguished members of the committee. My name is Shelby Knox, and I am a 21-year-old speaker and sexual health educator. It is an honor to be here to share my personal experience with abstinence-only until-marriage programs and to provide a youth perspective on their appropriateness and effectiveness.

I was born and raised in a Southern Baptist family in Lubbock, TX, a city with some of the highest rates of sexually transmitted infection and teen pregnancy in the Nation. At 15, in accordance with my faith, I took a virginity pledge at my church. The same pastor who officiated at my religious pledge ceremony also presented a secularized abstinence-only program to students in my school district. Many students were already having sex and needed information to protect their health; however, he expounded on the ineffectiveness of condoms, explaining in graphic detail and with even more graphic pictures the sexually transmitted infections one could get if we trusted our health to a flimsy piece of latex.

We were all too intimidated or embarrassed to ask for clarification, but it seemed as if sex with a condom was the equivalent of sex without a condom.

He also touched on the ills of masturbation and warned against homosexual sex. One demonstration he used left little doubt as to our worth as a future spouse or partner or person if we were to engage in sexual activity before marriage. He pulled an often squirming and reluctant and always female volunteer onto the stage, took out a toothbrush that looked like it had been used to scrub toilets, and asked her if she would brush her teeth with it. When she predictably refused, he pulled out another toothbrush, this one pristine, in its original box, and asked her if she would brush her teeth with that toothbrush. When she answered in the affirmative, he turned to the assembly and said, If you have sex before marriage, you are a dirty toothbrush.

Many of my peers were struggling with questions, and most were not abstaining from sex. The statistics became alarmingly personal when the girl who sat next to me in math class got pregnant. She told me her boyfriend had said she couldn't get pregnant the first time she had sex. Her growing belly was the result of that first and only time.

Another friend, trying to be responsible, used two condoms at once. He had been taught that using a condom wouldn't work, so he tried two. Only later did I find out that using two condoms together was likely to cause both to break.

I believed in abstinence in a religious sense, but it was clear that abstinence-only as a policy for students who simply were not abstaining was dangerous. Even if we did wait until marriage, we still lacked a basic understanding of our bodies, reproduction, and how to prevent pregnancy, as well as a long list of sexually transmitted infections, including HIV, and the skills to have conversations about sex and protection. I felt betrayed by the people who I trusted to tell me the truth—my pastor, my teachers, the school

district, and the elected officials who deemed an ineffective policy good politics if not sound science.

I got involved with a group urging the school district to change the abstinence-only policy to a more comprehensive sexuality education curriculum that would include abstinence, as well as medically accurate information on a wide range of human sexuality topics.

My parents, proud conservatives who encouraged my virginity pledge, joined me in asking the school board to change the curriculum, because they wanted me to have complete and accurate information about my body and sexuality. They didn't see a conflict with encouraging me to remain abstinent while at the same time ensuring that my classmates and I received the tools in school to make healthy and responsible decisions about our lives. They were in good company—85 percent of parents believe that teens should receive information about abstinence as well as how to protect themselves.

Abstinence works. Abstinence-only until-marriage does not. It is morally unethical to leave young people without the information they need to protect themselves. Studies have shown a more comprehensive approach to sex education that gives us a strong message about abstinence and information about condoms and contraception does a better job helping young people abstain than do abstinence-only until-marriage programs.

So why is it that not a single Federal dollar has ever been dedicated to a comprehensive approach while more than \$1 billion has been spent on abstinence-only education? As a young person with first-hand experience about the misinformation, shame, guilt, and intolerance propagated by these programs, I urge you to eliminate funding for abstinence-only until-marriage programs and to, instead, allocate those funds to comprehensive, medically accurate sex education that provides young people with the tools they need to make responsible, informed decisions about their sexual health.

Once again, it was an honor to speak to you today, and I will be happy to answer any of your questions at the appropriate time.

[The prepared statement of Ms. Knox follows:]

Statement by Shelby Knox
Committee on Oversight and Government Reform
House of Representatives
April 23, 2008

Good morning Chairman Henry Waxman, Ranking Member Tom Davis, and distinguished Members of the House Committee on Oversight and Government Reform. My name is Shelby Knox and I am a twenty-one year old speaker, writer, and sexual health educator. It is an honor to be here to share my personal experience with abstinence-only programs and to provide a youth perspective on their appropriateness and effectiveness.

Purity Pledges: Efficacy and Side-Effects

I was born and raised in a Southern Baptist family in Lubbock, Texas – a city with some of the highest rates of teen pregnancy and sexually transmitted infections in the nation. At fifteen, in accordance with my faith, I took a virginity pledge as part of a ceremony at my church. Even though I was well past puberty, I still held an embarrassingly vague notion of the physiological definition of the act we were told to avoid. The pastor reiterated throughout the virginity pledge discussion how disappointed our parents, church, and future spouse would be if we relinquished our virginity before marriage. Some of my friends already intimately understood this pressure – they were having sex, but taking the pledge to appease their suspicious parents or to inoculate themselves against the slurs reserved for those whose refusal to pledge was seen as a de facto admission of sexual sin.

While purity pledges were first the domain of religious abstinence-only programs presented in churches, they have gained popularity in secular, school-based abstinence-only programs in recent years. In fact, many of the programs participating in the evaluation of federally funded Title V abstinence-only-until-marriage programs contain some version of a virginity pledge. New research has shown that this component is not only ineffective, but may actually be harmful because they undermine contraceptive use and inadvertently promote risky oral and anal sex among teens who see these activities as a “loophole” in their pledge.

A study done on the virginity pledges found that teenagers who sign a pledge do delay sexual activity eighteen months longer than their peers who did not pledge – far short of marriage – but are one-third less likely to use contraception upon initiating sexual activity than students who did not pledge.¹ Students who pledged also have the same rates of sexually transmitted infections as their non-pledging peers, but are less likely to seek

¹ Peter Bearman and Hanah Brückner, “Promising the Future: Virginity Pledges and the Transition to First Intercourse,” *American Journal of Sociology* 106.4 (2001): 859-912.

testing or treatment for a sexually transmitted infection.² In addition, male and female pledgers are six times more likely to engage in oral sex than peers who have not pledged, and male pledgers are four times more likely to engage in anal sex than their non-pledging contemporaries.³

Abstinence-Only Programming in the Public Schools: What’s Actually Being Taught?

The same pastor who officiated at the religious pledge ceremony also presented a secularized abstinence-only program to junior high and high school students in my school district. Although he still refused to give an exact definition of sex in this setting, he did go into detail about the ineffectiveness of condoms, explaining in graphic detail, and with even more graphic pictures, the sexually transmitted infections students could get if we trusted our health to a “flimsy piece of latex.” We were all too intimidated or embarrassed to ask for clarification, but it seemed as if sex with a condom was equivalent to sex without one.

Another demonstration left little doubt as to our worth as a future spouse or partner if we were to engage in sex before marriage. He pulled an often squirming and reluctant and always female volunteer onto the stage, took out a toothbrush that looked like it had been used to scrub toilets and asked if she would brush her teeth with it. When she predictably refused, he pulled out another toothbrush, this one pristine in its original box, and asked her if she would brush her teeth with that one. When she answered in the affirmative, he turned to the assembly and said, “If you have sex before marriage, you are the dirty toothbrush.”

Federally funded abstinence-only-until-marriage programs commonly use messages of fear and shame, present gender stereotypes as scientific fact, and impart confusing, incomplete, or plainly inaccurate information about condoms and other forms of contraception. In fact, a 2004 survey conducted by the minority staff of this Committee found that 11 of the 13 federally funded abstinence-only-until-marriage programs reviewed contained “false, misleading, or distorted information.”⁴

Sexuality Education: What Works? What Doesn’t?

When I got to high school, I realized many of my peers were struggling with the same questions about sex, relationships, and sexuality as I was – and most were not abstaining from sex. The statistics became alarmingly personal when the girl who sat next to me in math class got pregnant. She told me her boyfriend had said she couldn’t get pregnant the first time she had sex – her growing belly was the result of that first and only time. I

² Peter Bearman and Hanah Brückner, “After the promise: The STD consequences of adolescent virginity pledges,” *Journal of Adolescent Health* 36.4 (2005): 271-278.

³ *Ibid.*

⁴ U.S. House of Representatives, Committee on Government Reform. *The Content of Federally Funded Abstinence-Only Education Programs*, Prepared for Rep. Henry A. Waxman. Washington, DC: Author, 2004.

watched as her pregnancy advanced and she endured the cruelty of “righteous” high school students in the form of whispered insults and disgusted stares. One day she simply didn’t come back to school.

Another friend had a scare after both condoms he and his partner were using broke – they had figured, wrongly, that if one wouldn’t work, two might do the trick. If either of these two friends had received even the most basic sex education instead of abstinence-only-until-marriage programs that withheld information and vilified condoms as ineffective, they would have been able to make better and more informed decisions. Knowledge is power. The ignorance promoted by abstinence-only-until-marriage programs is a recipe for disaster that plays out everyday in communities like mine.

I believed in abstinence in a religious sense, but it was clear that abstinence-only as a policy for students who simply were not abstaining was dangerous. Even if we did wait until marriage, we still lacked a basic understanding of our bodies, reproduction and how to prevent pregnancy as well as a long list of sexually transmitted infections, and the skills to navigate conversations about sex and protection.

Studies have repeatedly shown abstinence-only-until-marriage curricula to be ineffective as well as inaccurate. A federally funded evaluation of abstinence-only-until-marriage programs conducted by Mathematica Policy Research and released in 2007 showed the programs had little effect on teen sexual behavior.⁵ Another 2007 study commissioned by the National Campaign to Prevent Teen and Unplanned Pregnancy came to an identical conclusion. And in 2006, the Society for Adolescent Medicine released a paper that found “the efficacy of abstinence-only interventions may approach zero.”⁶

Comprehensive sex education programs, on the other hand, include age-appropriate, medically accurate information on a broad set of topics related to sexuality including human development, relationships, decision-making, abstinence, contraception, and disease prevention. And, unlike abstinence-only-until-marriage programs, they actually work: A study released in March 2008 in the *Journal of Adolescent Health* found that teens receiving comprehensive sex education had lower rates of teen pregnancy than peers who received either abstinence-only or nothing at all. Parents also overwhelmingly support comprehensive sexuality education. A study featured in the *Journal of Adolescent Health* found that 89% of parents surveyed favored teaching about abstinence and contraception.

Conclusion: Eliminate Funding for Abstinence-Only-Until-Marriage Programs

⁵ Mathematica Policy Research, Inc. *Impact of Four Title V, Section 510 Abstinence Education Programs (Final Report)*. Princeton, NJ: MPR, 2005.

⁶ J. Santelli *et al.* Abstinence-only education policies and programs: a position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health* 2006; 38: 83-87.

It is a perilous and confusing time to be young in the United States: just this year the CDC announced that teen birth rates are up for the first time in sixteen years and that one in four teen girls has a sexually transmitted infection. Although the research has yet to be completed on the male half of the population, it's clear that something must be done to reverse these startling trends.

Abstinence works. Abstinence-only-until-marriage does not. In fact, studies have shown a more comprehensive approach to sex education that gives us strong messages about abstinence and information about condoms and contraception, do a better job of helping young people abstain than do abstinence-only-until-marriage programs. So why is it that there is not a single federal dollar dedicated to a comprehensive approach while more than a billion has been spent on abstinence-only-until-marriage?

As a young person with firsthand experience about the misinformation, shame, guilt, and intolerance propagated by these programs, I urge you to eliminate funding for abstinence-only-until-marriage programs and instead to allocate those funds to comprehensive, medically accurate sex education that provides young people with the tools they need to make responsible, informed decisions about their sexual health.

Once again, it was an honor to speak to you today. I will be happy to answer any questions at the appropriate time.

Mr. SARBANES. Thank you very much for the testimony, everybody on the panel, in particular Mr. Siegel and Ms. Knox for relating your personal perspective on these issues.

I share the concern of a number who have already spoken today about the failure of these programs to demonstrate success, the abstinence-only programs, to demonstrate success, and the fact that we plow over \$1 billion now into these programs.

One of the questions that I wanted to ask you, Dr. Benjamin, you noted—and I have taken note of this, as well—that 17 States have now refused to take this funding because of the restrictions that accompany it, and you mentioned that is a huge decision. I mean, States are strapped. They need as many dollars as they can to support their public health initiatives. I was curious if you could maybe expound on that a little bit. What would go into a decision at the State level to pass up that kind of funding? what would the discussion process be inside the department?

Dr. BENJAMIN. You know, we would first of all look at the program guidance and see if a particular program strapped our hands around our other programs. That would be the first thing we looked at. If that did, that creates a real problem for us.

Second, we have lots of programs already in place, and the question is would it create a dilemma for us to have a program where our citizens were going into Door A and getting one kind of program, which was maybe State funded and supported, which was more comprehensive, and then Door B, where they could only get another particular program. That creates logistical, ethical, and programmatic problems.

I think at the end of the day are the reporting requirements and are the logistical problems and ethical problems not worth taking the money, quite frankly. At least that is what we would do at my health department. We would have sat down and had those discussions.

We would certainly also ask ourselves how can we effectively evaluate these programs. In other words, you know, we are always doing pilots. As you know, I am from Maryland, so we love pilots in Maryland, at least we did. We might have even tried to do a pilot program. Let's see if they work. But then, of course, we would have to have adequate funds to evaluate that program. And then, of course, if it didn't work we would stop.

Mr. SARBANES. Beyond the logistics of it, presumably these States have made a judgment, based on the research and the success or lack of success of these programs, that it is not worth the funding.

Dr. BENJAMIN. I think from a programmatic and policy perspective, absolutely.

Mr. SARBANES. Right.

Dr. BENJAMIN. And the more evidence that comes out that suggests they may not work, the more States you will see not taking the dollars.

Mr. SARBANES. This is a question I would put to anyone on the panel who would like to answer it, including Mr. Siegel and Ms. Knox, and that is: I am getting the impression that there has been a lot of testimony that the comprehensive sex education programs are more effective, and the debate is largely a false one because we

keep hearing people interpret the objection to abstinence-only programs as an objection to abstinence education, when, in fact, I don't think that is what anyone is saying here who opposes abstinence-only. So we kind of dance around the concept, but not landing on it four square yet, and that is this: listening to testimony and reading the research, it strikes me that the abstinence education actually is advanced and reinforced when it is inside of a comprehensive program, so that those who feel strongly about the message of abstinence—and I echo the parents who have spoken here today. I have a 17-year-old, a 14-year-old, and a 9-year-old, so all these statistics are ones that catch my attention, and I understand what my own kids are grappling with. But as somebody who would like them to get that message of the benefits of abstinence, I come away from this discussion believing strongly that if they get that message inside a larger program it is going to be more effective.

I invite anybody to address that. We can just go down the line here.

Mr. WEED. I would like to respond to that, Mr. Chairman.

Looking at the evidence in terms of abstinence in the context of the broader, there are some studies that have produced effects in terms of initiation of sexual activity, but those effects have been smaller for initiation than the effects that we find in programs that are abstinence centered, and I will use that term advisedly rather than abstinence-only. The effects are smaller when it is in the context than they are when it is done well and separately.

Mr. SARBANES. Let me get some other perspectives on that, going down the line.

Dr. SANTELLI. I guess I would firmly agree with you. I draw the attention of the committee to the written testimony of Doug Kirby, who is, I think, the leading expert at reviewing sexuality education. It is fully consistent with what Dr. Fineberg was talking about, the Cochrane reviews. Those evaluations suggest that many of the comprehensive sexuality education programs are effective when they deliver both messages, if you will, are effective at getting kids to delay initiation.

Now, on the other hand I would point out that across these programs, even the best ones, we are talking about a delay of maybe 4 to 6 months, sometimes smaller, and that really begs the question: what are we doing for kids for the rest of their lives? So if we delay from 15 to 15½ or 17 to 17½ or 18, we need to make sure that those young people are ready.

Dr. BLYTHE. Can I have another comment?

Mr. SARBANES. Yes.

Dr. BLYTHE. As a physician in the field, in the trenches, one of the issues that has come up is the teaching that we give in clinics, and even families give to their young people, are being revoked by the education in school. We had a clear example of this last week when a young man was being pulled into the clinic by his Mom, 16-year-old, with an obvious genital infection, and his comment to her was, But, Mom, I was told in school they don't work. So when our clinical messages are being revoked by the education that they are getting in the schools, it is clearly counterproductive to the health of these young people.

Mr. SARBANES. I have run out of time, but maybe if you two have a brief response.

Mr. SIEGEL. It is a blatant indication of policymakers' distrust of youth to make responsible decisions about their sexual health, and it is not empirically supported. It has been shown repeatedly in Federal evaluation that comprehensive sexuality education is better at leading to abstinence, which should be the goal of these programs, along with preventing HIV and other STIs and unintended pregnancy.

Mr. SARBANES. Thank you very much.

Mr. Sali.

Mr. SALI. Thank you, Mr. Chairman.

First of all, I have a written statement that I had intended to give at the beginning of the meeting but wasn't allowed the opportunity. I would ask unanimous consent that be added to the record.

Mr. SARBANES. Without objection.

[The prepared statement of Hon. Bill Sali follows:]

Statement of Bill Sali
Oversight and Government Reform Committee
Hearing on Abstinence-Only Programs
April 23, 2008

Mr. Chairman and Ranking Member Davis,

I want to thank you for calling this important hearing on abstinence education. Abstinence education teaches that “abstinence from sexual activity outside marriage as the expected standard for all school age children,” and stresses the social, psychological, and health benefits of abstinence. In a study released just yesterday by the Heritage Foundation, 21 studies were analyzed and 16 reported positive findings concerning the effectiveness of abstinence education programs. I ask unanimous consent that this report be inserted into the Committee Report.

There are many reports that show abstinence education works, and in Idaho I have heard how abstinence programs are helping teens avoid risky behavior. Unfortunately, most Americans don't even know what teens are being taught in sex education classes, abstinence-based or otherwise. I hope that today's hearing and the testimony of Dr. Stan Weed will help to highlight the value and nature of abstinence education programs.

Effective abstinence education teaches teens far more than to ‘just say no’ to sex. These programs offer a public health message that promotes risk-avoidance to young people. Unfortunately, most of America does not know that abstinence education *does* teach teens about contraception and sexually transmitted diseases (STDs), including symptoms and modes of transmission along with the relative effectiveness of contraception methods. However, abstinence education seeks to educate without engaging in the explicit demonstrations that most parents and school communities, especially those in my District, reject as distasteful and in some cases a violation of moral and religious convictions.

In addition, in abstinence education programs, teens are taught how to build healthy relationships while learning to identify the warning signs of unhealthy relationships which

often lead to sexual coercion and abuse. These programs teach how to set goals for the future and how to avoid the dangers of alcohol and drugs, which frequently open the door to sexual activity.

Abstinence education is a complete approach to teaching teens about sexuality, and since Congress began funding Community Based Abstinence Education (CBAE), abstinence education has been credited for part of the decline in teen pregnancy. This is a positive and encouraging trend, but as we were reminded when the CDC released its recent report on teens and STDs, an unwanted pregnancy is not the only risk of teen sex. If government is going to spend money to teach youth about sex, teens deserve more than just the promotion and use of condoms.

I have read with shock about the manuals that are labeled “comprehensive” sex education, and was stunned to see that the CDC approved curriculum that encourage young people to shower together or cuddle naked, along with other behaviors I would frankly be embarrassed to discuss before this Committee. I would wager that everyone on this committee understands where showering together and cuddling naked will lead. No one in this room could honestly believe that those kinds of actions will promote abstinence. In fact, quite the opposite. Yet these activities are considered “abstinent” behavior in the most widely used “comprehensive” sex education curricula. Mr. Chairman, most of us on this Committee are parents. I would submit that none of us would want our daughters or sons to cuddle without clothing or perform other acts we would be ashamed to discuss publicly – yet these acts are commended in materials regularly distributed to public school children.

Such graphic messages cannot fairly be equated with effective abstinence education and simply do not belong in schools, and certainly not at the expense of taxpayers. Abstinence education offers a real alternative – one that is tested, practical and respects the beliefs and concerns of Moms and Dads across the country. Let’s give it a fair hearing and a healthy dose of support.

Mr. SALI. As a part of this, as well, Senator Brownback referred to a Heritage Foundation study that was released yesterday, and I would ask unanimous consent that be included as part of the record of the hearing today, as well.

Mr. SARBANES. Without objection.

[The information referred to follows:]

Executive Summary Backgrounder

No. 2126
April 22, 2008

Published by The Heritage Foundation

Abstinence Education: Assessing the Evidence

Christine C. Kim and Robert Rector

Teen sexual activity remains a widespread problem confronting the nation. Each year, some 2.6 million teenagers become sexually active—a rate of 7,000 teens per day. Among high school students, nearly half report having engaged in sexual activity, and one-third are currently active.

Sexual activity during teenage years poses serious health risks for youths and has long-term implications. Early sexual activity is associated with an increased risk of sexually transmitted diseases (STDs), reduced psychological and emotional well-being, lower academic achievement, teen pregnancy, and out-of-wedlock childbearing. Many of these risks are avoidable if teens choose to abstain from sexual activity. Abstinence is the surest way to avoid the risk of STDs and unwed childbearing.

Abstinence education “teaches abstinence from sexual activity outside marriage as the expected standard for all school age children” and stresses the social, psychological, and health benefits of abstinence. Abstinence programs also provide youths with valuable life and decision-making skills that lay the foundation for personal responsibility and developing healthy relationships and marriages later in life. These programs emphasize preparing young people for future-oriented goals.

The Evidence. Studies have shown that abstinent teens report, on average, better psychological well-being and higher academic achievement than those who are sexually active. Delaying the initiation of or reducing early sexual activity among teens

can decrease their overall exposure to risks of unwed childbearing, STDs, and psycho-emotional harm. Authentic abstinence programs are therefore crucial to efforts aimed at reducing unwed childbearing and improving youth well-being.

Opponents of abstinence education contend that these programs fail to influence teen sexual behavior. At this stage, the available evidence supports neither this assessment nor the wholesale dismissal of authentic abstinence education programs.

This paper discusses 21 studies of abstinence education. Fifteen studies examined abstinence programs that were intended primarily to teach abstinence. Of these 15 studies, 11 reported positive findings. The other six studies analyzed virginity pledges, and of these six studies, five reported positive findings. Overall, 16 of the 21 studies reported statistically significant positive results, such as delayed sexual initiation and reduced levels of early sexual activity, among youths who have received abstinence education. Five studies did not report any significant positive results.

The Current Environment. Today’s young people face strong peer pressure to engage in risky

This paper, in its entirety, can be found at:
www.heritage.org/Research/Welfare/bg2126.cfm
Produced by the Domestic Policy Studies Department
Published by The Heritage Foundation
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behavior and must navigate media and popular culture that endorse and even glamorize permissiveness and casual sex. Alarming, the government implicitly supports these messages by spending over \$1 billion each year to promote contraception and safe-sex education—at least 12 times what it spends on abstinence education.

Although 80 percent of parents want schools to teach youths to abstain from sexual activity until they are in a committed adult romantic relationship nearing marriage—the core message of abstinence education—these parental values are rarely communicated in the classroom.

In the classroom, the prevailing mentality often condones teen sexual activity as long as youths use contraceptives. Abstinence is usually mentioned only in passing, if at all. Sadly, many teens who need to learn about the benefits of abstaining from sexual activity during the teenage years never hear about them, and many students who choose to abstain fail to receive adequate support for their decisions.

Conclusion. Teen sexual activity is costly, not just for teens, but also for society. Teens who engage in sexual activity risk a host of negative outcomes including STD infection, emotional and psychological harm, and out-of-wedlock childbearing.

Genuine abstinence education is therefore crucial to the physical and psycho-emotional well-being of the nation's youth. In addition to teaching the benefits of abstaining from sexual activity until marriage, abstinence programs focus on developing character traits that prepare youths for future-oriented goals.

When considering federal funding for abstinence education programs and reauthorization of Title V abstinence education programs, including maintaining the current definition of "abstinence education," lawmakers should consider *all* of the available empirical evidence.

—Christine C. Kim is a Policy Analyst and Robert Rector is a Senior Research Fellow in the Domestic Policy Studies Department at The Heritage Foundation.

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Sexual activity during teenage years poses serious health risks for youths and has long-term implications. Early sexual activity is associated with an increased risk of sexually transmitted diseases (STDs), reduced psychological and emotional well-being, lower academic achievement, teen pregnancy, and out-of-wedlock childbearing. Many of these risks are avoidable if teens choose to abstain from sexual activity. Abstinence is the surest way to avoid the risk of STDs and unwed childbearing.

Abstinence education “teaches abstinence from sexual activity outside marriage as the expected standard for all school age children” and stresses the social, psychological, and health benefits of abstinence.³ Abstinence programs also provide youths with valuable life and decision-making skills that lay the foundation for personal responsibility and developing healthy relationships and marriages later in life. These programs emphasize preparing young people for future-oriented goals.

Studies have shown that abstinent teens report, on average, better psychological well-being and higher academic achievement than those who are sexually active.⁴ Delaying the initiation of or reducing early sexual activity among teens can decrease their overall

Talking Points

- Teen sexual activity is costly, not just for teens, but also for society. Teens who engage in sexual activity are at risk for a host of negative outcomes including infection with a sexually transmitted disease, emotional and psychological harm, and out-of-wedlock childbearing.
- Abstinence education teaches the social, psychological, and health benefits of abstinence from sexual activity outside marriage. These programs focus on preparing young people for future-oriented goals. They provide youths with valuable life and decision-making skills that lay the foundation for personal responsibility and developing healthy relationships later in life.
- Of the 15 authentic abstinence programs discussed in this paper, 11 reported positive findings. Five of the six studies of virginity pledges also reported positive findings. Overall, 16 of the 21 studies reported positive results, such as delayed initiation of sexual activity, among youths who received abstinence education.

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Opponents of abstinence education contend that these programs fail to influence teen sexual behavior. At this stage, the available evidence supports neither this assessment nor the wholesale dismissal of authentic abstinence education programs.

Studies of Abstinence Education

This paper discusses 21 studies of abstinence education. Fifteen studies examined abstinence programs that were primarily intended to teach abstinence. Of these 15 studies, 11 reported positive findings. The other six studies analyzed virginity pledges, and of these six studies, five reported positive findings. Overall, 16 of the 21 studies reported statistically significant positive results, such as delayed sexual initiation and reduced levels of early sexual activity, among youths who have received abstinence education. Five studies did not report any significant positive results.

In addition to these 21 studies, five other studies have been cited in various reviews of abstinence pro-

gram evaluations.⁵ However, these five studies are not fully discussed in this paper for several reasons.

First, a 2007 study evaluated a voluntary component of a three-part abstinence program that focused on life skills education. The voluntary component does not represent the core abstinence curriculum of the Heritage Keepers program, but an evaluation of the abstinence curriculum is discussed in this paper. Because the students who participated in the voluntary section had already received the core abstinence education curriculum, the study effectively measured the “incremental impact” of the voluntary component, not the full program impact.⁶

A second study evaluated the Operation Keepsake program in Cleveland. While the study reported positive results (i.e., reduced levels and delayed initiation of sexual activity), the statistical significance of findings was less certain. While the findings were positive, they were statistically significant at only the 94 percent and 93 percent confidence levels—below the standard 95 percent confidence threshold.⁷ An evaluation of For Keeps, an updated version of Operation Keepsake, is discussed in this paper.

1. Mark Regnerus, *Forbidden Fruit: Sex & Religion in the Lives of American Teenagers* (New York, N.Y.: Oxford University Press, 2007), p. 3. This calculation is based on data from the National Survey of Family Growth.
2. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Youth Risk Behavior Survey, 2005. Those who have engaged in sexual activity during the three months preceding the survey are considered “currently active.”
3. Section 510 of Title V of the Social Security Act contains eight standards by which all abstinence programs must abide. See U.S. Department of Health and Human Services, Administration for Children and Families, “Fact Sheet: Section 510 State Abstinence Education Program,” updated November 6, 2007, at www.acf.hhs.gov/programs/fysyb/content/abstinence/factsheet.htm (March 13, 2007).
4. Denise D. Hallfors, Martha W. Waller, Carol A. Ford, Carolyn T. Halpern, Paul H. Brodish, and Bonita Iritani, “Adolescent Depression and Suicide Risk: Association with Sex and Drug Behavior,” *American Journal of Preventative Medicine*, Vol. 27, No. 3 (October 2004), pp. 224–230; Denise D. Hallfors, Martha W. Waller, Daniel Bauer, Carol A. Ford, and Carolyn T. Halpern, “Which Comes First in Adolescence—Sex and Drugs or Depression?” *American Journal of Preventative Medicine*, Vol. 29, No. 3 (October 2005), pp. 163–170; and Robert Rector and Kirk Johnson, “Teenage Sexual Abstinence and Academic Achievement,” paper presented at the Ninth Annual Abstinence Clearinghouse Conference, August 2005, at www.heritage.org/Research/Welfare/upload/84576_1.pdf.
5. Lauren Sue Scher, Rebecca A. Maynard, and Matthew Stagner, “Interventions Intended to Reduce Pregnancy-Related Outcomes Among Teenagers,” Campbell Collaboration, updated April 2006, at www.campbellcollaboration.org/doc-pdf/teenpregreview_dec2006.pdf (January 17, 2008); Douglas Kirby, “Emerging Answers 2007,” National Campaign to Prevent Teen and Unplanned Pregnancy, November 2007, at www.thenationalcampaign.org/EA2007 (February 27, 2008).
6. Melissa A. Clark, Christopher Trenholm, Barbara Devaney, Justin Wheeler, and Lisa Quay, “Impacts of the Heritage Keepers Life Skills Education Component,” Mathematica Policy Research, August 2007, p. 1, at www.mathematica-mpr.com/publications/PDFs/heritagekeepers08-07.pdf (February 27, 2008).

A third study examined a teen pregnancy prevention program in Denmark, South Carolina, in the early 1980s.⁸ Although teen pregnancy rates declined during the early intervention period, the results cannot be meaningfully interpreted because of the uncertain nature of the services received by the students.

A fourth study examined a Canadian program, which was designed as a traditional sex education program but was delivered without a contraception component in the evaluation's specific context.⁹

Finally, a fifth study analyzed the Postponing Sexual Involvement program in Atlanta in the mid-1980s.¹⁰ Although the study reported positive findings (i.e., delayed onset of sexual activity), the content of the program has been questioned. For example, was the intervention a pure abstinence program, or were other components critical?

Study Design

The research field of abstinence program evaluation is developing, so only a few programs have been evaluated thus far.¹¹ Currently, several hundred abstinence programs are in operation nationwide. These programs vary substantially in the youth populations that they serve, in their imple-

mentation, and in their curricula. Importantly, the few evaluated programs inadequately represent the spectrum of abstinence programs. Consequently, the available findings are mostly generalizable to the specific conditions under which those particular programs were implemented and to the youth populations that they served.

The studies discussed in this paper used a variety of research methods to assess the degree to which specific abstinence programs influenced teen sexual behavior.¹²

Experimental studies have the most rigorous evaluation design. A true experiment enables the researchers to draw conclusions about the program's impact with a high degree of confidence. To simulate the scenario of how abstinence program participants would have behaved if they had not received any abstinence education, an experiment randomly assigns youths to receive or not to receive abstinence education. In theory, random assignment eliminates any systematic differences between the intervention group and the control group, making the two virtually identical except for the intervention—in this case, abstinence education. In reality, well-designed and well-implemented exper-

7. Elaine Borawski *et al.*, "Evaluation of the Teen Pregnancy Prevention Programs Funded Through the Wellness Block Grant (1999–2000)," Case Western Reserve University School of Medicine, Center for Health Promotion Research, Department of Epidemiology and Biostatistics, March 23, 2001.
8. Helen P. Koo, George H. Dunteman, Cindee George, Yvonne Green, and Murray Vincent, "Reducing Adolescent Pregnancy Through a School- and Community-Based Intervention: Denmark, South Carolina, Revisited," *Family Planning Perspectives*, Vol. 26, No. 5 (September–October 1994), pp. 206–211 and 217.
9. B. Helen Thomas, Alba Mitchell, and M. Corinne Devlin, "Small Group Sex Education: The McMaster Teen Program," in Brent C. Miller, Josefina J. Card, Roberta L. Paikoff, and James C. Peterson, eds., *Preventing Adolescent Pregnancy: Model Programs and Evaluations* (Newbury Park, Calif.: Sage Publications, Inc., 1992), pp. 28–52. According to the study, contraception was not taught because at the time this subject was not within Ontario Ministry of Education guidelines for seventh and eighth grade students.
10. Marion Howard and Judith Blamey McCabe, "Helping Teenagers Postpone Sexual Involvement," *Family Planning Perspectives*, Vol. 22, No. 1 (January–February 1990), pp. 21–26.
11. A 2006 Government Accountability Office report notes that "the efforts to study and build a body of research on the effectiveness of most abstinence education programs have been under way for only a few years, in part because grants under the two programs that account for the largest portion of federal spending on abstinence—the State Program [Title V] and the Community-Based Program—were not awarded until 1998 and 2001, respectively." U.S. Government Accountability Office, *Abstinence Education: Efforts to Assess the Accuracy and Effectiveness of Federally Funded Programs*, GAO–07–87, October 2006, pp. 20 and 31, at www.gao.gov/newitems/d0787.pdf (April 16, 2008).
12. A number of studies have analyzed changes in teens' intentional behavior, such as attitude toward abstinence, characteristics important to behavioral change, self-efficacy, and STD knowledge. The present analysis reports only studies that measured actual behavioral outcomes.

iments are few. This is particularly true for abstinence program evaluation.¹³

Most of the evaluations reported in this analysis are quasi-experiments, which incorporate certain elements of experimental design, such as identifying a comparable group of youths for comparison and using statistical methods to account for pre-intervention differences between youths who received abstinence education and those who did not.

Quasi-experimental studies adjust for a host of observable factors other than abstinence education that might confound the results. Depending on the rigor of the evaluation design and the adequacy of the statistical analysis employed by the researchers, the degree of confidence with which conclusions may be drawn about the findings from non-experimental studies can vary. Consequently, all findings should be interpreted with the full context of the program and evaluation in view.

The virginity pledge studies used a longitudinal survey of self-reported data.¹⁴ The longitudinal survey followed the same group of individuals from adolescence to young adulthood. The pledge studies applied various statistical methods to estimate the underlying relationship between pledging during adolescence and behavioral outcomes in young adulthood.

This paper focuses on the significant positive behavioral outcomes as reported by the studies, such as delayed onset of sexual activity, reduced levels of early sexual activity, and fewer sexual partners among adolescents.¹⁵ In addition, this paper discusses five studies that reported no significant impact. (For a list of the studies, summary findings, and evaluation design characteristics, see the Appendix and the Reference List.)

While abstinence programs emphasize the message of abstinence until marriage as the standard for

all school-age children, simply delaying the initiation or reducing current levels of sexual activity among teens can decrease teens' overall exposure to the risk of physical and psycho-emotional harm.

Studies That Reported Positive Behavioral Change

Positive behavioral changes were reported in 11 studies of abstinence programs. (See the Appendix and Reference List.)

Reasons of the Heart. Taught over 20 class periods by certified and program-trained health educators, the Reasons of the Heart (ROH) curriculum focuses on individual character development and teaches adolescents the benefits that are associated with abstinence until marriage.

A 2008 study evaluated the ROH curriculum's impact on adolescent sexual activity among seventh grade students in three suburban northern Virginia public schools.¹⁶ The researchers also collected data on a comparison group of seventh grade students in two nearby middle schools that did not participate in the program. Students in those schools instead received the state's standard family life education, which included two videos on HIV/STD prevention and one on abstinence.

The evaluators surveyed seventh grade students in all five schools before and after the program. They found that, a year after the program, 32 (9.2 percent) of the 347 ROH students who were virgins at the initial survey had initiated sexual activity, compared with 31 (or 16.4 percent) of the 189 comparison group students. Controlling for the differences between the comparison group and ROH students,¹⁷ the study reported that ROH students were half as likely as comparison group students to initiate sexual activity.¹⁸ The evaluators concluded, "This result appears to compare favorably to the re-

13. See Scher *et al.*, "Interventions Intended to Reduce Pregnancy-Related Outcomes Among Teenagers."

14. The reliability of self-reported data on youth sexual behavior has been raised as an issue. See Janet E. Rosenbaum, "Reborn a Virgin: Adolescents' Retracting of Virginity Pledges and Sexual Histories," *American Journal of Public Health*, Vol. 96, Issue 6 (June 2006), pp. 1098-1103.

15. Findings are considered statistically significant if they have a statistical confidence level of 95 percent or greater. Some of the studies reporting positive results also reported non-significant results, which are included in the Appendix.

16. Stan Weed, Irene H. Ericksen, Allen Lewis, Gale E. Grant, and Kathy H. Wibberly, "An Abstinence Program's Impact on Cognitive Mediators and Sexual Initiation," *American Journal of Health Behavior*, Vol. 31, No. 1 (2008), pp. 60-73.

ductions in initiation achieved by some of the abstinence programs [evaluated in earlier studies].¹⁹

Sex Can Wait. Sex Can Wait is a three-series abstinence education program with one series for upper-elementary students, a second for middle school students, and a third for high school students. The Sex Can Wait program lasts five weeks and offers lessons on character building, important life skills, and reproductive biology.

A 2006 study evaluated the program's long-term (18-month) impact on adolescent sexual behavior.²⁰ The researchers compared students who participated in Sex Can Wait to those who received their school districts' standard sex education curricula on two behavioral outcomes: overall abstinence and abstinence during the last 30 days. As the authors noted, "the study compared the effects of the Sex Can Wait curriculum to 'current practice' rather than true 'control conditions.'"²¹

The researchers found that, 18 months after the program, upper-elementary students who participated in Sex Can Wait were less likely than non-participants to report engaging in recent sexual activity. Among middle school students, participants were also less likely than non-participants to report

engaging in sexual activity ever and in the preceding month before the 18-month follow-up. Finally, among high school students, the authors found reduced levels of sexual activity in the short term but not in the 18-month follow-up.²²

Heritage Keepers. Heritage Keepers is a primary prevention abstinence program for middle school and high school students. The program offers an interactive three-year, two-level curriculum.

To assess Heritage Keepers' impact, a group of evaluators compared some 1,200 virgin students who attended schools that faithfully implemented the program to some 250 students in demographically and geographically comparable schools who did not receive the abstinence intervention.²³ One year after the program, 14.5 percent of Heritage Keepers students had become sexually active compared with 26.5 percent of the comparison group.

Overall, Heritage Keepers students "were about one-half as likely" as comparison group students to initiate sex after adjusting for pre-program differences between the two groups.²⁴ The study found similar results in subsets of African-American students, Caucasian students, boys, and girls.

17. Students in the comparison group and ROH students matched on 10 of the 12 demographic and attitudinal characteristics measured. The comparison group had a higher proportion of African-American students. Comparison group students also felt they would have more opportunity for sex in the coming year.
18. The odds ratio was 0.413, and the relative risk ratio was 0.457. The finding is statistically significant at the 99.2 percent confidence level.
19. Weed *et al.*, "An Abstinence Program's Impact on Cognitive Mediators and Sexual Initiation," p. 70.
20. George Denny and Michael Young, "An Evaluation of an Abstinence-Only Sex Education Curriculum: An 18-Month Follow-Up," *Journal of School Health*, Vol. 76, No. 8 (October 2006), pp. 414-422.
21. *Ibid.*, p. 415.
22. These findings were statistically significant at the 95 percent confidence level and above.
23. Stan E. Weed, Irene H. Ericksen, and Paul James Birch, "An Evaluation of the Heritage Keepers Abstinence Education Program," Institute for Research and Evaluation (Salt Lake City), November 2005, at www.heritageservices.org/Stans%20Weed's%20HHS%20Conference%20article.pdf (December 1, 2006). Presented at a national conference, this study was reviewed by a team of program evaluation experts selected through an external consultant by the Office of Population Affairs in the U.S. Department of Health and Human Services. The Heritage Keepers program also includes a voluntary life skills education component. The participants were youths who had already received the Heritage Keepers abstinence program. Mathematica Policy Research evaluated the skills life education component, which measured the *marginal* impact of this component as all participants had already received the Heritage Keepers abstinence program. Because the life skills education does not represent the core Heritage Keepers abstinence program, its evaluation is not discussed in this paper.
24. The finding was statistically significant at the 99 percent confidence level and above. Students in the comparison group were at somewhat higher risk of early sexual activity than program participants were. However, the authors used statistical methods to control for the differences between the two groups.

For Keeps. A study published in 2005 evaluated the For Keeps curriculum as implemented in five urban and two suburban middle schools in the Midwest.²⁵ Schools were assigned by the school districts to receive the program, which was part of a county-wide teen pregnancy prevention initiative.

Taught by outside facilitators, For Keeps was a five-day curriculum with 40-minute sessions that focused on character development and the benefits of abstinence and tried to help students understand how pregnancy and sexually transmitted diseases can impede their long-term goals. It also emphasized the psycho-emotional and economic consequences of early sexual activity. The curriculum was intended both for students who had become sexually active and for those who had not.

The evaluation collected data on all students through a pretest survey, and some 2,000 youths (about 70 percent of those who took the pretest survey) responded to a follow-up survey conducted about five months after the program ended.²⁶ Among youths who engaged in any sexual behavior during the follow-up period, some who participated in For Keeps reported a reduction in "the amount of casual sex, as evidenced by fewer episodes of sex and fewer sexual partners" during the evaluation period,²⁷ although program participants did not differ from non-participants in the likelihood of engaging in sexual activity during the follow-up interval.²⁸

Best Friends. The Best Friends (BF) program began in 1987 and operates in about 90 schools across the United States. The Best Friends curricu-

lum is an abstinence-based character-building program for girls starting in the sixth grade and offers a variety of services such as group discussions, mentoring, and community activities. Discussion topics include friendship, love and dating, self-respect, decision making, alcohol and drug abuse, physical fitness and nutrition, and AIDS/STDs. The curriculum's predominant theme is encouraging youths to abstain from high-risk behaviors and sexual activity.

A 2005 study evaluated the District of Columbia's Best Friends program, which operated in six of the District's 20 middle schools.²⁹ The study compared data on BF participants to data from the Youth Risk Behavior Surveys (YRBS) conducted for the District. When the authors of the study compared Best Friends schools to District schools that did not have the program, they found that Best Friends schools tended to be located in the more disadvantaged sections of the city and were academically comparable to or slightly worse than the District's middle schools in general.

Adjusting for the survey year, students' age, grade, and race and ethnicity, the study reported that Best Friends girls were nearly 6.5 times more likely to abstain from sexual activity than YRBS respondents. They were 2.4 times more likely to abstain from smoking, 8.1 times more likely to abstain from illegal drug use, and 1.9 times more likely to abstain from drinking.³⁰

Not Me, Not Now. Not Me, Not Now, a community-wide abstinence intervention program, targeted children ages nine through 14 in Monroe County,

25. Elaine A. Borawski, Erika S. Trapl, Loren D. Lovegreen, Natalie Colabianchi, and Tonya Block, "Effectiveness of Abstinence-Only Intervention on Middle School Teens," *American Journal of Health Behavior*, Vol. 29, No. 5 (September/October 2005), pp. 423-434.
26. The program group had a higher proportion of suburban students, and the follow-up interval for the program group averaged five days longer than the comparison group. Students who completed the follow-up survey were also more likely to be female, younger, white, living with two parents, suburban, and more abstinence-oriented.
27. Borawski *et al.*, "Effectiveness of Abstinence-Only Intervention on Middle School Teens," pp. 429-431. Frequency of sexual activity was measured by the likelihood of engaging in six or more episodes versus the likelihood of engaging in five or less episodes during the evaluation period. The number of sexual partners was measured by the likelihood of having two or more sexual partners during the evaluation period. The findings were statistically significant at the 95 percent confidence level and above.
28. This was the finding for the entire sample, the sub-sample of virgins, and the sub-sample of sexually active youths.
29. Robert Lerner, "Can Abstinence Work? An Analysis of the Best Friends Program," *Adolescent & Family Health*, Vol. 3, No. 4 (April 2005), pp. 185-192.

New York, which includes the city of Rochester. The Not Me, Not Now program devised a mass communications strategy to promote the abstinence message through paid television and radio advertising, billboards, posters distributed in schools, educational materials for parents, an interactive Web site, and educational sessions in school and community settings. The program had five objectives: raising awareness of the problem of teen pregnancy, increasing understanding of the negative consequences of teen pregnancy, developing resistance to peer pressure, promoting parent-child communication, and promoting abstinence among teens.

Not Me, Not Now was effective in reaching early teens, with some 95 percent of the target audience in the county reporting that they had seen a Not Me, Not Now ad. During the intervention period, there was a statistically significant positive shift in attitudes among pre-teens and early teens in the county.

The sexual activity rate of 15-year-olds across the county dropped by a statistically significant amount, from 46.6 percent to 31.6 percent, during this period.³¹ The pregnancy rate for girls ages 15

through 17 in Monroe County fell by a statistically significant amount, from 63.4 pregnancies per 1,000 girls to 49.5 pregnancies per 1,000. The teen pregnancy rate fell more rapidly in Monroe County than in comparison counties and upstate New York in general, and the differences in the rates of decrease were statistically significant.³²

Abstinence by Choice. Abstinence by Choice operated in 20 schools in the Little Rock area of Arkansas. The program targeted seventh, eighth, and ninth grade students and reached about 4,000 youths each year. The curriculum included a five-day workshop with speakers, presentations, skits, videos, and an adult mentoring component.

A 2001 evaluation analyzed a sample of 329 students and found that only 5.9 percent of eighth grade girls who had participated in Abstinence by Choice a year earlier had initiated sexual activity compared with 10.2 percent of non-participants. Among eighth grade boy participants, 15.8 percent had initiated sexual activity, compared with 22.8 percent among non-participating boys.³³ (The sexual activity rate of students in the program was compared with the rate of sexual activity among

30. All results were statistically significant at the 99.99 percent and higher confidence level. The study's evaluator conducted further analyses on the possibility of spurious program effects. When the sample consisted only of students who remained in the program throughout the year, excluding students who joined the program in mid-year, Best Friends girls were still less likely to report smoking, using illegal drugs, drinking, or engaging in sexual activity. Furthermore, compared with girls who completed the Best Friends program, those who dropped out were *not* more likely to smoke, use illegal drugs, drink, and engage in sexual activity. Girls who dropped out were also more likely to be older. Even when the evaluator artificially increased the incidence of these four risk behaviors among Best Friends participants at the baseline by 100 percent, the hypothetical estimates with the 100 percent increase would still be lower than the actual incidents among YRBS respondents.
31. Laura Kahn *et al.*, "Youth Risk Behavior Surveillance—United States 1997," Centers for Disease Control and Prevention *Morbidity and Mortality Weekly Reports*, Vol. 47, 1998, pp. 1–89.
32. Andrew Doniger, John S. Riley, Cheryl A. Utter, and Edgar Adams, "Impact Evaluation of the 'Not Me, Not Now' Abstinence-Oriented, Adolescent Pregnancy Prevention Communications Program, Monroe County, N.Y.," *Journal of Health Communication*, Vol. 6, No. 1 (January–March 2001), pp. 45–60. One caveat is that the study did not assess trend data on the counties prior to the intervention campaign. With only one pre-intervention data point (1992 data on sexual activity rates and 1993 data on pregnancy rates), the study cannot completely rule out the possibility that the declines would have occurred independent of the campaign. Both the shift in attitudes and the decline in sexual activity rate were statistically significant at the 95 percent confidence level. The differences between the rates of decline in adolescent pregnancy in Monroe County and the other geographic areas were statistically significant at the 95 percent to 99 percent confidence levels.
33. Stan E. Weed, "Title V Abstinence Education Programs: Phase I Interim Evaluation Report to Arkansas Department of Health, Institute for Research and Evaluation," October 15, 2001. The study did not adjust for the differences between program participants and non-participants. The written report does not include data on statistical significance, but data provided by Dr. Weed to the authors of this paper showed that the program's effects in reducing the onset of sexual activity were statistically significant at the 98 percent confidence level.

control students in the same grade and schools prior to commencement of the program.)

HIV Risk-Reduction Intervention. A 1998 study evaluated a two-day abstinence-based HIV risk-reduction intervention. The program was delivered to some 200 African-American middle school students in Philadelphia.³⁴ Students volunteered to participate in a weekend health promotion program, and the volunteers were then randomly assigned to an abstinence education program, a safer-sex education program, or a regular health program (the control group) delivered by trained adult and peer (high school student) facilitators.

The researchers found that, during the three-month follow-up, students in the abstinence programs were less likely to report having engaged in recent sexual activity compared with students in the control group and that they were marginally less likely to report having engaged in recent sexual activity compared to students in the safer-sex program.³⁵

Although the three groups generally did not differ in their reports of sexual activity in the preceding three months during the six-month and 12-month follow-ups, the researchers did report that, among students who had sexual experience before the intervention, those in the safer-sex group reported fewer days of sexual activity on average than students in the control group and the abstinence group reported.

Stay SMART. Delivered to Boys and Girls Clubs of America participants, Stay SMART integrated abstinence education with substance-use preven-

tion and incorporated instructions on general life skills as well. The 12-session curriculum, led by Boys and Girls Club staff, used a postponement approach to early sexual activity and targeted both sexually experienced and sexually inexperienced adolescents. Participation in Boys and Girls Clubs and Stay SMART was voluntary.

A 1995 study evaluated Stay SMART's impact on adolescent sexual behavior. The study measured the sexual attitudes and behavior of more than 200 youths who participated in Stay SMART or Stay SMART plus the boosters and compared their outcomes to some 100 youths who did not participate in Stay SMART but were still involved in the Boys and Girls Clubs.³⁶ The analysis controlled for demographic and baseline characteristics to test for the program's independent effect on adolescent sexual behavior and attitudes.

The study found that, two years after the program, youths who had engaged in prior sexual activity and participated in the stand-alone Stay SMART program exhibited reduced levels of recent sexual activity compared with non-participants and, interestingly, participants in the Stay SMART-plus-boosters program as well.³⁷ Among participants who were virgins prior to the program, the study did not find a statistically significant program effect.

Project Taking Charge. Project Taking Charge was a six-week abstinence curriculum delivered in home economics classes during the school year. It was designed for use in low-income communities with high rates of teen pregnancy. The curricu-

34. John B. Jemmott III, Loretta Sweet Jemmott, and Geoffrey T. Fong, "Abstinence and Safer Sex HIV Risk-Reduction Interventions for African American Adolescents: A Randomized Controlled Trial," *JAMA*, Vol. 279, No. 19 (May 20, 1998), pp. 1529-1536. The study also measured condom use. For the three follow-ups, the study reported three sets of 24 comparison estimates. One of the 24 comparison estimates between the abstinence and control groups was statistically different, favoring the abstinence group. Ten of the 24 comparison estimates between the safer-sex and control groups were statistically different, favoring the safer-sex group. Three of the 24 comparison estimates between the abstinence and safer-sex groups were statistically different, favoring the safer-sex group.

35. The findings from the comparison between the abstinence and control groups were statistically significant at the 98 percent confidence level. However, the findings from the comparison between the abstinence and safer-sex groups were statistically significant only at the 92 percent and 94 percent confidence levels.

36. Tena L. St. Pierre, Melvin M. Mark, D. Lynne Kaltreider, and Kathryn J. Aikin, "A 27-Month Evaluation of a Sexual Activity Prevention Program in Boys & Girls Clubs Across the Nation," *Family Relations*, Vol. 44, No. 1 (January 1995), pp. 69-77.

37. This finding was statistically significant at the 99 percent and above confidence level. The sub-sample of non-virgins in the 27-month follow-up was small: about 67 youths (28 in the Stay SMART only program, 18 in the program plus the boosters, and 21 in the control group).

lum contained elements on self-development; basic information about sexual biology (e.g., anatomy, physiology, and pregnancy); vocational goal-setting; family communication; and values instruction on the importance of delaying sexual activity until marriage.

The program was evaluated in Wilmington, Delaware, and West Point, Mississippi, based on a small sample of 91 adolescents.³⁸ Control and experimental groups were created by randomly assigning classrooms either to receive or not to receive the program. The students were assessed immediately before and after the program and at a six-month follow-up. In the six-month follow-up, Project Taking Charge was shown to have had a statistically significant effect in increasing adolescents' knowledge of the problems associated with teen pregnancy, the problems of sexually transmitted diseases, and reproductive biology.

The program may also have delayed the onset of sexual activity among some of the participants. About 23 percent of participants who were virgins at the pretest initiated sexual activity during the follow-up interval, compared with 50 percent of the youths in the control group, although the authors urged caution in interpreting these numbers due to the small sample size.³⁹

Teen Aid and Sex Respect. An evaluation of the Teen Aid and Sex Respect abstinence programs in three Utah school districts reported that certain

groups of youths who received these programs delayed the initiation of sexual activity.⁴⁰ To determine the effects of the programs, students in schools with the abstinence programs were compared with students in similar control schools within the same school districts. Statistical adjustments were applied to control for any initial differences between program participants and control group students.

In the aggregate sample, the researchers did not find any differences in the rates of sexual initiation between youths who had received abstinence education and those who had not. However, analyzing a cohort of high school students who had fairly permissive attitudes,⁴¹ they found that program participants were one-third less likely to engage in sexual activity one year after the programs compared with non-participants (22.4 percent versus 37 percent).⁴²

Even when the researchers adjusted for students' dating and drinking behavior, religious involvement, family composition, peer pressure, and other factors, the differences between the two groups remained statistically significant. (Statistically significant changes in behavior were not found among a similar group of junior high school students.) The researchers found it notable that youths who had more permissive attitudes were "not only receptive and responsive to the abstinence message in the short run, but that some influence on behavior [was] also occurring."⁴³

38. Stephen R. Jorgensen, Vicki Potts, and Brian Camp, "Project Taking Charge: Six-Month Follow-Up of a Pregnancy Prevention Program for Early Adolescents," *Family Relations*, Vol. 42, No. 4 (October 1993), pp. 401-406.

39. The finding was statistically significant at the 95 percent confidence level. Seven (23 percent) of the 30 youths in the intervention group initiated sexual activity during the six-month follow-up period, compared with 10 (50 percent) of the 20 youths in the control group.

40. Stan E. Weed *et al.*, "Predicting and Changing Teen Sexual Activity Rates: A Comparison of Three Title XX Programs," report to the U.S. Department of Health and Human Services, Office of Adolescent Pregnancy Programs, December 1992.

41. Permissive attitudes in the study were measured by responses to the following statements: "Having sexual intercourse should be treated as just a normal and expected part of teenage dating relationships"; "Having sex with a boyfriend or girlfriend is a good way to show how much you care for them"; "Teens who have been dating for a long time should be willing to go along and have sexual intercourse if their partner wants to"; "It is all right for teenagers to have sex before marriage if they are in love"; and "I think it is OK for unmarried teenagers to have sexual intercourse if they use birth control." Weed *et al.*, "Predicting and Changing Teen Sexual Activity Rates," pp. 25-26.

42. The sub-sample here included Sex Respect, Teen-Aid, and Value & Choices participants. The effects on the cohort of high school students with more permissive attitudes were significant at the 99 percent confidence level.

43. Weed *et al.*, "Predicting and Changing Teen Sexual Activity Rates," p. 64.

Virginity Pledge Studies

Using the National Longitudinal Study of Adolescent Health (Add Health), a nationally representative sample of American youth,⁴⁴ several studies have found that adolescent virginity pledging was associated with delayed or reduced levels of teen sexual activity, other risky behaviors, teen pregnancy, and STDs. (See the Appendix and the Reference List.)

Delayed Sexual Activity. A 1997 study published in the *Journal of the American Medical Association* examined a large national sample of teenagers in the seventh through 12th grades.⁴⁵ The study compared students who had taken a formal virginity pledge with students who had not taken a pledge but were otherwise identical in race, income, school performance, degree of religiousness, and other social and demographic factors. Based on this analysis, the authors found that the level of sexual activity among students who had taken a formal pledge of virginity was one-fourth the level of their counterparts who had not taken a pledge. The researchers also noted that “[a]dolescents who reported having taken a pledge to remain a virgin were at significantly lower risk of early age of sexual debut.”⁴⁶

Another study of the virginity pledge movement, published in 2001, found a similar association between pledging and delayed sexual activity. According to the authors:

Adolescents who pledge, controlling for all of the usual characteristics of adolescents and their social contexts that are associated with the transition to sex, are much less likely than adolescents who do not pledge,

to have intercourse. The delay effect is substantial and robust. Pledging delays intercourse for a long time.⁴⁷

Based on a sample of more than 5,000 students, the study reported that taking a virginity pledge was associated with a reduction of approximately one-third in the likelihood of early sexual activity, adjusted for a host of other factors linked to sexual activity rates including gender, age, physical maturity, parental disapproval of sexual activity, school achievement, and race. When taking a virginity pledge was combined with strong parental disapproval of sexual activity, the probability of initiating sexual activity was reduced by 75 percent or more. The authors did note that the pledge effect depended on youths’ age and their peer group context.

Life Outcomes in Young Adulthood. By the third wave of the Add Health survey, administered in 2001, respondents had reached young adulthood, ranging between 19 and 25 years of age. In some cases, the virginity pledge may have been taken up to seven years earlier. Nonetheless, for many respondents, the delaying effect associated with pledging during adolescence appeared to last into young adulthood.

Analyzing the most recent Add Health data, a 2004 study found that adolescent virginity pledging was linked to a number of positive life outcomes.⁴⁸ For example, a 22-year-old white female pledger from an intact family with median levels of family income, academic performance, self-esteem, and religious observance was two-thirds less likely to become pregnant before age 18 and 40 percent less

44. Add Health is a major longitudinal survey of adolescent and young adult behavior and is funded by 17 federal agencies. It is based on a nationally representative survey of approximately 14,000 youth. The survey began in 1994, and the same respondents were interviewed again in 1995 and 2001.

45. Michael Resnick *et al.*, “Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health,” *JAMA*, Vol. 278, No. 10 (September 10, 1997). The association between virginity pledging and reduced sexual activity was statistically significant at the 99.9 percent confidence level.

46. *Ibid.*, p. 830.

47. Peter S. Bearman and Hanna Brückner, “Promising the Future: Virginity Pledges and First Intercourse,” *American Journal of Sociology*, Vol. 106, No. 4 (January 2001), pp. 861 and 862. The virginity pledge effects were statistically significant at the 95 percent confidence level.

48. Robert E. Rector, Kirk A. Johnson, and Jennifer A. Marshall, “Teens Who Make Virginity Pledges Have Substantially Improved Life Outcomes,” Heritage Foundation Center for Data Analysis Report No. CDA04-07, September 21, 2004, at www.heritage.org/Research/Abstinence/cda04-07.cfm.

likely to have a birth out of wedlock compared with a non-pledger with identical characteristics. Strong pledgers⁴⁹ with the same characteristics were 40 percent less likely to initiate sexual activity before age 18 and had an average of one-third fewer sexual partners compared with non-pledgers with the same demographic profile.

STDs and Risky Sexual Behaviors. Analyzing the same sample of respondents, another study found that virginity pledging during adolescence was also associated with lower rates of STD infection among young adults. The STD rate among pledgers averaged 25 percent lower than the rate of non-pledgers of the same age, gender, race, family background, and religiosity. Significantly, the study found that virginity pledging was a stronger predictor of STD reduction than condom use on five different measures of STDs.⁵⁰

The protective effect of pledging may have extended to other behaviors as well. According to a 2005 study, young adults who took a virginity pledge during adolescence were less likely to engage in a number of risky sexual behaviors compared with those who did not take a pledge.⁵¹

Studies Reporting No Significant Effects

The Mathematica Study. In 2007, Mathematica Policy Research released a study that evaluated four abstinence programs: My Choice, My Future! in Powhatan, Virginia; ReCapturing the Vision in Miami, Florida; Families United to Prevent Teen

Pregnancy in Milwaukee, Wisconsin; and Teens in Control in Clarksdale, Mississippi.⁵² Primarily preventive in their intent, these programs focused on upper elementary and middle school children. The average age of the participants ranged from 10 to 13. Two of the sites were in urban settings, and two were in rural communities.

The four programs varied in duration and intensity. Three programs—two multi-year curricula and a one-year curriculum—required participation. Their intensity ranged from several sessions a year to daily classes. One program, an up-to-four-year curriculum, met daily but made participation optional. In that program, only about half of the students assigned to the program actually participated. Of those who participated at all, less than half attended a meaningful portion of the sessions offered.

The evaluation employed a rigorous experimental design. The researchers surveyed students four to six years after initial program enrollment to assess the impact of the four programs on youth behavior. Although long-term impact is ideal, some students in this study's sample were last surveyed later than is conventional in this field.⁵³ For example, at the program site with the shortest curriculum length (about one year), students averaged about 13 years old at enrollment, and the gap between program completion and the last follow-up survey was as long as five years. During this gap, the students received no additional abstinence education or intervention support.

49. The question "Have you ever signed a pledge to abstain from sex until marriage?" appears in all three waves of Add Health. Strong pledgers are a subgroup of pledgers who provided consistent answers to the question in all three waves of the survey. If they reported having taken a pledge, their answer in the subsequent wave(s) remained the same.
50. Robert Rector and Kirk A. Johnson, "Adolescent Virginity Pledges, Condom Use, and Sexually Transmitted Diseases Among Young Adults," paper presented at the Eighth Annual National Welfare Research and Evaluation Conference of the Administration for Children and Families, U.S. Department of Health and Human Services, June 14, 2005, at www.heritage.org/Research/Welfare/upload/79366_1.pdf.
51. Robert Rector and Kirk A. Johnson, "Adolescent Virginity Pledges and Risky Sexual Behaviors," paper presented at the Eighth Annual National Welfare Research and Evaluation Conference of the Administration for Children and Families, U.S. Department of Health and Human Services, June 14, 2005, at www.heritage.org/Research/Welfare/upload/79314_1.pdf.
52. Christopher Trenholm, Barbara Devaney, Ken Fortson, Lisa Quay, Justin Wheeler, and Melissa Clark, *Impacts of Four Title V Section 510 Abstinence Education Programs: Final Report*, Mathematic Policy Research, April 2007, at www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf (November 13, 2007).
53. To assess short-term program impact, evaluation follow-ups usually take place immediately to a year after the program. For longer-term impact, studies have employed follow-up intervals ranging from 12 to 48 months after program completion.

In the final follow-up survey, the study reported no statistically significant differences between program participants and non-participants. Among both program and control groups, half of the students remained abstinent. Among students who had become sexually active by the time of the final survey, program participants and non-participants had similar rates of condom use. (The four abstinence programs did not promote contraceptive use.)

At one of the program sites, the study found that 48 percent of the program participants remained abstinent in the final follow-up compared with 43 percent of the non-participants. At the same site, program participants were also more likely (a difference of 7 percentage points) to report expectations of abstinence until marriage compared with non-participants. Although these differences were not statistically significant, the study's authors noted that, "[g]iven the smaller sample sizes available for estimate impact at the site level... the study cannot rule out modest site-specific impacts on these outcomes."⁵⁴

WAIT Training. A 2005 study evaluated the WAIT Training abstinence education program as it was implemented in four high schools in Colorado.⁵⁵ Except for one of the program schools, students in the study's sample were mostly in the ninth grade. The study did not specify what type of sex education services, if any, students in the control group received. In the 12-month follow-up, the researchers did not find any differences in the sexual initiation transition rates between students in the program group and those in the control group.

California's Postponing Sexual Involvement (PSI). In the early 1990s, California incorporated the PSI curriculum into its statewide Education Now and Babies Later (ENABL) initiative to reduce teenage pregnancy. However, proponents of abstinence education have challenged whether or not the initiative is a genuine abstinence program given Planned Parenthood's role in its implementation.⁵⁶

The PSI curriculum included five sessions of 45 to 60 minutes, delivered either in school or in community settings by adult or youth instructors. Youths who received PSI were also required to receive reproductive health education before beginning the PSI curriculum. Students in the control groups received the standard sexuality curriculum offered by their schools.

An experimental study evaluated California's PSI program.⁵⁷ Based on data collected on some 7,300 students, the study found no significant differences between PSI youths and non-participants in their sexual behavior, pregnancy rates, and STD rates 17 months after the program.⁵⁸ However, the study did find short-term positive effects on youths' beliefs and intentions about sexual activity and self-efficacy.

Will Power/Won't Power. In the mid-1980s, Girls Incorporated (formerly Girls Clubs of America) developed a series of programs designed to prevent teen pregnancy. Will Power/Won't Power targeted younger adolescent girls, ages 12 to 14. The program taught young girls skills to help them resist peer pressure and risky behavior. The full curriculum was delivered in six two-hour lessons.

54. Trenholm et al., *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report*, p. xxii.

55. Lisa A. Rue and Stan E. Weed, "Primary Prevention of Adolescent Sexual Risk Taking: A School-Based Model," presented at the 2005 Abstinence Evaluation Conference, Baltimore, Maryland. The study did not adjust for the differences between participants and non-participants.

56. Helen H. Cagampang, Richard P. Barth, Meg Korpi, and Douglas Kirby, "Education Now and Babies Later (ENABL): Life History of a Campaign to Postpone Sexual Involvement," *Family Planning Perspectives*, Vol. 29, No. 3 (May-June 1997), p. 111, and Brad Hayward, "Some Foes of Abortion Call Budget Plan a Gain—Wilson Denies Tilt on Family Planning," *Sacramento Bee*, January 21, 1996.

57. Douglas Kirby, Meg Korpi, Richard P. Barth, and Helen H. Cagampang, "The Impact of the Postponing Sexual Involvement Curriculum Among Youths in California," *Family Planning Perspectives*, Vol. 29, No. 3 (May-June 1997), pp. 100-108.

58. Given the number of non-significant findings in the study, it was surprising that the one significant finding was on the reported pregnancy rate among the sample of PSI programs delivered by youth instructors. In that sample, PSI participants were more likely to report ever being pregnant or causing a pregnancy. Further analysis revealed that six seventh grade boys in one school that received the program reported having caused a pregnancy, and their reports appeared to have driven this result.

A study evaluating the effectiveness of Will Power/Won't Power in delaying the onset of sexual activity compared some 250 participants to 155 non-participants.⁵⁹ Participants volunteered to join the program; youths who declined enrollment became the control group.

Students were surveyed a year after the program. At that point, the study found that 12.8 percent of participants versus 13.5 percent of non-participants had initiated sexual activity since the program. However, the difference was not statistically significant. Further analysis suggested that the level of program participation might have played a role.

Virginity Pledges and STDs. Drs. Hannah Brückner and Peter Bearman, who found, using the Add Health data, that “[a]dolescents who pledge are much less likely to have intercourse than adolescents who do not pledge,”⁶⁰ also analyzed the pledge effect on STD infection among young adults. They reported “no significant differences in STD infection rates between pledgers and non-pledgers, despite the fact that they [pledgers] transition to first sex later, have less cumulative exposure, fewer partners, and lower levels of non-monogamous partners.”⁶¹

Conclusion

Today's young people face strong peer pressure to engage in risky behavior and must navigate media and popular culture that endorse and even glamorize permissiveness and casual sex. Alarmingly, the government implicitly supports these messages by spending over \$1 billion each year promoting contraception and safe-sex education—12 times what it spends on abstinence education.⁶²

Although 80 percent of parents want schools to teach youths to abstain from sexual activity until they are in a committed adult romantic relationship nearing marriage—the core message of abstinence education—these parental values are rarely communicated in the classroom.⁶³

In the classroom, the prevailing mentality often condones teen sexual activity as long as youths use contraceptives. Abstinence is usually mentioned only in passing, if at all.⁶⁴ Sadly, many teens who need to learn about the benefits of abstaining from sexual activity during the teenage years never hear them, and many students who choose to abstain fail to receive adequate support for their decisions.

Teen sexual activity is costly, not just for teens, but also for society. Teens who engage in sexual

59. Leticia Postrado and Heather Johnston Nicholson, “Effectiveness in Delaying the Initiation of Sexual Intercourse of Girls Age 12–14: Two Components of the Girls Incorporated Preventing Adolescent Pregnancy Program,” *Youth and Society*, Vol. 23, No. 3 (March 1992), pp. 356–379.
60. Bearman and Brückner, “Promising the Future,” p. 859 (emphasis in original).
61. Hannah Brückner and Peter Bearman, “After the Promise: The STD Consequences of Adolescent Virginity Pledges,” *Journal of Adolescent Health*, Vol. 36, Issue 4 (April 2005). Although this 2005 study reported other significant positive findings associated with virginity pledging, it is counted as one of the studies that showed no significant effects because of its main finding on STD rates. Much attention has also been focused on another finding in the study that virgin pledgers were more likely than virgin non-pledgers to engage in certain risky sexual behaviors. When interpreting the results of these risky behaviors, the small size of these selective sub-samples should be considered. For more discussion of this finding, see Rector and Johnson, “Adolescent Virginity Pledges and Risky Sexual Behaviors,” and Jeremy E. Uecker, Nicole Angotti, and Mark D. Regnerus, “Going Most of the Way: ‘Technical Virginity’ Among American Adolescents,” *Social Science Research*, in press, available online November 5, 2007.
62. Melissa G. Pardue, Robert E. Rector, and Shannan Martin, “Government Spends \$12 on Safe Sex and Contraceptives for Every \$1 Spend on Abstinence,” *Heritage Foundation Backgrounder* No. 1718, January 14, 2004, at www.heritage.org/Research/Abstinence/bg1718.cfm.
63. Robert E. Rector, Melissa G. Pardue, and Shannan Martin, “What Do Parents Want Taught in Sex Education Programs?” *Heritage Foundation Backgrounder* No. 1722, January 28, 2004, at www.heritage.org/Research/Abstinence/bg1722.cfm.
64. A review of nine popular comprehensive sex-ed curricula found that an average of only 4.7 percent of the page content references abstinence. Shannan Martin, Robert Rector, and Melissa G. Pardue, *Comprehensive Sex Education vs. Authentic Abstinence: A Study of Competing Curricula* (Washington, D.C.: The Heritage Foundation, 2004), p. 11, at www.heritage.org/Research/Welfare/upload/67539_1.pdf.

activity risk a host of negative outcomes including STD infection, emotional and psychological harm, lower educational attainment, and out-of-wedlock childbearing.

Genuine abstinence education is therefore crucial to the physical and psycho-emotional well-being of the nation's youth. In addition to teaching the benefits of abstaining from sexual activity until marriage, abstinence programs focus on developing character traits that prepare youths for future-oriented goals.

When considering federal funding for abstinence education programs and reauthorization of Title V abstinence education programs, including maintaining the current definition of "abstinence education,"⁶⁵ lawmakers should consider *all* of the available empirical evidence.

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65. 42 U.S. Code § 710(b)(2).

Studies Reporting Significant Results

Abstinence Program	Author(s)	Publication	Peer Reviewed	Program Population	Evaluation Design	Statistical Method	Behavioral Outcome Measured	Findings*
1 Reasons of the Heart	Weed et al. (2008)	American Journal of Health Behavior	✓	7th grade students in suburbs Northern Virginia (N = 492).	Quasi-experimental. Study controlled for pre-intervention differences between program participants and controls. Differences between study's design include observed differences between program group and control group although the study accounted for these differences and the possibility of unobserved differences between the two groups.	Logistic regression	Initiation of sexual activity	Positive
2 Sex Can Wait	Denny and Young (2006)	Journal of School Health	✓	Upper elementary, middle school, and high school students from 15 unspecified school districts (upper elementary: N = 25; middle school: N = 393; high school: N = 279).	Quasi-experimental. Pretest, posttest, and follow-up surveys were conducted on program youths and on nonparticipants. As the authors noted, limitations include the reliability of the scaled measures, attrition at 18-month follow-up, and comparison group contamination.	ANCOVA and logistic regression	Abstinence (overall) Upper elementary Middle school High school	NS Short term; NS; 18 months; positive Short term; positive; 18 months; NS
3 Heritage Keepers	Weed et al. (2005)	Paper presented at a conference sponsored by HHS-OPA	✓	7th through 9th grade students from 31 South Carolina schools. The sample consisted of students from a variety of demographic and geographic backgrounds (N = 1,535).	Quasi-experimental. Pretest, posttest, and 12-month follow-up surveys were conducted. The authors used limited controls such as high attrition and unobserved differences between program group and comparison group.	Logistic regression	Rate of sexual initiation	Positive

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* "Positive" indicates positive outcomes in the desired direction, e.g., delayed initiation of sexual activity, reduced levels of recent sexual activity, or fewer sexual partners; "NS" indicates non-significant results; "Negative" indicates adverse outcomes. Findings are statistically significant at or above the 95 percent statistical confidence level.

B.2126

Studies Reporting Significant Results (continued)

Absstinence Program	Author(s)	Publication	Peer Reviewed	Program Population	Evaluation Design	Statistical Method	Behavioral Outcome Measured	Findings*
4 For Keeps	Boraski et al. (2005)	<i>American Journal of Health Behavior</i>	✓	7th and 8th grade students from five urban and two suburban middle schools in the Midwest (N = 2,069).	Quasi-experimental. Pretest and 16- to 25-week follow-up surveys were conducted. Program group and control group were comparable. The authors listed several limitations to the evaluation design: small size effects that might be influenced by measurement issues, an evaluation model more suited for traditional sex education programs, a sample that is not representative of all 7th grade students, potential contamination between program participants and non-program participants, one-time outcomes, and a follow-up interval that was less than six months.	Binary logistic regression or linear regression	Sexual activity between the pretest and posttests All students (N = 2,069) Sexually inexperienced students at the pretest (N = 1,462) Sexually experienced students at the pretest (N = 439)	NS NS NS
5 Best Friends	Lerner (2005)	<i>Adolescent and Family Health</i>	✓	Program participants included 6th–8th grade girls from six of the 20 middle schools in the District of Columbia. Comparison data came from a survey of middle school youths in the District in general (N = 27,730).	Pretest and posttest with comparison survey data. The study controlled for age, school grade, and race and ethnicity of the respondents and conducted further analyses that tested alternative explanations for the results. One significant limitation of the study is its use of survey data as comparison data.	Logistic regression	Initiation of sexual activity	Positive Positive Positive NS
6 Not Me, Not Now	Donger et al. (2001)	<i>Journal of Health Communication</i>	✓	Middle school and high school students in Monroe County, New York (N = 1,395 to 1,737 for sexual initiation).	Cross-sectional time series. Data on sexual initiation rates came from the Youth Risk Behavior Surveys for Monroe County, NY. Data on pregnancy rates came from the New York State Department of Health, Office of Vital Statistics. Sexual initiation rates in 1992 (pre-program), 1995 (second year of program), and 1997 (fourth year) were compared. Pregnancy rates from 1993–1996 were compared among Monroe County, two counties in upstate and western New York, and New York state. Having only one pre-intervention data point is a limitation of the study.	Test of difference in proportions; chi-square for trend test; t-test for differences in regression slopes	Rate of sexual initiation Pregnancy rate	Positive Positive

* See first page of Appendix.

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Studies Reporting Significant Results (continued)

Abstinence Program	Author(s)	Publication	Peer Reviewed	Program Population	Evaluation Design	Statistical Method	Behavioral Outcome Measured	Findings*
7 Abstinence by Choice	Weed (2001)	Report to Arkansas Department of Health	✓	7th through 9th grade students in Little Rock, AR (N = 323).	Quasi-experimental. Pretest and 12-month posttest were conducted. The study did not control for differences between program and control groups, which is a major limitation.	Test of difference in initiation rate	Rate of sexual initiation	Positive
8 HIV Risk-Reduction Intervention	Jemmott et al. (1998)	JAMA	✓	6th and 7th grade African-American youths in Philadelphia. Students attended schools that served primarily low-income communities. Of the students participating in the initial survey, 26.5 percent were African American, 16.4 percent were Hispanic, and 15.4 percent reported having recently engaged in sexual activity (N = 659).	Experimental. Pretest and 3-, 6-, and 12-month follow-up surveys were conducted. Youths volunteered to participate in a weekend health promotion program, and volunteers were randomly assigned to receive one of three interventions: abstinence, safer sex, and general health. The researchers cited self-reported data and limited generalizability of the results as limitations to the study.	Analysis of covariance and logistic regression	Sexual activity in the last 3 months 3-month follow-up 6- and 12-month follow-ups Frequency of sexual activity in the last 3 months 3-month follow-up 6- and 12-month follow-ups	Positive (vs. control) NS (vs. safer sex) NS (vs. control and safer sex) NS (vs. control) NS (vs. control) NS (vs. safer sex)**
9 Stay SMART	St. Pierre et al. (1995)	Family Relations	✓	Participants came from 14 Boys and Girls Clubs across the country. Participants and youths in the control group came from comparable demographic and socioeconomic neighborhoods. Sample respondents averaged 13.6 years of age and were 60 percent male (N = 152 27-month posttest).	Quasi-experimental. Pretest and 3-, 15-, and 27-month posttests were conducted. Some differences were detected between youths who completed the program and those who did not. Non-virgins in the standard-care program reported on average, more favorable attitudes toward sexual behavior than non-virgins in the booster and control groups. The study controlled for the pre-program differences. Limitations include selection bias, small sample sizes, unbalanced differences between program and control groups, and differences in program sites.	ANCOVA	Virgins at pretest Recency and frequency of sexual activity (3-, 15-, and 27-month follow-ups) Non-virgins at pretest Recency and frequency of sexual activity 3-month follow-up 15-month follow-up 27-month follow-up	NS NS
10 Project Taking Charge	Jorgensen et al. (1993)	Family Relations	✓	7th grade students in Wilmington, DE, and West Point, MS, from disadvantaged socioeconomic backgrounds (N = 50).	Quasi-experimental, random assignment at class-room level. Study included a pretest, posttest, and 6-month follow-up with no attrition. Study limitations include a small sample and a short-term follow-up period. The study did not control for differences between the two groups at baseline.	ANCOVA	Rate of sexual initiation	Positive

* See first page of Appendix.
** Except among youth with prior sexual experience, in which case results favored safer sex.

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Studies Reporting Significant Results (continued)

Abstinence Program	Author(s)	Publication	Peer Reviewed	Program Population	Evaluation Design	Statistical Method	Behavioral Outcome Measured	Findings*
I1 Teen Aid and Sex Respect	Viced (1992)	Report to HHS and Utah Department of Education	✓	7th and 10th grade students from three districts in Utah (N = 336; more "permissive attitudes" sub-sample)	Quasi-experimental. Pretest, posttest, one-year follow-up conducted. Students who completed either the pretest or follow-up were more at risk for engaging in sexual activity than those who completed both surveys. Comparison group students attended schools in the same school district. The study controlled for group differences. The authors noted that the findings may be generalizable only to youths with similar characteristics and in similar geographic locations as the sample.	MANOVA	Rate of sexual initiation Entire sample "Permissive attitude" High school Middle school	NS Positive NS
I2 Virginity Pledging	Resnick et al. (1997)	JAMA	✓	Nationally representative sample of 7th-12th grade students from the National Longitudinal Study of Adolescent Health, Waves 1 and 2 (N = 4,982).	Longitudinal survey. Study controlled for key demographic characteristics.	Cox regression	Age at sexual initiation	Positive
I3 Virginity Pledging	Beaman and Bruckner (2001)	American Journal of Sociology	✓	Nationally representative sample of 7th-12th grade students from the National Longitudinal Study of Adolescent Health, Waves 1 and 2 (N = 5,679).	Longitudinal survey. Study controlled for a host of demographic characteristics, religiosity, and other protective factors.	Proportional hazards models	Initiation of sexual activity Contraceptive use at initiation	Positive Negative
I4 Virginity Pledging	Rector et al. (2004)	Center for Data Analysis Report		Nationally representative sample of 19- to 25-year-olds in 2001 from the National Longitudinal Study of Adolescent Health, Wave 3 (N = 5,679).	Longitudinal survey. Study controlled for a number of factors, including gender, race, age, family income, religiosity, self-esteem, and school performance.	Multivariate logistic regression	Initiation of sexual activity Pregnancy rate Out-of-wedlock birth rate	Positive Positive Positive
I5 Virginity Pledging	Rector and Johnson (2005a)	Paper presented at the 8th Annual National Welfare Research and Evaluation Conference, sponsored by the HRSA-ACE		Nationally representative sample of 19- to 25-year-olds in 2001 from the National Longitudinal Study of Adolescent Health, Wave 3.	Longitudinal survey. Study controlled for gender, age, race, family structure, and religiosity.	Multivariate logistic regression	STD rates	Positive

* See first page of Appendix.

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82126

Studies Reporting Significant Results (continued)

Abstinence Program	Author(s)	Publication	Peer Reviewed	Program Population	Evaluation Design	Statistical Method	Behavioral Outcome Measured	Findings*
16 Virginity Pledging	Rector and Johnson (2005b)	Paper presented at the 8th Annual National Welfare Research and Evaluation Conference, sponsored by the HHS-ACF		Nationally representative sample of 19- to 25-year-olds in 2001 from the National Longitudinal Study of Adolescent Health, Wave 3	Longitudinal survey study controlled for gender, age, race, family structure, and religiosity.	Multivariate logistic regression	Risky sexual behavior	Positive
Studies Reporting No Significant Results								
1 My Choice, My Future! Re-Capturing the Vision Families United to Prevent Teen Pregnancy—Teens in Control	Trenholm et al. (2008)	Journal of Policy Analysis and Management	✓	Two programs targeted upper elementary students, and two targeted middle school students. The four program sites were in Indiana, VA, Maryland, and the District of Columbia. The students came from lower socioeconomic backgrounds (Powhatan, N = 448; Miami, N = 414; Milwaukee, N = 414; Clarksville, N = 715).	Experimental. The final follow-up surveys were conducted 42 to 78 months after program enrollment.	Tests of difference in regression-adjusted means	Abstinence (overall and last 12 months) Number of sexual partners Contraceptive use (first experience and last 12 months) Pregnancy, birth, and STI rates	NS NS NS NS
2 WAIT Training	Rue and Weed (2005)	Paper presented at the 2005 Abstinence Evaluation Conference		The program was delivered to students, mostly 9th graders between the ages of 15 and 17 in four Colorado high schools (N = 318).	Quasi-experimental. Pretest, posttest, and 12-month follow-up conducted. The analysis did not control for baseline differences in characteristics between students in the program and those in the control group—a significant limitation.	Not specified	Initiation of sexual activity	NS

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* See first page of Appendix.

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Studies Reporting No Significant Results (continued)

Abstinence Program	Author(s)	Publication	Peer Reviewed	Program Population	Evaluation Design	Statistical Method	Behavioral Outcome Measured	Findings*
3 California's Postponing Sexual Involvement	Kirby et al. (1997)	Family Planning Perspective	✓	Californian youths averaging 12.8 years old and in the 7th grade. The samples were racially and ethnically diverse (N = 7,340).	Experimental, three levels (classroom, school, and individual youth). Pretest and 17-month follow-up survey were conducted. In the sample based on school-level randomization, the control group was less likely to speak English at home and more likely to be Hispanic, have higher grades, have mothers with less education, have engaged in sexual activity ever and have had more sexual partners. The study controlled for these differences. Study limitations include a lack of a strict no-treatment companion group.	T-tests and chi-square tests of differences in changed outcome. Due to the large sample size, only findings at or above the 99 percent confidence level were considered statistically significant.	Initiation of sexual activity, sexual activity in past 3 and 12 months, and number of sexual partners Contraceptive use Pregnancy rates STD rates	NS NS Negative NS
4 Will Power! Won't Power!	Postrado and Nicholson (1992)	Youth and Society	✓	12- to 14-year-old girls who were involved with four Girls Incorporated member organizations (N = 412).	Pretest and one-year follow-up. Study participants who voluntarily enrolled in the program became the "treatment" group. The control group consisted of those who did not enroll. Program and control groups matched on a number of characteristics.	Chi-square tests, logistic regression	Initiation of sexual activity	NS
5 Virginity Pledging	Brückner and Bearman (2005)	Journal of Adolescent Health	✓	Nationally representative sample of 19- to 25-year-olds in 2001 from the National Longitudinal Survey of Adolescent Health Wave 3 (N = 1,788 to 11,471, depending on the STD measure).	Longitudinal survey.	Cross-tabulations, tests of difference in the distribution of frequency (Wald test), and Kaplan-Meier	STD rates Initiation of sexual activity and number of sexual partners Risky behaviors Condom use First experience Previous 12 months, last episode	NS Positive Negative Negative NS

* See first page of Appendix.

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1. *Supra*, p. 4.

Mr. SALI. Thank you.

Dr. Benjamin, a moment ago I was hearing some discussion about the delay of sexual activity, and I think I heard a number of 4 to 6 months delay. I think in your testimony you refer to a delay from abstinence pledges by up to 18 months, delaying the sexual activity. Am I correct, No. 1, in your statement? And can you tell me why we are getting that disparity in the figures that we are hearing here?

Dr. BENJAMIN. The answer is yes, that is what we said.

Dr. SANTELLI. I mean, one has to look at programs that are attempting and a curriculum that are attempting to change something and a study that is following kids who then self report. OK? So the 18-month delay which was found by Peter Bearman and his colleagues was a study where kids said they signed up for a virginity pledge. If you intend to be abstinent, you are more likely.

I would also point out that in Dr. Bearman's own work, that the long-term followup of that was that STD rates were the same among the pledging group and among the non-pledging group, and, in fact, there was—what shall we say, a displacement phenomenon? So anal sex was increased in the pledging group. So yes, there is one study that shows this long delay, but in terms of the outcomes that Stan was mentioning, we are not seeing them.

Mr. SALI. That would lead me to believe that the information about abstinence was incomplete. Is that what you are saying? In other words, nobody told the kids that if they deviate from regular intercourse, heterosexual intercourse, that wouldn't be abstinent? Is that the message you are telling?

Dr. BENJAMIN. That is correct. I think the point is that if you don't give kids all of the information, then they misinterpret vaginal intercourse and they totally associate that with abstinence, and yet then they have these other risky behaviors, which they do continue because they don't think that is sex.

Mr. SALI. Thank you.

Dr. Weed, you had a couple slides you didn't get to. Is there any way we could see those at this time?

Mr. WEED. I could tell you something. Put No. 15 up there. There are effective programs, there are less-effective programs when it comes to abstinence education. Just to clarify, however, on the Bearman study, we wouldn't call that an abstinence education program. It was kind of a rally and a pledge deal, but it didn't fulfill the kinds of requirements we think that effective programs need.

I have listed them up here. First of all, an effective program has adequate dosage. Successful programs attend to the critical factor of adequate dosage and deliver that dosage on an effective schedule.

The pledge programs don't meet that criteria. There are important mediating factors, and this goes beyond the simplistic notion of providing information, but effectively addressing the key predictors of adolescent sexual risk behavior that are amenable to intervention, and we have identified at least a half dozen of these important mediating variables, and if a program doesn't address those it will not, in all likelihood, produce an effect on sexual activity.

We have also determined that the messenger in a program is at least as important as the message. I am thinking of Max's example. I think he didn't have a very good messenger in that gym teacher. Effective teachers make more of a difference in program outcomes than do printed materials. These teachers engage students in the learning process, gain their respect, model their message, and believe in their ability to impact students.

Finally, effective programs conduct quality program evaluation and take seriously the lessons learned, especially those that identify program shortcomings.

So it is a process of growth and development and maturation, and effective programs that follow even those basic steps are within a 12-month period, after a 12-month period are reducing transition rates by 50 percent.

Mr. SALL. Dr. Weed, if I understand you correctly, your message here is that an effective abstinence program will make a difference, but the program in most of what has been passing for abstinence, that message is either not the message, it is not delivered in the correct manner, or the people who are delivering it are not doing a good job at it. Is that accurate?

Mr. WEED. That is correct.

Mr. SALL. Thank you.

Mr. WEED. And there are good ones, there are weak ones. They vary.

Dr. BLYTHE. Can I just hasten to make a comment?

Mr. SALL. Quickly.

Dr. BLYTHE. That particular study is good, but we also have to realize that was in 7th graders, and so when the rate of sexual experience is very low we need to look at programs that carry forth the message of abstinence in a realistic way into the high school years in terms of as kids get older. I just hesitate to say that this gives a good example of all the information that kids need, obviously.

Mr. SARBANES. Thank you.

Mr. Hodes.

Mr. SIEGEL. May I also respond to the personal statement about my personal experience?

Mr. SARBANES. Let me just get to Mr. Hodes, because I know he has to get to another hearing.

Mr. Hodes.

Mr. HODES. Thank you very much, Mr. Chairman.

I want to thank the panel for your testimony. We are dealing with what strikes me as a public health crisis, and we are doing so in a society which has an extraordinarily uneasy relationship with the issues of sexual activity, given what we see in the media, given the messages our kids get, given my experience prior to coming to Congress as a family lawyer where I saw divorce rates above 50 percent, so marriage isn't always working the way it should.

But our Nation is facing a crisis in adolescent reproductive health—750,000 pregnancies among teens aged 15 to 19 annually, nearly one in three teen girls becomes pregnant before reaching the age of 20. Last year, as we have heard, the teen birth rate rose for the first time in 15 years, and the CDC is telling us that one in four teen girls has a sexually transmitted disease.

In terms of an effective response to this public health crisis, does the impartial, peer-reviewed, scientific evidence support abstinence-only programs as an effective response to this crisis? Dr. Santelli.

Dr. SANTELLI. No. You would have to say no. I mean, I think science operates by a number of mechanisms, one of which is peer review, another of which is weight of the evidence, so one realizes that it is difficult to establish cause and effect, that the program actually worked. These are not easy things, and so scientists work together through their professional associations, through journals, medical and scientific journals, to establish what we understand is the weight of the evidence. And then people like the Cochrane Group in Great Britain, people like Doug Kirby then try to review the evidence.

The answer, from both Cochrane and Dr. Kirby, is no, these programs are not working. I know we have heard some evidence presented today. I would take exception to some of the specifics that I heard today. At least one of the studies was passing out condoms that is represented as an abstinence-only study. I think that the work of Mr. Rector and Stan's review here needs to be subjected to peer review, and I don't think it is going to hold up.

Mr. HODES. Dr. Benjamin.

Dr. BENJAMIN. I think the answer is not as currently constructed for the abstinence-only programs. May I go further by saying that I do think that we have a crisis. I agree wholeheartedly with you. And I believe that means that we need to structure, fund, and fully support a more comprehensive approach. I do believe those programs should be evaluated, and then we should continue to fund those things that work, and they need to have a very strong abstinence component to them.

Mr. HODES. Dr. Blythe.

Dr. BLYTHE. I think the short answer is no, obviously both from the reviews that are being mentioned, but also from a clinical perspective, as well as a policy perspective.

Mr. HODES. Dr. Weed.

Mr. WEED. Thank you. It is true that there is a small amount of evidence even available on abstinence education. There is not a lot of people that do that kind of work. Our company probably does more than anybody in the Nation. But if you look on balance, you look at where we are with contraceptive programs, contraceptive education, and after 115 peer-reviewed studies they haven't been able to demonstrate an impact on STD rates, then we are not very good in that camp, either. So let's look at both, figure out what is going to work, and be fair about how we compare them.

Dr. Fineberg mentioned that there were nine studies that showed some positive outcomes. Well, that is great, but if they don't produce consistent condom use they are not going to be protected, and we can't find any studies in a school or community setting, never mind the clinic, but in a school or community setting where consistent condom use has been increased by contraceptive and comprehensive sex education.

Mr. HODES. Dr. Weed, could I just drill down for a moment?

Mr. WEED. You bet.

Mr. HODES. One thing I would like to ask you. You understand the importance and value and general accepted standard of impartial peer review of studies, do you not?

Mr. WEED. Sure.

Mr. HODES. Has an impartial peer review journal ever endorsed or reported your findings?

Mr. WEED. Yes. The three that I put up, two of them have been peer reviewed and the third one is in the pipeline.

Mr. HODES. Could I ask one last question, just finish this with Dr. Fineberg?

Briefly, Dr. Fineberg, my question: does the impartial peer-reviewed scientific evidence support abstinence-only as an effective response to our public health crisis?

Dr. FINEBERG. It does not.

Mr. HODES. Thank you.

Thank you, Mr. Chairman.

Mr. SARBANES. Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman. I would ask unanimous consent that my statement and some accompanying abstinence education material be included in the record.

Mr. SARBANES. Without objection.

[The prepared statement of Hon. Jim Jordan and referenced information follow:]

JIM JORDAN
FOURTH DISTRICT, OHIO

COMMITTEE ON THE JUDICIARY
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COMMERCIAL AND ADMINISTRATIVE LAW
DEPUTY RANKING MEMBER

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Statement by Rep. Jim Jordan (OH-04)

Oversight and Government Reform Committee Hearing on Abstinence Programs

April 23, 2008

Mr. Chairman, I was disappointed by the misleading assertions made in the 2004 report on abstinence education issued under your supervision and researched at the behest of several anti-abstinence groups. Having read the factually inaccurate majority memorandum for this hearing, I am again disappointed. It is obvious that what we will get today is an ideologically-motivated attack rather than a fair examination of the facts or an even-minded consideration of the pros and cons of various government-funded sex-education programs.

First, I object to the highly misleading assertion, made in the majority memorandum, that “the federal government has no designated funding specifically for comprehensive sex education programs,” but that “there are three abstinence-only initiatives that together have received over \$1.3 billion in federal funding over the past decade.” This statement implies a major funding disparity between the two types of programs, despite the fact that the Department of Health and Human Services (HHS), which is finalizing exact calculations of federally funded comprehensive sex education programs, has assured us that comprehensive sex education programs receive higher funding than abstinence education programs. A review of funding streams for both approaches shows that comprehensive sex education received twice as much funding. What is the majority trying to suggest here? As of 2002, the most recent available data, 22% of schools provided abstinence education, while 68% provided birth control instruction. There is no inequity favoring abstinence education—quite the opposite is the case.

Second, the majority memo points out that some states no longer apply for the Abstinence Education (Title V) block grant, as if to suggest a lack of interest in abstinence programs. While it is true that some states do not apply, what they don’t mention is that this is largely driven by state governors influenced by the anti-abstinence campaign and Congress’s failure to do a long term reauthorization and thereby assure steady funding for the program. According to the Administration for Children and Families (ACF) at HHS, there is still robust demand for program funding among the states.

Third, parents overwhelmingly desire for their children to be abstinent until marriage. A 2007 Zogby survey on sex education found that 8 out of 10 parents think it is important for their child to be abstinent until marriage, that parents prefer abstinence education over comprehensive sex education by a 2 to 1 margin and that at least 8 in 10 parents support the core teaching components of abstinence education, which are:

- Developing healthy relationships to improve their chances for a healthy future marriage
- The benefits of renewed abstinence for young people who have not been abstinent in the past
- Increasing self-worth and self-control
- How an unplanned pregnancy or STD can negatively affect a teenager's future

While the majority party asserts that “the majority of parents support comprehensive sex education,” they omit this other data that provides a more balanced picture.

Fourth, while the majority attempts to make the point that abstinence programs are largely ineffective, I have yet to see a study that proves comprehensive sex education reduces either STD rates or raises the rates of consistent condom use among teenagers—one of the very things they are aimed at improving. A review by Dr. Doug Kirby, from the National Campaign to Prevent Teen and Unplanned Pregnancy, of 115 of the best sex education research studies over the past 15 years found that only 22 measured reduction of STDs as a program outcome. Of those that did, only two found a reduction in STDs and these particular studies were of patients in a clinical setting rather than of teenagers in a curriculum-based sex education program. So, we have yet to see any solid evidence of the results comprehensive sex education provides with regard to STDs, and the story on condom use is much the same. In attacking abstinence education, the majority assumes that their alternative yields better results. I contend that we should subject both comprehensive sex education and abstinence education to the same evaluation criteria and get a more balanced view.

I would add that, in May of this year, ACF did a review of the nine most widely used comprehensive sex education curricula in the country and found they presented some disturbing and inaccurate information. Not only did the contents contain seven times more references to condoms and contraception than references to abstinence (in addition to some highly graphic information—remember this is being presented to our kids), they also promoted the use of nonoxynol-9, a spermicide that has been shown not to reduce, and perhaps even to increase, the transmission of HIV and other STDs. Other inaccuracies from the study included a statement that the first-year condom failure rate is 12%, when it is actually 15%, and a statement that condoms prevent pregnancy 97% of the time when the failure rate is approximately 15-20%. Every curriculum ACF reviewed had an inaccuracy of some sort.

Lastly, while much more time is needed to fairly assess the effectiveness of the relatively new abstinence education concept (ideally a full generation or more), these programs are already showing some promise. Some well-crafted programs, such as Heritage Keepers and Reasons of the Heart, have been shown to reduce rates of teen sexual activity by as much as half for significant amounts of time. Seven peer reviewed studies show that abstinence education decreases sexual initiation, increases abstinence among teens who have not been abstinent in the past, and decreases the number of partners among sexually active teens. Much has been made of a few studies seeming to show no results, like the Mathematica study commissioned by HHS, but such studies have not been comprehensive enough (the Mathematica study reviewed only 4 out of over 700 Title V programs). More time and thorough study is needed. If given a fair evaluation, abstinence education will likely prove as effective as common sense suggests it would be.



Correcting Misinformation in the Sex Ed Debate

Critics attack Abstinence Education through the use of deliberate misinformation. These attacks may be posed to you in the form of questions. This document provides factual responses to the most frequently asked questions regarding abstinence education. We hope this information is helpful as you advocate for the sexual health of youth across America.

Question: Why should abstinence education funding continue when there is no evidence that it works?

Response: Despite what you may read in the newspapers, there is a growing body of research that confirms that abstinence education decreases sexual initiation, increases abstinent behavior among sexually experienced teens, and/or decreases the number of partners among sexually experienced teens.¹ And if individuals do initiate sex after being in an abstinence program, they are no less likely to use condoms than anyone else.² Researchers acknowledge that it takes about a decade before a new program or strategy begins having positive published research, and despite the fact that abstinence education has received widespread federal funding for less than 10 years, there is already research to show what most people intuitively know – abstinence works!

Question: Isn't "abstinence only" really a "just say no" message?

Response: No – on both counts. Abstinence education, as funded by Congress, has nothing to do with "only" and the message is decidedly more inclusive than "just say no". The term, "abstinence only" is strategically attached to this funding by opponents to create the false perception that abstinence education is a narrow and unrealistic approach. Abstinence education is overwhelmingly more comprehensive and holistic than other approaches and focuses on the real-life struggles that teens face as they navigate through the difficult adolescent years.

Abstinence education realizes that "having sex" can potentially affect a lot more than the sex organs of teens, but as research shows, can also have emotional, psychological, social, economic and educational consequences. That's why topics frequently discussed in an abstinence education class include how to identify a healthy relationship, how to avoid or get out of a dangerous, unhealthy, or abusive relationship, developing skills to make good decisions, setting goals for the future and taking realistic steps to reach them, understanding and avoiding STDs, information about contraceptives and their effectiveness against pregnancy and STDs, practical ways to avoid inappropriate sexual advances and why abstinence until marriage is optimal. So, within an abstinence education program, teens receive all the information they need in order

to make healthy choices. That's a lot of information and skills packed into an abstinence curriculum! And all of these topics are taught within the context of why abstinence is the best choice. There's nothing "only" about the abstinence approach!

Question: Then how does abstinence education differ from so-called 'comprehensive sex education' (CSE)?

Response: There are vast differences between abstinence education and CSE. The major distinction is how each approach regards teens. Abstinence education believes teens can and increasingly do, avoid sex,³ so the discussion empowers them to make the healthiest sexual decision – which is to abstain. By contrast, CSE assumes that teens don't have the ability to avoid sexual experimentation, so most of their time is spent talking about sex and the use of condoms and other forms of contraception.⁴

Abstinence curricula discuss many topics that confront teens, always within the context of why abstaining is the best choice, but the same is not true with CSE texts. While the most frequently used and recommended CSE curricula may include the word or concept of 'abstinence' in their texts, the concept rarely goes beyond a passing mention. In fact, a review of CSE curricula show that, on average, about 5% of their time is devoted to the abstinence message,⁵ and rather than clear guidance, the definition of abstinence is usually subjectively defined by the student. One popular "abstinence plus" text promoted by comprehensive sex ed providers, asks students to brainstorm "what sexual behaviors a person *could* engage in and still be 'abstinent'"⁶ and such suggested activities as "cuddling with no clothes on", "masturbating with a partner", "rubbing bodies together" and "touching a partner's genitals" are given as possible abstinent behaviors.⁷ Students are sent nondirective and confusing definitions for abstinence that are filled with risk and predictably, the discussion quickly moves to "the endless possibilities of outercourse"⁸ and "making the transition from sexual abstinence."⁹ Alarmingly, CSE curricula present abstinence and condom use as equally "safe" options, promoting dangerous and medically inaccurate information to teens. (Read Straight From the Source for a more exhaustive discussion of the content of popular CSE texts.)

So the focus of Abstinence Education is one that empowers teens to avoid risk by making good health decisions, regardless of their sexual history, in contrast to so-called Comprehensive Sex Education that sets the bar much lower, assuming teens will engage in high risk sexual behavior and content to merely reduce the risk of that behavior.

Question: Is it fair that abstinence education receives federal funding, but comprehensive sex education receives no federal funding?

Response: The fact is comprehensive sex education (CSE) receives at least twice as much federal funding as abstinence education.¹⁰ In addition, CSE has received funding since the 1970s, while significant funding for abstinence education did not begin until 1998. So cumulative comparisons between the two approaches are overwhelmingly in favor of CSE funds.¹¹

Despite this funding disparity, abstinence education fits soundly within the public health model for prevention and risk avoidance. And with a growing body of research showing its effectiveness, continued funding, with annual increases, is not only warranted but also highly advisable to impact teen health in America.

Question: How much does abstinence education cost taxpayers?

Answer: Current federal funding for Abstinence Education is about \$170 million dollars, but the result is actually a cost savings to taxpayers! In terms of savings associated with reductions in teen births, abstinence education saves taxpayers \$6 for every \$1 spent.¹² Abstinence education provides a beneficial return for the taxpayer and a brighter future for teens. (For more information, see Federal Funding for Abstinence Education: A win/win for taxpayers and teens.)

Question: Is the media report that most schools teach abstinence education true?

Response: While there are increasing numbers of schools that teach abstinence education, the majority of schools still focus on reducing the risk of sex through birth control instruction,¹³ rather than the risk avoidance skill-building message of abstinence. In 1995, only 8% of schools taught abstinence education but 84% taught birth control instruction.¹⁴ In 2002, 22% taught abstinence education, and 68% taught birth control instruction. Information only up to the year 2002 is available, but this data indicates that fewer than 1 in 4 students across America are receiving abstinence education. At least partly due to the unequal federal funding between both initiatives, more than 2/3 of all teens receive so-called comprehensive sex education, a message that assumes that teens will have sex. This is why the recent accusation that rises in teen birth and STD rates are due to abstinence education is absurdly false.

Question: Does the abstinence message have any relevance for teens that are sexually active?

Response: Absolutely! Sexually experienced teens receive the skills and positive empowerment to make healthier choices in the future as a result of abstinence education. A recent published study shows that sexually experienced teens enrolled in an abstinence program were much more likely to choose to abstain than their sexually experienced peers who did not receive abstinence education.¹⁵ Among teens that have had sex, 55 percent of boys and 72 percent of girls wish they had waited.¹⁶ The abstinence message provides the only practical approach away from high-risk behavior and toward decision that removes all future risk for that teen.

Question: Why does abstinence education oppose medical accuracy?

Response: NAEA strongly believes that all youth serving organizations should provide accurate information to teens, regardless of the funding stream. That means that organizations receiving federal funds for pregnancy prevention, HIV/AIDS prevention, and all other programs, including abstinence education, should be held to the same standards of accountability. Abstinence organizations share this commitment to accuracy.

While ideologically motivated individuals and organizations have tried to assert that inaccurate statements characterize abstinence education, this is simply not true. For example, the 2004 report, *The Content of Federally Funded Abstinence-Only Education Programs*, commissioned by Rep. Henry Waxman and compiled, primarily by special interest groups who are historical opponents to abstinence, relied upon misrepresentation, distortion, and error rather than an honest appraisal of abstinence education curricula. (Read *Abstinence and its Critics* by Rep. Mark Souder for more information).

Most reports on "medical accuracy" fail to note that CSE curricula regularly overstate the effectiveness of condoms, underestimate the risk of certain sexual activities, and infer that sex can be made safe and without consequences as long as a condom is used.¹⁷ One widely used text even warns facilitators not to mention any limitations on condom effectiveness to students.¹⁸

Abstinence education continues its commitment to provide accurate information to teens so that they are fully equipped to make the best decisions for their sexual health.

Question: Why should the government fund religiously based abstinence education? Isn't that a separation of church and state conflict?

Response: The curricular content of abstinence education programs funded by the federal government is consistent with the public health prevention model for risk avoidance. In terms of general public health policy, the best health outcomes are made possible by the best positive health behavior messaging. Abstinence education follows this model, while all other approaches offer a message that still leave youth at risk for some of the consequences of sexual activity. Abstinence education provides all the information necessary for teens to make the best choice for their sexual health. The fact that the world's major religions support abstinence until marriage does not disqualify abstinence as an important public health message. What needs to be recognized is that while the abstinence until marriage message often converges with religious belief, it does not promote religious belief, but stands alone as a crucial, primary health message.

Question: With most people having sex before marriage, isn't the "abstinence until marriage" message unrealistic?

Response: The fact that many individuals have sex before marriage and 1 in 3 births are outside of marriage does not diminish the benefits of waiting to have children until marriage, nor does it mean we should abandon the goal of changing the cultural norm for this behavior. In fact, historically, if a cultural behavior or norm is in conflict with the desired outcome, efforts are redoubled, not discarded. For example, a generation ago, smoking was a desired, normative behavior, but today smoking is almost universally viewed as undesirable and unhealthy - proof that cultural and social norms can and do change. Similarly, although growing numbers of Americans are overweight, efforts to encourage

exercise and healthy eating habits have increasingly become public health priority messages. We do not capitulate our highest public health standards based on the unhealthy choices of a majority, but on standards that promote optimal health outcomes in the population.

Overwhelming social science data reveals that children who are born within a committed married relationship fare better economically, socially, physically and psychologically.¹⁹ In terms of child outcomes, the facts are clear – waiting until after marriage to have children is indisputably in the child's best interest.

Further, most teens are not sexually active and more and more teens are choosing to be abstinent, proving that the message of abstinence increasingly resonates with youth.²⁰ Amplified efforts to link the personal benefits of abstinence with the positive effects for children born from a marital union are warranted and necessary if positive changes in cultural norms are to be realized.

Question: I've heard that most parents want their children to receive "comprehensive sex education" rather than "abstinence education". Isn't abstinence education out of touch with what parents want their children to be taught?

Response: When parents understand the differences between CSE and abstinence curricula, they prefer abstinence education over so-called comprehensive sex education by a 2:1 margin.²¹ Only surveys that provide incomplete or erroneous information show a result different from these findings. Parents across all ideological, political, and demographic boundaries want what is best for their children and in terms of sexual health; the favored approach is abstinence education, as currently funded by Congress.

¹ Santelli, et al. Can Changes in Sexual Behaviors Among High School Students Explain the Decline in Teen Pregnancy Rates in the 1990's? *Journal of Adolescent Health*, 2004.

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² "Trenholm, Christopher, et al. Impacts of Four Title V, Section 510 Abstinence Education Programs." Princeton, NJ: Mathematica Policy Research, Inc., April 2007

³ YRBSS, Trends in the Prevalence of Sexual Behavior. CDC 2005.

⁴ Review of Comprehensive Sex Education Curricula The Administration for Children and Families (ACF) Department of Health and Human Services (HHS) .May 2007.

⁵ Martin, S; Pardue M. *Comprehensive Sex Education vs. Authentic Abstinence: A Study of Competing Curricula*, Heritage Foundation, August 10, 2004

⁶ *Ibid*

⁶ Taverner, B. Montfort, S. *Making Sense of Abstinence*, Planned Parenthood of Greater Northern New Jersey, (2005), p4

- ⁷ Ibid, p5.
- ⁸ Ibid, p62
- ⁹ Ibid, p125
- ¹⁰ "Abstinence Education vs Contraceptive Sex Education Funding Comparison", NAEA, January 2008, provide link
- ¹¹ Title X family planning funding began in 1971 and block grants for abstinence education through Title V began in 1998.
- ¹² "Federal funding for Abstinence Education: A Win-win for taxpayers and teens", NAEA, January 2008 provide link
- ¹³ Lindberg LD, Santelli JS, Singh S; *Perspec Sex Reprod Health*, 2006-Dec; vol 38 (iss 4); pp 182-9
- ¹⁴ Ibid
- ¹⁵ Borawski, Trapl, Lovegreen, et al. Effectiveness of abstinence-only intervention in middle school teens. *American Journal Health Behavior*. 2005
- ¹⁶ "With One Voice: America's Adults and Teens Sound Off about Teen Pregnancy" The National Campaign to Prevent Teen and Unplanned Pregnancy. 2007. Accessed at: <http://www.teenpregnancy.org/resources/data/polling.asp>
- ¹⁷ For more information on the inaccuracies in CSE texts, see "Straight from the Source: What so called 'comprehensive' sex education teaches to America's youth, NAEA, June 2007.
- ¹⁸ Jemmott, L, Jemmott, J, McCaffre, K, *Making a Difference!*, Select Media Inc, NY,NY, 2005 p 75.
- ¹⁹ Why Marriage Matters, Second Edition: Twenty-Six Conclusions from the Social Sciences, September 2005.
- ²⁰ What Is a Healthy Marriage? Kristin Anderson Moore; Susan M. Jekielek; Jacinta Bronte-Tinkew; Lina Guzman; Suzanne Ryan; Zakia Redd. September 2004. Waite, L. Gallagher, M, *The Case for Marriage, Broadway Books*, NY,NY 2000;
- ²¹ YRBSS, Trends in the Prevalence of Sexual Behavior. CDC 2005.
- ²² Zogby Survey of Nationwide Parents of Children Age 10-16 3/27/07 thru 4/5/07; May 2007



A win/win for taxpayers and teens
NATIONAL ABSTINENCE EDUCATION ASSOCIATION

Federal funding for Abstinence Education: A win/win for taxpayers and teens

Spending money on abstinence education is a cost savings for taxpayers. Providing youth with the skills to wait to have sex is easier and less expensive than treating youth for the possible consequences of teen sex. Teens who avoid these consequences are more likely to be successful in reaching their goals. As research now indicates that abstinence education programs reduce teen sexual activity by approximately 50%, it is increasingly clear that abstinence education provides a good return for the taxpayer and a brighter future for teens.

Note: This study is not an exhaustive computation of all of the cost savings and benefits associated with a teen choosing abstinence. This fact sheet only details the cost savings associated with the decrease in teen births.

Abstinence Education saves taxpayers \$6 for every \$1 spent for pregnancy prevention.

Both the increase in teens choosing abstinence and the decline in teen pregnancy have coincided with the increase in federal funding for Abstinence Education, suggesting that Abstinence Education has played a major role in these tax savings. Current funding for abstinence education is approximately

Significant Savings of Abstinence Education

Indicator	Amount
Annual number of students served with Title V & CEAAE federal abstinence education funding ¹	2,500,000
2006 preliminary teen birth rate to teens aged 15-19 ²	41.9/1000
Of 2.5 million teens, number who could be expected to give birth if they received no abstinence education, using 2006 rates ³	104,750
Taxpayer cost per birth ⁴	\$21,562
Taxpayer cost for 104,750 births ⁵	\$2,258,619,500
Decrease in sexual activity (and thus teen births) attributed to teens choosing abstinence ^{6,7}	50% decrease
Savings to taxpayer due to abstinence education ⁸	\$1,129,309,750
Savings per \$1 spent ⁹	\$6.49

\$174 million per year¹, which translates into a savings of over \$1 billion taxpayer dollars.

Teens who choose abstinence and avoid becoming pregnant are saving taxpayers over \$1 billion in teen childbearing costs.

- Teen childbearing costs U.S. taxpayers \$9.1 billion per year.¹²
 - The percentage of students who are virgins has increased from 46% in 1990 to 53% in 2005.¹³
- Abstinence education has been shown to decrease teen sexual activity by approximately 50% and increased abstinence is responsible for at least half of the decrease in teen pregnancy,¹⁴ saving taxpayers over \$1 billion each year.¹⁵

There are additional health benefits from Abstinence Education, which, if quantified, would reveal even greater savings to taxpayers.

- Teens account for one quarter of all new STDs each year.¹⁶ Abstinence teens, however, avoid sexually transmitted diseases and all corresponding medical costs.
- Studies reveal increased risks of depression and attempted suicide among sexually active teens.¹⁷ Abstinence teens, however, avoid negative emotional consequences resulting from sexual activity and all associated mental health costs.
- Teen birth rates have dropped significantly since major funding for abstinence education became a federal priority in 1998. As a result, billions more tax dollars have been saved.¹⁸

Abstinence Education funding must continue to preserve the positive behavioral trends among teens and corresponding savings to taxpayers.

- Only abstinence programs devote over 50% of course time promoting abstinence among teens. In contrast, comprehensive programs spend less than 5% of course time promoting abstinence.¹⁹

- Numerous published studies show that Abstinence Education decreases sexual initiation, increases abstinent behavior among sexually experienced teens, and/or decreases the number of partners among sexually experienced teens.²⁰

Americans support continued funding for Abstinence Education.

- In a recent survey, parents said they wanted more funding given to Abstinence Education than to Comprehensive Sex Education by a 3 to 1 margin.²¹

Conclusion.

These findings of significant savings to taxpayers come at a critical time. With levels of teen sexual activity still too high and state and national lawmakers struggling to balance budgets, expenditures through abstinence education programs have an important impact. Continued funding and expansion of the nationwide abstinence education effort is warranted.

¹ FY 2008 budget as passed by Congress, December 19, 2007

² Based on students served through Title V and CBAE Abstinence Education Funding

³ National Center for Health Statistics Report, accessed 12/28/2007 at <http://www.cdc.gov/nchs/pressroom/07newsreleases/teenbirth.htm>. Released Dec 5, 2007.

⁴ 2.5 million students x 40.5/1000 teen birth rate = 101,250 births

⁵ \$9.1 billion total taxpayer cost / 422,043 total 2004 teen births = \$21,562 per birth (ibid)

⁶ \$21,562 x 101,250 (2.5 million students using the 40.5/1,000 rate) = \$ 2,183,152,500

⁷ Weed, Erikson, Birch, et al. An Abstinence Program's Impact on Cognitive Mediators and Sexual Initiation. *American Journal Health Behavior* (January 2008). The study concluded that those students receiving abstinence education were about one-half (45.7%) as likely to initiate sexual activity as students who did not receive abstinence education.

⁸ Santelli, et al. Can Changes in Sexual Behaviors Among High School Students Explain the Decline in Teen Pregnancy Rates in the 1990's? *Journal of Adolescent Health*, 2004.

⁹ Mohr, J, Tingle LR, Finger R. An Analysis of the Causes of the Decline in Non-marital Birth and Pregnancy Rates for Teens from 1991 to 1995. *Journal of Adolescent and Family Health*, April, 2004, No.1, 39-47.

¹⁰ 104,750 teens x 50% to reflect decrease in sexual activity = 52,375 teens who are likely to give birth (using 2006 rates). 50% reduction in teen pregnancy translates into a cost savings of \$1,129,309,750

¹¹ 1,091,576,250 divided by \$174,000,000 = \$6.49 savings for each \$1 spent in abstinence education.

¹² National Campaign to Prevent Teen Pregnancy. "By the Numbers: The Public Costs of Teen Childbearing." See http://www.teenpregnancy.org/costs/pdf/resources/key_data.pdf

¹³ CDC MMWR, *Youth Risk Behavior Survey*, June 9, 2006. Accessed at www.cdc.gov/mmwr/PDF/SS/SS55505.pdf

¹⁴ Mohr, J, Tingle LR, Finger R. An Analysis of the Causes of the Decline in Non-marital Birth and Pregnancy Rates for Teens from 1991 to 1995. *Journal of Adolescent and Family Health*, April, 2004, No.1, 39-47.

¹⁵ Computed as described in above chart

¹⁶ Centers for Disease Control, *Tracking the Hidden Epidemics*, 2000.

¹⁷ The Heritage Foundation, Rector, et al., "Sexually Active Teenagers are More Likely to be Depressed and Attempt Suicide." Washington, D.C., 2003.

¹⁸ National Vital Statistics Reports, Vol. 56, No. 7, December 5, 2007; accessed at <http://www.cdc.gov/nchs/pressroom/07newsreleases/teenbirth.htm>; National Vital Statistics Reports, Vol. 49, No. 10, September 25, 2001; accessed at <http://www.cdc.gov/nchs/pressroom/01facts/teenbirths.htm>. The drop in birth rate from 51.1/1,000 in 1998, the first year of Title V abstinence education funding to 41.9/1,000 in 2006 is significant.

¹⁹ The Heritage Foundation, Rector, et al., "Comprehensive Sex Education vs. Authentic Abstinence" Washington, D.C., 2004.

²⁰ Santelli, et al. Can Changes in Sexual Behaviors Among High School Students Explain the Decline in Teen Pregnancy Rates in the 1990's? *Journal of Adolescent Health*, 2004.

²¹ Weed, Erikson, Birch, et al. An Abstinence Program's Impact on Cognitive Mediators and Sexual Initiation. *American Journal Health Behavior*, Jan 2008.

²² Doniger, Adams, Uiter, Riley, "Impact Evaluation of the 'Not Me, Not Now' Abstinence-Oriented, Adolescent Pregnancy Prevention Communications Program." Monroe County, NY. *Journal of Health Communication*, Jan-Mar, 2001.

²³ Rozewski, Tagli, Lovregren, et al. Effectiveness of abstinence-only intervention in middle school teens. *American Journal Health Behavior*, 2005

²⁴ Olsen JA, Weed SE, et al. The effect of abstinence education programs on virgin versus non-virgin students. *Journal of Research and Development in Education*, 1992

²⁵ Marion Howard and Judith Blarney McCabe, "Helping Teenagers Postpone Sexual Involvement," *Family Planning Perspectives*, January/February 1990, pp. 21-26

²⁶ Weed, Erikson, Birch. An evaluation of the Heritage Keepers Abstinence Education Program. In Golden A (Ed.)

Evaluating Abstinence Education Programs: Improving Implementation and Assessing Impact. Washington DC: Office of Population Affairs and the Administration for Children and Families, Dept of Health and Human Services, 2005 ix

²⁷ Lerner, Robert, "Can Abstinence Work?" *Adolescent and Family Health*, 2005 April Vol 3, No. 4

²⁸ Zogby survey, April 2007.

Zogby International Poll
Parental Support for Abstinence Education
NAEA Executive Summary of Key Findings
May 2, 2007

Summary:

This poll, commissioned by NAEA, was conducted through a telephone survey of parents of children age 10-16 by Zogby International. The purpose of the poll was to determine the level of support for abstinence education among parents. The target sample was 1,002 interviews with parents from across the United States, representing a variety of demographics. Samples were randomly drawn from telephone CDs of national listed sample. Zogby International surveys employ sampling strategies in which selection probabilities are proportional to population size within area codes and exchanges within those area codes. The margin of error is +/- 3.2 percentage points. Margins of error are higher in sub-groups.

- **The overwhelming majority of parents want their teens to be abstinent until they are married.**
 - 9 out of 10 parents agree that being sexually abstinent is best for their child's health and future, with 8 in 10 strongly agreeing.
 - 8 out of 10 parents think it's important for their child to wait until they're married to have sex, with 6 in 10 strongly agreeing.
- **Parents prefer abstinence education over comprehensive sex education by a 2 to 1 margin.**
 - Once they understand what abstinence education actually teaches, 6 out of 10 parents would rather their child receive abstinence education vs. comprehensive sex education. Only 3 out of 10 prefer comprehensive.
- **At least 8 in 10 parents support the overall approach of abstinence education.**
 - 8 out of 10 parents think sex education in public schools should place more emphasis on promoting abstinence vs. contraceptive use.
 - 9 out of 10 of parents think that given the high number of STDs among teens, it is important for schools to emphasize abstaining from sex.
- **At least 8 in 10 parents support the core teaching components of abstinence education:**
 - Developing healthy relationships to improve their chances for a healthy future marriage.
 - The benefits of renewed abstinence to sexually experienced students.
 - Increasing self-worth and self-control as methods for reducing premarital sexual activity.
 - How an unplanned pregnancy and/or STD can negatively affect a teen's future physically, financially, and emotionally.

- **Most parents reject comprehensive sex education, which focuses on promoting and demonstrating contraceptive use.**
 - 2 out of 3 parents think that the importance of the “wait to have sex” message ends up being lost when programs demonstrate and encourage the use of contraception.
 - Over half of parents think that promoting and demonstrating condom usage encourages sexual activity.
 - 8 out of 10 parents think teens will not use a condom every single time.
 - 2 out of 3 parents believe that promoting alternatives to intercourse (such as showering together and mutual masturbation, which are presented in some comprehensive programs) encourages sexual activity.

- **9 out of 10 parents want teens to be taught about contraception in a manner that is consistent with the approach of abstinence education.**
 - 9 out of 10 parents think teens should be taught how often condoms fail to prevent pregnancy based upon typical use.
 - Over 9 out of 10 parents think that teens should be taught the limitations of condoms in preventing specific STDs.

- **Parents want more funding given to abstinence education than to comprehensive sex education by a 3 to 1 margin.**
 - 6 out of 10 parents think more government funding should be given to abstinence education vs. comprehensive sex education. Only 2 out of 10 want more funding for comprehensive sex education.



Response To CDC Report: 1 in 4 Teen Girls Has an STDⁱ

Overview

A study released during the CDC's 2008 National STD Prevention Conference in Chicago reveals that one in four (26%) of teen girls, between the ages of 14 and 19 have at least one STD. That means that 3.2 million girls have one or more of the most common STDs: HPV, Chlamydia, Genital Herpes, or Trichomoniasis. Overall, 40% of sexually active teen girls have at least one STD. Data was based on an analysis of the 2003-2004 National Health and Nutrition Examination Survey.

Commentary

Incredulously, many would try to "blame" abstinence education for these alarming statistics, but a careful look at the facts makes such an accusation baseless. The evidence clearly indicates that contraceptive-based sex education must acknowledge complicity for spiraling STD rates for the following reasons:

- Most students receive contraceptive-based sex education; fewer than 1 in 4 teens receive authentic abstinence educationⁱⁱ;
 - The contraceptive approach includes only brief discussions of abstinence and often leaves the definition of "abstinence" open-ended while encouraging risky activities that serve as a 'gateway to intercourse.'ⁱⁱⁱ ^{iv}
- Most sexually active girls receive contraceptive or STD services^v
- Condom use is on the rise^{vi}
- Most clinics do not refer clients for STD testing^{vii}. In contrast, abstinence education programs routinely encourage screening for sexually active teens.
 - This is important because up to 80% of people with STDs do not realize they have them, so testing is critical as this is the only method for diagnosis and treatment.^{viii}

Conclusion

Abstinence removes **all** risk for acquiring an STD. Growing research shows that abstinence education **is effective**. Research demonstrates that abstinence education delays sexual onset, decreases number of partners, and discontinues current sexual activity.^{ix} Students who participate in an abstinence education program are no less likely to use a condom if they become sexually active.^x "Now more than ever, funding and support for abstinence education should increase in order to stem the tide in STDs and other consequences associated with teen sexual activity.

- ¹ Center For Disease Control And Prevention (2008, March 11). Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis among Female Adolescents in the United States: Data from the National Health and Nutritional Examination Survey (NHANES) 2003-2004
- ² Laura Duberstein Lindberg, John Santelli, and Susheela Singh, "Changes in Formal Sex Education: 1995-2002," *Perspectives on Sexual and Reproductive Health*, Vol. 38, No. 4 (December 2006)
- ³ NAEA, June 17, 2007: Straight From The Source: What so called "Comprehensive" Sex Education Teaches to America's Youth (June 17, 2007), Available at <http://www.abstinenceassociation.org/research/index.html>
- ⁴ US Department of Health and Human Services, "Review of Comprehensive Sex Education Curricula". May 2007. Available at <http://www.acf.hhs.gov/programs/fysb/content/abstinence/06122007-153424.PDF>
- ⁵ (2008, March 11) CDC Press Release: Integration of Contraceptive and STD/HIV Services for Young Women in the United States. "82% of women in the US received either contraceptive or STD/HIV services....younger women (aged 15-22) were more likely to receive both types of services (41%)...Overall, women were almost twice as likely to receive contraceptive services as STD/HIV services (79% vs 42%)."
- ⁶ CDC YRBSS Youth Online-Comprehensive Report: Among students who had sexual intercourse during the past three months, the percentage who used a condom during last sexual intercourse: 1991:46% 2005:62.8%
- ⁷ Sherry L Farr et al, CDC (2008, March 11) CDC Press Release: Integration of Contraceptive and STD/HIV Services for Young Women in the United States
- ⁸ CDC Fact Sheets for STDs; Accessed at www.cdc.gov/std/
- ⁹ Weed, Eriksen, Birch, et al. An Abstinence Program's Impact on Cognitive Mediator's and Sexual Initiation. *American Journal Health Behavior* (January 2008);Doniger, Adams, Utter, Riley, "Impact Evaluation of the 'Not Me, Not Now' Abstinence-Oriented, Adolescent Pregnancy Prevention Communications Program," Monroe County, NY, *Journal of Health Communications*, Jan-Mar. 2001; Borawski, Trapl, Lovegreen, et al, Effectiveness of abstinence-only intervention in middle school teens. *American Journal Health Behavior*. 2005 ; Olsen JA, Weed SE, et al. The effect of abstinence education programs on virgin versus non-virgin students. *Journal of Research and Development in Education*. 1992; Marion Howard and Judith Blarney McCabe, "Helping Teenagers Postpone Sexual Involvement," *Family Planning Perspectives*, January/February 1990, pp. 21-26 ;Weed, Eriksen, Birch. An evaluation of the Heritage Keepers Abstinence Education Program. In Golden A (Ed.) *Evaluating Abstinence Education Programs: Improving Implementation and Assessing Impact*. Washington DC: Office of Population Affairs and the Administration for Children and Families, Dept of Health and Human Services. 2005 ;Lerner, Robert, "Can Abstinence Work?" An Analysis of the Best Friends Program," *Adolescent and Family Health*, 2005 ,April Vol 3, No. 4
- ¹⁰ Douglas Kirby, PhD. November, 2007 Emerging Answers Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Disease, p15
- ¹¹ Christopher Trenholm, Barbara Devaney, Ken Fortson, Lisa Quay, Justin Wheeler, and Melissa Clark "Impacts of Four Title V, Section 510 Abstinence Education Programs." Princeton, NJ: Mathematica Policy Research, Inc., April 2007,.



April 24, 2008

Overview

The April 23, 2008 hearing of the Oversight & Government Reform Committee entitled "Domestic Abstinence-Only Programs: Assessing the Evidence" was called, according to Mr. Waxman, so that Congress may "base our policy on the best available science and evidence, not ideology". However, when the panel of experts selected by the majority was asked by Rep. Foxx if they would support funding for abstinence education if there was evidence of effectiveness, all but 1 of the 6 admitted they would not support continued funding for abstinence education, regardless of the evidence. This response revealed that the intent of this hearing was actually to recommend that abstinence education, as currently funded by Congress, be defunded. And so the implicit intent was to base policy on ideology rather than evidence. NAEA calls upon Congress to renounce the ideological politicization of this discussion and focus on the optimal health message for youth.

It is well established that adolescent sexual activity has significant potential physical consequences including pregnancy as well as high percentage of several common STDs. Growing research also points to the potential emotional consequences of sexual activity for teens. This research reveals that even if it were possible to remove all the potential physical consequences of sexual activity, there are still significant consequences that can never be eliminated by better condom use. Certainly priority should be given to eliminating these risks from an adolescent's already stressful years. Abstinence education, as currently funded by Congress, offers this necessary primary prevention message and provides accommodating skills to give the message reality in the student's life.

Abstinence Education does not preclude Comprehensive Sex Education from being taught. But the sensitive nature of sex education instruction begs that local communities be given the choice of how to educate their children on sexually related topics. Differentiated funding streams permit a clear distinction between the two approaches and are necessary for consumer parents and consumer schools. Additionally, to avoid mission creep, it is imperative that the two funding streams remain separate. As this document will show, there is significant funding for the secondary intervention of comprehensive sex education and much less for the primary prevention message of abstinence education. It is vital that priority continues to be given to this risk avoidance strategy and that funding be continued without legislative change.

The Risk Avoidance Message of Abstinence Education

There are significant differences between abstinence education and Comprehensive Sex Education. The major distinction is how each approach regards teens. Abstinence education believes teens can and increasingly do, avoid sex¹ The term, "abstinence only" is used by opponents to create the false perception that abstinence

education is a narrow and unrealistic approach. Abstinence education realizes that “having sex” can potentially have physical, emotional, psychological, social, economic and educational consequences. Therefore, classes frequently discuss how to identify a healthy relationship, how to avoid or end a dangerous, unhealthy, or abusive relationship, developing skills to make good decisions, setting goals for the future and taking realistic steps to reach them, understanding and avoiding STDs, information about contraceptives and their effectiveness against pregnancy and STDs, practical ways to avoid inappropriate sexual advances and why abstinence until marriage is optimal. Abstinence curricula discuss many topics that confront teens, always within the context of why abstaining is the best choice. Abstinence education is overwhelmingly more comprehensive than other approaches and focuses on the real struggles that teens face as they navigate through the difficult adolescent years. Teen sexual activity can derail future aspirations and goals, so abstinence educators believe that no one should be prevented from receiving skills that give him or her every advantage for the future. Whether a student is abstinent, sexually active, homosexual or heterosexual, all teens receive the skills and positive empowerment to move away from high-risk behavior and toward a decision that removes all future risk for that teen.ⁱⁱ Among teens that have had sex, 55 percent of boys and 72 percent of girls wish they had waited which indicates that abstinence is a viable option for sexually experienced studentsⁱⁱⁱ. Sexually active teens are directed by abstinence educators to immediately seek medical care to be tested for STDs and receive treatment if necessary.

The longer a person waits to become sexually active, the fewer lifetime partners they will have and will therefore be at less risk for one or more STDs. Recent research by the CDC reveals that 1 in 4 adolescent girls have at least one STD and the risk is considerable even with only one partner^{iv}. Although condoms reduce HIV risk by 85% for heterosexual sex^v, they are much less effective against other STDs, still putting even consistent users at significant risk. Consistent use contributes to a risk reduction of 50% or less^{vi} but inconsistent use, as is typical for most teens and adults, may even increase the risk of acquisition of certain STDs^{vii}, possibly because of a combination of condom fatigue and risk compensation – “increases in risky behavior sparked by decreases in perceived risk.”^{viii}

The Message of Comprehensive Sex Education

Comprehensive Sex Education is promoted as the commonsense approach for sex education, placing a strong emphasis on abstinence, but also giving information to students on contraception and condoms. A careful review of the most popular texts, however, reveals a very different picture. This approach assumes that teens don’t have the ability to avoid sexual experimentation, so most of their time is spent talking about sex and the use of condoms and other forms of contraception.^{ix} Recently, the U.S. Department of Health and Human Services released a report^x on the most widely recommended comprehensive sex education curricula and found that while advocates tout the presumed strong emphasis of abstinence within comprehensive sex education, the evidence shows only the briefest mention of abstinence. Another review found that only about 5% of their time is devoted to abstinence.^{xi} Additionally, rather than providing clear guidance, the definition of abstinence is usually subjectively defined by the student. One popular “abstinence plus” text asks students to brainstorm “what sexual behaviors a

person could engage in and still be ‘abstinent’^{xii} and such suggested activities as “cuddling with no clothes on”, “masturbating with a partner”, “rubbing bodies together” and “touching a partner’s genitals” are given as possible abstinent behaviors.^{xiii} Students are provided nondirective and confusing definitions for abstinence that are filled with risk and predictably, the discussion quickly moves to “the endless possibilities of outercourse”^{xiv} and “making the transition from sexual abstinence.”^{xv} These are not only gateway-to-intercourse activities, but also many of these recommended “abstinent” behaviors put a teen at risk for STD acquisition. Alarming, several of the most popular CDC-recommended comprehensive sex education curricula present abstinence and condom use as equally “safe” options, which provides inaccurate information to teens^{xvi}.

Comprehensive sex education curricula fail to provide full and accurate information on condoms. One CDC-approved text instructed teachers; “Don’t bash condoms or provide information on failure rates”^{xvii} Such information restricts students from the fact that even with consistent use, condoms still present significant risk for STD acquisition. Another text recommends students participate in activities that contribute to STD transmission^{xviii} The most common inaccuracy refers to the recommendation that students use condoms with the spermicide N-9 which may increase a person’s risk of acquiring HIV and other STDs^{xix} Every comprehensive sex education text that was reviewed revealed overstated, exaggerated claims of contraceptive effectiveness or omission of information about possible skin to skin transmission of certain common STDs.^{xx}

The Growing Body of Evidence of Effectiveness for Abstinence Education

Researchers acknowledge that it takes at least a generation before a new approach begins to show effectiveness through documented research. The Head Start Program, for example, was in existence for decades before any meaningful research was conducted on the approach. Although abstinence education has received widespread federal funding for less than a generation, numerous peer-reviewed studies reveal that abstinence education is effective to

- Delay sexual onset^{xxixxxiiixxixxxvixxxvii}
- Discontinue sexual activity among previously sexually experienced^{xxviii}
- Decrease number of partners for those sexually active^{xxix}
- No less likely to use a condom if they become sexually active.^{xxx xxxi}

The most recent Youth Risk Behavior Survey (2005) reveals a continued downward trend in sexual behaviors among high schoolers. The percentage of high school students who have not had sex has increased from 45.9% in 1991 to 53.2% in 2005.^{xxxii} Simply put, the abstinence message is realistic for increasing numbers of teens. Fewer teens are having sex, which means more teens are choosing abstinence.

A study conducted by John Santelli, using the most appropriate dataset to date, noted that 53% of the decline in pregnancy rates could be attributed to decreased sexual experience.^{xxxiii}

Other significant studies contribute to the growing research showing that beyond the intuitive understanding that abstinence works every time, empirical evidence points to a growing understanding that the abstinence approach has great merit. Some of the most compelling results indicate:

- Adolescent virgins who received a Virginia Title V abstinence education program were approximately one-half as likely as non-participants to initiate sexual activity after one year.^{xxxiv}
- After a 5-year county-wide mass communications program there was a 32% reduction in the percent of teens under 16 who had experienced sex ($P < .05$). The adolescent pregnancy rate for the county dropped from 63.4% in 1993 to 49.5% in 1996. By comparison, county rate was higher than two surrounding counties in 1993 and lower than both counties in 1996.^{xxxv}
- Intervention students in an Ohio abstinence education program who were sexually active were about one-half as likely to be sexually active after 5 months than those who did not receive the program and sexually experienced students who received the program demonstrated a reduction in partners.^{xxxvi}
- Two abstinence programs together were shown to reduce the rate of initiation of sexual activity among at-risk students by 25% when compared with a control group of similar students who were not exposed to the program.^{xxxvii}
- A comparison of program participants with a control population showed that by the end of eighth grade, students in the control group were five times more likely to have begun having sex than program students (20 percent versus 4 percent). By the end of ninth grade, the difference between groups was still significant, with rates of 39 percent versus 24 percent.^{xxxviii}
- After one year program participants were about one-half as likely to become sexually initiated as their peers in the comparison group.^{xxxix}
- At risk Washington DC, program participants were seven times more likely than the comparison group to avoid sexual activity.^{xl}
- Of the 16 year olds who started the South Carolina abstinence education programs five years earlier, 82% indicated they had abstained during the previous year and 73% reported they had *never* had sex. By comparison, the average rate of abstinence among high school students in South Carolina was 48% and nationally is 53%.^{xli}

The Evidence in Support of Comprehensive Sex Education

Despite the frequent reporting of effectiveness in comprehensive sex education programs, a careful look at the research shows that such enthusiasm is imprudent. Of the numerous studies cited in Doug Kirby's *Emerging Answers*^{xlii} very few show measurable success for comprehensive sex education. Dr. Stan Weed detailed this fact in his written and oral testimony. Clearly, the claim of "effectiveness" does not ring true when research is examined and compared for the minimum standard of consistent condom use.

Sex Education in America

Title X: Prior to 1981, all federally funded efforts to address teen sexual activity focused on teen pregnancy prevention and a risk-reduction model under such funding as Title X of the Public Health Services Act, passed in 1970. This funding increased widespread accessibility to contraceptives and provided the first federal funding for comprehensive contraceptive education for teens.

Title XX AFL: Abstinence education changed the focus toward a primary prevention,

risk elimination model with the passage of the Adolescent Family Life (AFL) Program in 1981. A significant portion of AFL focuses on promoting abstinence until marriage to teens with primary emphasis on research and identifying best practices for helping teens avoid sexual activity before marriage.

Title V Section 510: When the US Congress passed the Welfare Reform Act in 1996, it added a provision to extend abstinence education to every state through state block grants. Signed by Democratic President Clinton, after having passed a Republican Congress, this funding was designed to address the economic and personal cost of escalating out of wedlock births in America by funding educational programs that had abstinence until marriage as their “exclusive purpose”. As noted in a White Paper drafted shortly after the passage of the Welfare Reform Act, the purpose of this funding is to effect a cultural change: “That both the practices and standards in many communities across the country clash with the standard required by the law is precisely the point. As in the cases of civil rights and smoking, the explicit goal of the abstinence education programs is to change both behavior and community standards for the good of the country.”^{xliii}

SPRANS-CBAE: Growing support for abstinence education at the national level brought about the third funding source for abstinence education. Initiated in 2000, this funding program, initially known as Special Projects of Regional and National Significance Community Based Abstinence Education (SPRANS-CBAE) has since been shortened to “CBAE”, to emphasize the community-based aspect of funded programs. This funding stream provides the greatest amount of money for abstinence education. CBAE funding has enabled abstinence programs to be implemented in regions that were especially needy, but unfunded in the past. *Even so, the number of community organizations seeking this funding is so great that only about 10% of all proposals are funded, making this one of the most competitive grants offered by the federal government. This points to the fact that **the need and support for the implementation of abstinence education far exceeds the funds available for this approach.***

Priority of Sex Education Content: While there are increasing numbers of schools that teach abstinence education, a report released in December 2006^{xliiv} showed the majority of schools still teach so-called comprehensive sex education which focuses on condom and birth control instruction, rather than the risk avoidance message of abstinence. In 1995, only 8% of schools taught abstinence education but 84% taught birth control instruction. In 2002, 22% taught abstinence education, and 68% taught birth control instruction^{xliv}. This data indicates that fewer than 1 in 4 students across America receive abstinence education. At least partly due to the unequal federal funding between both initiatives, more than 2/3 of all teens receive so-called comprehensive sex education.

Separating Ideology From Fact

Opponents who wish to defund abstinence education seek to reframe the grant parameters for current abstinence education funding. In this way, they hope to divert federal funds specifically designated for abstinence and instead use them for “comprehensive” sex. Additionally, they have erroneously framed abstinence education, challenging “medical accuracy” and using terms such as “state choice” and “responsible, science-based education”. Critics craft their messaging to make it appear that they are motivated by a

quest for providing the best information to youth while maintaining local control, but, it is, in actuality, motivated with one sole purpose in mind- and that is to defund abstinence education at all costs. Planned Parenthood acknowledged that they are conducting a state-by-state campaign by providing governors with inaccurate information about abstinence education in an effort to persuade them to turn back Title V Abstinence Education Funds from their states.^{xlvi} This misinformation has been successful in turning the funds back in 17 states to date. Rather than seeking to provide the best health message to teens, anti-abstinence ideologues use selective science to “prove” their claims. The overwhelming number of experts for this hearing verified the accuracy of this assertion. When policy makers and other stakeholders learn that the true nature of abstinence education is much different than how it is portrayed by its opponents, they are surprised and supportive of the approach.

Parents Support Abstinence Education

An independent survey indicates that when parents understand the differences between comprehensive sex education and abstinence curricula, they prefer abstinence education to so-called comprehensive sex education by a 2:1 margin.^{xlvii} Parents across all ideological, political, and demographic boundaries want what is best for their children and in terms of sexual health; the favored approach is abstinence education, as currently funded by Congress. Specifically:

- 9 out of 10 parents agree that being sexually abstinent is best for their child’s health and future.
- Upon learning what abstinence education actually teaches, 6 out of 10 parents prefer it to comprehensive sex education. Only 3 out of 10 prefer comprehensive.
- At least 8 in 10 parents agree with these important tenets of abstinence education:
 - o Developing healthy relationships to improve chances for a healthy future marriage.
 - o The benefits of renewed abstinence to sexually experienced students.
 - o Improving self-worth and self-control as means of reducing premarital sexual activity.
 - o How an unplanned pregnancy and/or STD can negatively affect a teen’s future.
- Most parents reject “comprehensive” sex education. 2 out of 3 parents think that the importance of the “wait to have sex” message ends up being lost when programs demonstrate and encourage the use of contraception.
- 9 out of 10 parents want teens to be taught about contraception in a manner that is consistent with the approach of abstinence education. 9 out of 10 parents think teens should be taught how often condoms fail to prevent pregnancy based upon typical use. Over 9 out of 10 parents think that teens should be taught the limitations of condoms in preventing specific STDs.
- Parents want more funding given to abstinence education than to comprehensive sex education by a 3 to 1 margin. 6 out of 10 parents think more government funding should be given to abstinence education vs. comprehensive sex education. Only 2 out of 10 want more funding for comprehensive sex education.

Funding disparity

Comprehensive sex education receives at least twice as much federal funding as abstinence education. In addition, comprehensive sex education has received funding since the 1970's, while significant funding for abstinence education did not begin until 1998. Cumulative funding comparisons between the two approaches are overwhelmingly in favor of comprehensive sex education funds. Using the most conservative computations, at least \$370.5 million is spent promoting "safe sex" initiatives vs. \$174 million promoting abstinence.

Abstinence Education		Comprehensive Sex Education	
<i>Funding Source</i>	<i>Amount (millions)</i>	<i>Funding Source</i>	<i>Amount (millions)</i>
CBAE	\$109 ^{xlviii}	Medicaid	\$109 ^{xlix}
Title V	\$50 ⁱ	CDC DASH	\$52 ⁱⁱ
AFL	\$13 ⁱⁱⁱ	Social Services Block Grants	\$14 ⁱⁱⁱ
Subtotal	\$172		\$175
Other Funding Sources			
CDC DASH	\$2 ^{iv}	CDC's Community Coalition Partnership Programs for the Prevention of Teen Pregnancy	\$3 ^{iv}
		CDC Comprehensive Sex Education Program	\$3 ^{vi}
		Title X	\$58.5 ^{vii}
		TANF	\$131 ^{viii}
Total	\$174		\$370.5

Current federal funding for Abstinence Education is a cost savings to taxpayers. In terms of savings associated with reductions in teen births, abstinence education save taxpayers \$6 for every \$1 spent^{ix}. There are additional health benefits from Abstinence Education, which, if quantified, would reveal even greater savings to taxpayers.

- Teens account for one quarter of all new STDs each year.^{ix} Abstinent teens, however, avoid sexually transmitted diseases and all corresponding medical costs.
- Studies reveal increased risks of depression and attempted suicide among sexually active teens^{xi}. Abstinent teens, however, avoid negative emotional consequences resulting from sexual activity and all associated mental health costs.

With levels of teen sexual activity still too high and state and national lawmakers struggling to balance budgets, expenditures through abstinence education programs have an important impact. Both the increase in teens choosing abstinence and the decline in teen pregnancy have coincided with the recent increase in federal funding for Abstinence Education, suggesting that Abstinence Education has played a major role.

The "Medical Accuracy" Debate

While anti-abstinence individuals and organizations have tried to assert that inaccurate statements characterize abstinence education, this is not true. For example, the 2004 report, *The Content of Federally Funded Abstinence-Only Education Programs*, commissioned by Rep. Henry Waxman and compiled, primarily by special interest groups who are historical opponents to abstinence, relied upon misrepresentation, distortion, and error rather than an honest appraisal of abstinence education curricula.^{lxii} Many quotes were taken out of context from abstinence curricula, thereby skewing both the intent and the message. For example, the report ‘quotes’ a text as saying that ‘touching can result in a pregnancy.’ The text actually states that, in very rare instances, during mutual masturbation, semen can be deposited just outside the vaginal opening, yet still result in a pregnancy. This statement is medically accurate, yet the report assertion makes abstinence education appear fear-based and ludicrous.

Additionally, ACF has implemented a process for assuring that abstinence programs provide accurate information to students and abstinence programs are eager to assure content accuracy. Comprehensive sex education programs do not have a similar requirement or process.

Most reports on “medical accuracy” fail to note that comprehensive sex education curricula regularly overstate the effectiveness of condoms, underestimate the risk of certain sexual activities, and infer that sex can be made safe and without consequences as long as a condom is used.^{lxiii} A recent report by the US Department of Health and Human Services noted that most comprehensive sex education curricula distort information presented to students.^{lxiv}

It is important that any discussion of medical accuracy steers away from ideological or subjective judgments and toward the desired goal of assuring that medical statements that are made are true. This means that medical information that is included in the program, that is, what is positively asserted, conforms to established medical data and is, therefore, referenced to a source that includes published journals, professional publications, and government agency documents in order to be internally correct to the greatest extent possible. This requirement should be limited to the informational content included. It should not be based on the omission of subjects that are clearly at odds with congressional intent or to which the need for inclusion has not been agreed. Medical accuracy should not be based on opinion articles or unsubstantiated generalizations. Efforts should be made to assure the veracity of medical facts but is not intended to direct the style, emphasis or any other aspect of teaching methodology. Discussions and application of material according to theories of learning, and teaching methods vary within the field of education, including abstinence education. Flexibility in teaching medical facts by service providers is constrained only by the parameters of funding as mandated by Congress. It should be further noted that different experts interpret medical data differently, so it is entirely possible that different conclusions might be drawn from the same data set and may each receive publication. For that reason, it is important that the term medical accuracy allow for this divergent analysis.

All youth serving organizations should provide accurate information to teens, regardless of the funding stream. That means that organizations receiving federal funds for pregnancy prevention, HIV/AIDS prevention, and all other programs, including abstinence education, should be held to the same standards of accountability. It is vital that programs provide accurate information to teens so that they are fully equipped to

make the best decisions for their sexual health.

Abstinence Education: Good Public Health Policy

The curricular content of abstinence education programs funded by the federal government is consistent with the public health prevention model for risk avoidance. In terms of general public health policy, the best health outcomes are made possible by the best positive health behavior messaging. Abstinence education follows this model, while all other approaches offer a message that still leave youth at risk for some of the consequences of sexual activity. Abstinence education provides all the information necessary for teens to make the best choice for their sexual health.

Although many individuals have sex before marriage this does not diminish the benefits of waiting to have children until marriage, nor does it mean we should abandon the goal of changing the cultural norm for this behavior. In fact, historically, if a cultural behavior or norm is in conflict with the desired outcome, efforts are redoubled, not discarded. For example, a generation ago, smoking was a desired, normative behavior, but today smoking is almost universally viewed as undesirable and unhealthy - proof that cultural and social norms can and do change. Similarly, although growing numbers of Americans are overweight, efforts to encourage exercise and healthy eating habits have increasingly become public health priority messages. We do not capitulate our highest public health standards based on the unhealthy choices of a majority, but on standards that promote optimal health outcomes in the population.

Evidence shows that most teens are not sexually active but are choosing to be abstinent, a positive trend in the direction of the desired healthy social. Public health models that are designed to address risk behaviors always promote the best health outcome at the population level. In an effort to increase general health and improve the general social norm, the message of primary health promotion aspires for risk elimination or avoidance. As noted above, this strategy for public health policy has found success in other areas. Primary prevention should be the topic for general messaging in the area of adolescent sexual health. To do otherwise, is to ignore the best interests of youth and is contrary to public health ethics.

¹ YRBSS, Trends in the Prevalence of Sexual Behavior. CDC 2005.

² Weed, Eriksen, Birch, et al. An Abstinence Program's Impact on Cognitive Mediator's and Sexual Initiation. *American Journal of Health Behavior* (January 2008); Doniger, Adams, Utter, Riley, "Impact Evaluation of the 'Not Me, Not Now' Abstinence-Oriented, Adolescent Pregnancy Prevention Communications Program, Monroe County, NY, *Journal of Health Communications*, Jan-Mar. 2001; Borawski, Trapl, Lovegreen, et al, Effectiveness of abstinence-only intervention in middle school teens. *American Journal of Health Behavior*. 2005 ; Olsen JA, Weed SE, et al. The effect of abstinence education programs on virgin versus non-virgin students. *Journal of Research and Development in Education*. 1992; Marion Howard and Judith Blarney McCabe, "Helping Teenagers Postpone Sexual Involvement," *Family Planning Perspectives*, January/February 1990, pp. 21-26 ;Weed, Eriksen, Birch. An evaluation of the Heritage Keepers Abstinence Education Program. In Golden A (Ed.) *Evaluating Abstinence Education Programs: Improving Implementation and Assessing Impact*. Washington DC: Office of Population Affairs and the Administration for Children and Families, Dept of Health and Human Services. 2005 ;Lerner, Robert, "Can Abstinence Work?" An Analysis of the Best Friends Program," *Adolescent and Family Health*, 2005, April Vol 3, No. 4

³ National Campaign to Prevent Unwanted & Teen Pregnancy, "With One Voice" 2007 survey, accessed at <http://www.thenationalcampaign.org/national-data/2007-polling-data.aspx>

⁴ Center For Disease Control And Prevention (2008, March 11).

Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis among Female Adolescents in the United States: Data from the National Health and Nutritional Examination Survey (NHANES) 2003-2004

⁵ National Institute of Allergy and Infectious Diseases. Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention. June 12-13, 2000, Hyatt Dulles Airport, Herndon, Virginia. Bethesda, MD: National Institute of Allergy and Infectious Diseases; 2001. Available from: <http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>.

⁶ Ahmed S, Lutalo T, Wawer M, et al. HIV incidence and sexually transmitted disease prevalence associated with condom use: a population study in Rakai, Uganda. *AIDS*. 2001; 15(16): 2171-2179.

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- ^{ix} <http://www.acf.hhs.gov/programs/fysh/content/docs/comprehensive.htm>
- ^x Martin, S; Pardue M, *Comprehensive Sex Education vs. Authentic Abstinence: A Study of Competing Curricula*. Heritage Foundation, August 10, 2004
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- ^{xii} Ibid, p5.
- ^{xiii} Ibid, p62
- ^{xiv} Ibid, p125
- ^{xv} Straight From the Source, accessed at <http://www.abstinenceassociation.org/research/index.html>
- ^{xvi} Making a Difference, p. 75
- ^{xvii} Making a Difference, p 249
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- ^{xx} Weed, Eriksen, Birch, et al. An Abstinence Program's Impact on Cognitive Mediator's and Sexual Initiation. *American Journal Health Behavior* (January 2008).
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- ^{xxix} Douglas Kirby, PhD. November, 2007 Emerging Answers Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Disease, p15
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- ^{xxxiii} Weed, et al (January 2008).
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- ^{sjv} *Ibid*
- ^{sjvi} Washington Post, Nov 21, 2007, page B01
- ^{sjvii} Zogby Survey of Nationwide Parents of Children Age 10-16 3/27/07 thru 4/5/07; May 2007
- ^{sjviii} FY 2008 budget passed by Congress on December 19, 2007 within Omnibus Appropriations Bill
- ^{sjvix} Based on response from Mary Kahn at the Centers for Medicare and Medicaid Services, stating "For 2004, Medicaid spent \$109 million on family planning for people between 13 and 18." The source is the Medicaid Statistical Information System (MSIS): http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp
- ^{sjvx} FY 2007 budget
- ^{sjvxi} For School HIV Prevention: FY 2006 actual -- \$41.8 million; FY 2007 JR--\$40.9; For Teen Pregnancy Prevention: FY 2006 actual -- \$11.1 million; FY 2007 JR--\$11.0; [\$41 + \$11 = \$52]
- ^{sjvxi} FY 2008 budget passed by Congress on December 19, 2007 within Omnibus Appropriations Bill
- ^{sjvxi} The information in the CRS report is derived from: Social Services Block Grant Program Annual Report 2005 , May, 2007. See chapter 2, "Expenditures".
- ^{sjvxi} <http://www.acf.hhs.gov/programs/ocs/ssbg/annrpt/2005/index.html> The \$14 million is based on \$8 million reportedly spent on the Pregnancy and Parenting Services category (described below) and an *estimated* \$6 million spent on adolescents in the Family Planning Services category (also described below). Assumption: States reported spending \$38 million on the Family Planning Services category. States also reported that 16% of recipients of that category were children. \$38 million X 16% = 6 million estimated for Family Planning Services category. [Family planning services are those educational, comprehensive medical, or social services or activities that enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved. Pregnancy and parenting services are those services or activities for married or unmarried adolescent parents and their families designed to assist young parents in coping with the social, emotional, and economic problems related to pregnancy and in planning for the future.
- ^{sjvxi} FY 2006 actual CDC DASH funds-- \$2.3 million; FY 2007 JR--\$2.4;
- ^{sjvxi} FY 2007. Includes \$1.8 million plus and estimated \$1.5 million (for regional projects as outlined below) = \$3.3 million, sourced from Jennifer Greaser, CDC/OD/CDCW..CDC's Division of Reproductive Health Prevention Programs: Support the use of science-based principals on teen pregnancy prevention by national organizations (3 currently funded) and state teen pregnancy prevention coalitions (9 entities are currently funded). Also supports efforts to promote reproductive health, including abstinence, and the prevention of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) infection. In FY 2005 \$1,460,229.00; In FY 2006 \$1,650,750.00; and FY 2007 \$1,888,155.00. Resources were spent on State Coalitions for Teen Pregnancy Prevention. The following entities are currently funded: South Carolina; Center for Health Training Resource group In Seattle, Washington; North Carolina; Minnesota; Hawaii; Colorado; Massachusetts; Pennsylvania; and Oklahoma. Supports STD and HIV prevention activities in 10 regional programs in MA, NY, PA, GA, IN, TX (2), CO, CA, and WA., awards for these projects average \$150,000.
- ^{sjvxi} FY 2008 budget passed by Congress on December 19, 2007 within Omnibus Appropriations Bill
- ^{sjvxi} FY 2008 budget passed by Congress on December 19, 2007 within Omnibus Appropriations Bill provided \$300 million for Title X funding. 39% of all Title X services are for women below the age of 20, *Title X: America's Family Planning Program*, accessed from Planned Parenthood website 12/28/07; <http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/birth-control-access-prevention/title-x-13163.htm>. Using this formula \$117 million of total Title X federal funds are used for teens for which we conservatively estimate that 1/2 is used for educational purposes or \$58,500,000
- ^{sjvxi} 2% or \$238,033,343 of the \$16,656,906,974 total federal TANF expenditures are spent on pregnancy prevention according to trends most recently documented in 2006 TANF Financial Data accessed 12/28/07 at http://www.acf.dhhs.gov/programs/ofa/data/2006/tableA1_break_2006.html. The TANF Fifth Annual Report to Congress states: "most pregnancy prevention efforts have focused on teenagers." Report accessed 12/28/07 at <http://www.acf.hhs.gov/programs/ofa/annualreport5/index.htm>. A conservative estimate of 55% is used to arrive at \$131 million in pregnancy prevention funds for teens.
- ^{sjvxi} NAEA, Federal funding for abstinence education: a win/win for taxpayers and teens, 2008
- ^{sjvxi} Centers for Disease Control, *Tracking the Hidden Epidemics*, 2000
- ^{sjvxi} The Heritage Foundation, Rector, et. al., "*Sexually Active Teenagers are More Likely to be Depressed and Attempt Suicide*. Washington, D.C., 2003.
- ^{sjvxi} *Abstinence and its Critics* by Rep. Mark Souder ; October 2006; accessed at : http://souder.house.gov/index.cfm?FuseAction=Issues.View&Issue_id=67CF58E1-7E9C-9AF9-7C80-D406673BE20E
- ^{sjvxi} For more information on the inaccuracies in CSE texts, see "Straight from the Source: What so called 'comprehensive' sex education teaches to America's youth, NAEA, June 2007;
- ^{sjvxi} Review of Comprehensive Sex Education Curricula ,May 2007

Mr. JORDAN. Thank you.

I want to thank the panel for being here, too. I have two fundamental questions that I want to ask, and I was going to ask these of the Senator and I should say at the start I kind of share the Senator's perspective on this entire issue, but I want to get to two fundamental questions. Do you really think the Federal Government should be involved in this area to begin with, the same Federal Government that can't secure the border, loses your tax return, the same Federal Government that is going to spend \$3.1 trillion this year? Do you really think this is an area that the Federal Government should be involved with to begin with, regardless of which one it is, but particularly, in my judgment, the comprehensive approach?

And then the second question—and you can all jump in on both of these when I finish—the premise of all this, particularly the comprehensive approach is—and we have heard this discussed here all morning long—the premise is the culture is such young people are bombarded with all kinds of messages, they are already engaging in some of this risky behavior, so we need to talk about a comprehensive approach, we need to give them the facts on how to prevent disease, etc.

But do you ever think that by the fact we are having educators, people in positions of authority, talk about this, we actually might contribute to the problem? I think, Doctor, we talked about effective educators versus those who aren't. Maybe this is just a country boy from Ohio talking, but I have heard this from constituents: the more you talk about it, the more it happens, particularly when someone in positions of authority giving mixed messages to young people.

I want to just cite one example of that, and then I will be happy to hear your response.

This is material our office obtained. It is called, Be Proud, Be Responsible: Strategies to Empower Youth to Reduce the Risk of HIV and AIDS. It was put together by a grant. Are any of you familiar with this curriculum? Heads shaking. OK.

I look at one of the worksheets here. Talk about mixed messages and are we maybe even contributing to some of the figures that were given to us. This is an HIV risk continuum worksheet, lists different things. Then it has on the side here red light, yellow light, green light. Red light, don't do; yellow light caution, obviously. And we are all familiar with this green light, or some of us view yellow lights as different than caution, but I understand.

But I will list just a couple. One says having sex with multiple partners and not using a condom, red light. Two others, though, showering together, green light. So maybe there is a green light, but think about the message that indirectly sends to young people. The third, doing drugs but not sharing needles and syringes, and the correct placement here on the side says yellow or green light.

Again, I think sometimes we get so focused on what is happening, but we might be sending the wrong kind of message, and that has always been my concern with the comprehensive approach, the mixed messages we are sending out there to people.

I would also argue that folks in west-central Ohio, which I get the chance to represent, when you talk to them about the Federal

Government getting involved—I made a statement yesterday to a group of folks I made a speech to, and I said 15 months on the job—I am just a rookie—has confirmed what I suspected: with the exception of the military, the Federal Government doesn't do anything very well. And now we are going to get into this whole area.

With all that, fire away and tell me if I am wrong or tell me if you agree with me.

Mr. SIEGEL. Can I respond? It is great to hear someone from Ohio speak. Ohio recently rejected the Title V funding and applied for CDC-DASH funding, so they are moving in the direction of comprehensive from what I can tell.

Responding to your first question about Government involvement, I definitely understand what you are saying. I mean, if Government is a consumer they have two products to buy from. They can buy from the abstinence-only program or they can buy from the comprehensive sexuality education program.

Mr. JORDAN. My point is this, though: should they be buying from the Federal Government, or would we be better served if they bought from the State and local government, parents, school boards, teachers, and folks at the State level.

Mr. SIEGEL. Which I agree with. I definitely think that local level they need to make those decisions, which Ohio is doing, from what I can tell.

Also, as far as mixed messages, I don't totally understand that logic and never have as an educator. I mean, I feel like if you teach students about fire extinguishers, you are not encouraging them to start fires. I don't see what the mixed message is and I don't think that shows up in the research as frequently.

Mr. JORDAN. Most everywhere else educators set the standard, recognizing that 100 percent of the students won't meet the standard, but we set the standard and that is what we aim for. We don't say, oh, because we know some of you aren't going to get there, here's what you should. Everywhere else in our culture, everywhere else in life, everywhere else in education we set the high standard. This is coming from someone that spent years in the coaching and teaching profession. That is what we do. Yet this area is different.

Mr. SIEGEL. It hasn't been different, though, is the thing.

Mr. JORDAN. I would argue it has.

Ms. KNOX. May I respond, as well? Could I say that west Texas is a lot like Ohio. That is where I come from, west Texas. My parents, who are no fans of Government involvement in anything, always told me that they wanted the school to be teaching this information because they didn't have that information themselves. They wanted me to have complete and accurate medical information about my sexual health, but neither of them had been to medical school, neither of them had gotten information about the up-to-date information to protect yourself, so they wanted a reliable sex education program within the schools to be teaching me that information. That is just coming from my perspective with my parents.

I also wanted to add really quickly—

Mr. JORDAN. I want to hear from two others up there.

Ms. KNOX. I have always liked the analysis that umbrellas don't cause rain. Young people are smart enough to make responsible de-

cisions, especially when they are given the tools to interpret those complex messages that we are receiving.

Mr. JORDAN. Let me hear from Dr. Weed and Dr. Santelli.

Mr. WEED. The question I think you are asking—let me get back to it—is should the Federal Government be involved in trying to promote good health and preventive medicine. If we could do it right, if we could do it well, I would say yes. So far we haven't done that. I think there are ways that we can structure policies and programs and funding strategies to be more effective.

For example, in the abstinence education area I have some suggestions on how that money could be better spent. I have also got some suggestions on how we could do better with our comprehensive sex dollars and hold them to a standard and evaluate them the same way we are doing with the abstinence programs.

I think there is a role, but it is that the responsibility is so huge and the impact is so large it has to be done extremely well, and we haven't been very good at it.

Mr. SARBANES. Thank you.

Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

I was in my office, and people were kind of watching this along with me, so I didn't get all of the testimony but quite a bit of it.

Dr. Blythe, if I could pull from the back end of your testimony, the Society of Adolescent Medicine summarizes its expert review of sexuality education with the following: "Abstinence from sexual intercourse represents a healthy choice for teenagers. As teenagers face considerable risk to their reproductive health from unintended pregnancies, STIs, including infection with HIV. Remaining abstinent—" and I am quoting from your words. I think this is wonderful. "Remaining abstinent, at least through high school, is strongly supported by parents and even adolescents, themselves. However, few Americans remain abstinent until marriage. Many do not or cannot marry, and most initiate sexual intercourse and other sexual behaviors as adolescents. Abstinence as a behavioral goal is not the same as abstinence-only programs. Abstinence from sexual intercourse, while theoretically is fully protective, often fails to provide against pregnancy, disease, and actual practice because abstinence is not maintained." In other words, it is having all the information available to you.

We talked to the earlier panel. There is a continuum of sex education. I mean, parents with different skill sets feel more comfortable talking to their children. We just heard Ms. Knox say her parents liked having accurate, scientific information made available to their daughter.

I would like you to address why it is so important that age-appropriate, parent-involved—and I think school boards need to involve the parents when they do this—why this is so important to a whole child's health, because pediatrics doesn't end when they are 10, 12, 13, or 14.

And then to the two women on the panel, I am kind of concerned about some of the things that have been said both in testimony and by some of my colleagues up here. One in four girls having sexually transmitted diseases. Well you know, folks, it just isn't the girls that have the sexually transmitted diseases. You know, checking

out who my son was going out with or who my daughter is going out with, with the implication one gender is more temptuous or whatever. I hope we can leave those stereotypes behind, because the stereotypes are also in some of the abstinence-only, such as the man's role is to protect the woman, or that women need financial support. Women, we need to protect ourselves and we need to support ourselves.

Doctor, would you please?

Dr. BLYTHE. Well, obviously the statement stands, as we believe. I think a couple comments. Abstinence is part of comprehensive sexuality education, and we have heard several comments this morning about parents want abstinence for their children, and that is correct, but in all the surveys that we have available—and the most recent one actually just came out of Minnesota—is that 89 percent of parents of school-aged children want their young people to have comprehensive, age-appropriate sexuality education, with abstinence as a center stage, but also giving them the tools to deal with the complexities of life that they are faced with on a day-to-day basis.

So in young people, meaning in the middle school age, strong messages of abstinence often work. But as they get older and they become more cognitively complex, then they need more answers than just this or that, so we need to be able to give them the tools to deal with the different issues, the different situations that come up on a day-by-day basis as they get older.

Ms. MCCOLLUM. Thank you.

Thank you, Mr. Chairman.

Mr. SARBANES. Thank you, Ms. McCollum.

Ms. FOXX.

Ms. FOXX. Thank you, Mr. Chairman.

There is so much to try to get on the record in so little time. I want to ask the panel a question. Mr. Hodes a few minutes ago made the comment that 50 percent of marriages end in divorce. How many of you have heard that before and think that it is the commonly accepted fact in our country? Would you hold up your hand? Just hold up your hand if you believe that.

Mr. WEED. That was 50 percent of what?

Ms. FOXX. That 50 percent of marriages end in divorce. How many of you have heard that comment over and over in our country and believe it? You believe it, hold up your hand.

[Show of hands.]

Ms. FOXX. All right. Well, let me tell you, in 1987 pollster Lew Harris has written, "The idea that half of American marriages are doomed is one of the most specious pieces of statistical nonsense ever perpetuated in modern times. It all began when the Census Bureau noted that during 1 year there were 2.4 million marriages and 1.2 million divorces. Someone did the math without calculating the 54 million marriages already in existence, and presto, a ridiculous but quotable statistic was born." Harris concludes, "Only one out of eight marriages will end in divorce. In any single year, only about 2 percent of existing marriages will break up." Task order my point on that is to support what Mark Twain said: figures often beguile me, particularly when I have the arranging of them myself, in which case the remark attributed to Desraili would often apply

with justice and force. There are three kinds of lies: lies, damn lies, and statistics. Both of those things I think sort of the framework for what we have been listening to this morning.

I want to also make a comment about what Ms. Knox said in her comments: "So why is it that there is not a single Federal dollar dedicated to a comprehensive approach, while more than \$1 billion has been spent on abstinence-only until-marriage?" This from someone who sat through all of the testimony this morning on the fact that seven times more money is going into comprehensive programs than abstinence programs.

I have one other question I would like to ask you, and I just want a yes or no answer from each member of the panel. I will start on that end.

If, provided evidence of abstinence education programs are as or more effective than comprehensive sex education, would you support optional Federal funding for such programs? I just want a yes or no.

Dr. SANTELLI. No.

Ms. FOXX. Next person.

Dr. BENJAMIN. No.

Dr. BLYTHE. No.

Mr. WEED. Yes.

Dr. FINEBERG. Yes.

Mr. SIEGEL. No.

Ms. KNOX. No.

Ms. FOXX. OK. Thank you very much. The record will show how each person answered.

To me I think this shows the situation that we are dealing with here. I also find it very interesting that the word scientific has been used a lot. Do we have scientific studies that prove the abstinence issue? Well, I would like to say to you that there is no more scientific fact than that abstinence is the only sure way to avoid pregnancy and sexually transmitted diseases. I don't know how anybody could argue that is the scientific fact. Yet, people keep saying we need scientific evidence that these programs are working, and we don't have the scientific evidence that they are working.

I want to tell you I come from a background of being a social scientists, so I know a little bit about how these things can be used.

I have one more question. Dr. Weed, you stated about goals, intensity, content, all of those things vary across all types of sex education programs. Do we have any kind of evidence as to the effectiveness of the programs? And, Dr. Fineberg, you can answer this, too, but, Dr. Weed, would you answer it? I believe you have a study that shows that; is that correct?

Mr. WEED. I am trying to sort the question out. The studies that we have done, if the program is designed well, implemented well, has the right kind of teachers, focuses on the right kind of issues, and is not narrowly defined and prescribed as an abstinence-only, which I think is a terrible misnomer, if it is done well, if it is done right we see impact. However, programs that are fairly new, fresh out of the block, they are trying to figure it out, it sometimes takes them about 3 years to work out the kinks and get on a track where they have an impact.

Ms. FOXX. Thank you.

Dr. Fineberg, would you like to say anything?

Dr. FINEBERG. Again, the most rigorous comparisons with very strict methodologic requirements to look at the studies find that the more comprehensive and inclusive programs do have approximately two-thirds of the time in those studies some positive effects. That was 23 of 39 studies.

Of the studies that were looked at, the 13 that were more narrowly framed as abstinence-only, they found in none of those cases that there were positive behavioral effects. That was in, again, applying this very strict, rigorous, methodologic screen for studies aimed at preventing infection of HIV and sexually transmitted infections.

Ms. FOXX. Who did that study?

Dr. FINEBERG. These are studies by the Cochrane Collaboration, the lead author is Underhill. I did include the citations in my written testimony.

Ms. FOXX. Mr. Chairman, I have just one other comment to make.

We have thrown again a lot of statistics around here, and much has been made about the fact that 17 States are not taking the funding, but let me point out 33 is more than 17.

Thank you, Mr. Chairman.

Chairman WAXMAN [presiding]. Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman. I thank all the witnesses.

Doctor Weed, you showed us some studies that indicated that in—I guess you call them abstinence-centered programs?

Mr. WEED. Abstinence-centered would be the preferred term.

Mr. YARMUTH [continuing]. Succeeded in reducing the rate of initiation of sex by 40 something percent, which I think people would say that is a benefit. That would be successful. But in the most optimum case, the rate of those who, if I read the chart correctly, who did initiate sex in spite of that was still around 10 percent. That was the best performance. So my question is, While we may say that the program was successful in one respect, was it a failure with regard to the 10 percent or more, and, in fact, did we not do them a disservice and maybe even put them at risk because we didn't give them other information?

Mr. WEED. I think that is a good question, because—by the way, it applies broadly. If we want to apply that standard of success, we say yes, we had a 10 percent failure, whereas in terms of consistent condom use we have 100 percent failure. So let's kind of balance it and look at both sides.

Mr. YARMUTH. I get that, but would not the real followup to that be: did you do any damage by including comprehensive? Did you make it worse for anyone by including comprehensive sex education, because, as I understand all the rest of the studies, there really isn't any evidence that comprehensive sex education increases the rate of sexual activity.

Mr. WEED. We can apply one standard that says it doesn't increase the rate, and we can apply the other standard that says it fails 10 percent of the time. Those are two different standards. I

am just asking for using the same standards when we do the comparison.

Mr. YARMUTH. All right. Let me ask Mr. Siegel and Ms. Knox, because they both alluded to things that have intrigued me, and I only focus on you because you are the youngest among us.

Is sex education, whether it is abstinence-only or comprehensive or anything else they learn in school the only thing kids learn about sex?

Mr. SIEGEL. Absolutely not.

Mr. YARMUTH. So what you may learn in abstinence-only education or in comprehensive sex education actually is considered, and it is input that is taken against a backdrop of a lot of different input about sex, including peers, information from your peers, including media, all sorts of things.

Ms. KNOX. Yes, I would agree, although let me point out quickly that I have undergone both abstinence-only and comprehensive sex education. Only comprehensive sex education gave me the tools, gave me the information to go out and interpret the other messages that I was getting from the media, from my peers, other things that I was hearing.

Mr. YARMUTH. So if you are getting information, let's say you are getting abstinence-only education in school or abstinence-centered education, there is a real danger that it is going to run up against a lot of different contrary input that you are getting from your friends. I mean, you may be talking to your friends who are having sex every weekend, unprotected, protected, but you are getting different information from them than you are getting in school. My question would be: how does that make you feel about the rest of your education? Does it undermine the credibility of what you are getting in other areas?

Ms. KNOX. It would be the same to me as if I went into math class and my teacher said two plus two is five. I mean, that doesn't jive with anything that I have ever heard out there in the world. That is what abstinence-only education was to me. It was not in reality as to what was happening in my life and in the lives of other people in my community.

Mr. SIEGEL. May I also add abstinence-only education teaches stigma. If you can't get married, how is abstinence ever going to help you? That is reinforced by the rest of society as a young person when you go out there, and it doesn't serve the needs of young people living with HIV, because they will need to know how to use condoms even if they get married. So once again it is neglected. It is neglected in greater culture and it is neglected in the classroom.

Mr. YARMUTH. I am not sure exactly how this relates, but I know it relates in some way. I was a journalist before I entered politics, and the paper that I worked with did a story several years ago about oral sex among 12 and 13-year-olds, and we sent actually teenage reporters out into the community and talked to them. The response that we got or our reporters got most frequently was they didn't consider that sex. This was just fun and games. It was no different than hugging.

So I wonder whether, when we talk about educating some of these programs starting in 7th grade, whether even that is early

enough, whether the horse is out of the barn on this issue even by that time.

Dr. Weed.

Mr. WEED. We found, of course, lots of variety. There are some places where 7th grade could be too late and other places where it wouldn't be. I think that the good programs really do take into account the cultural context in which they are being delivered, and the program that might work well in an inner city, high-minority, high-risk population, lots of broken families, might be a different kind of strategy than the one you would do in middle America where it is pretty calm and peaceful.

Mr. YARMUTH. My time is up. Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Yarmuth.

Mr. Burton.

Mr. BURTON. Dr. Fineberg, you talked about these studies. Have they ever included in these studies that you are referring to the Peers program in Indiana?

Dr. FINEBERG. Not to my knowledge, Mr. Burton. The studies that I talked to were premised on peer-reviewed, published studies that were randomized or quasi-randomized, and so these other experiences would not have been included.

Mr. BURTON. Gotcha. I understand. But you are not familiar with the Peers program in Indiana?

Dr. FINEBERG. I am not.

Mr. BURTON. The Peers program was started in 1994 by St. Vincent's Hospital in Indiana, and it is an abstinence program. I have been watching on television and listening to the debate on this issue. I just want to read you a little bit about this particular program that has been in effect since 1994.

"Does abstinence education really work?" This is one of their brochures. "Compared to non-participants, the Peers project participants were four times more likely to have remained virgins. Seventy percent of peers program participants reported that they have remained committed to abstaining from sexual activity at the conclusion of a 3-year, independent evaluation."

Then the brochures go into some other details about it. Since 1994 nearly 15,000 peer mentors—they use students that they train, come in and work with them at St. Vincent's—15,000 peer mentors have taught the Peer Educating Peers curriculum to 150,000 program participants throughout Indiana. Organizations and other States have replicated the Peers model.

The result in my Congressional District—they sent this to me—was in Miami County there was, for 15 to 17-year-olds between 2000 and 2005 there was a decrease in teen birth rates and sexually transmitted diseases by 34 percent. In Wabash County the decrease for that age group was 28 percent. So it has been very beneficial.

It was students talking to students after they had been made aware and trained in the Peers program. So abstinence programs do work. I know you can go across the country and do these national studies and come up with these statistics, like my colleague was talking about, which make it sound like it is a waste of money to train and create abstinence programs, but this is a fact in Indi-

ana. This is my Congressional District. It does work. I think that funding these programs does create some real positive results.

I know some of my colleagues say we ought to just have a complete sex education program, we don't need abstinence training, but it does work, and it is helping in Indiana, and I think it is something that we ought to continue to fund.

Dr. Weed, you are moving around there. Did you have anything you would like to comment on that?

Mr. WEED. Well, a point that I think is relevant is that we have heard discussion about embedding abstinence and comprehensive sex education together, and that may be more effective. But I think I have heard agreement, which I am encouraged by, that abstinence ought to be the central message and the major emphasis.

If you look, however, at the programs that claim to be abstinence-plus, the ratio of a contraceptive and condom education to abstinence education is about 9-to-1, so it is really not the major emphasis, it is kind of an afterthought. It is kind of stuck in there to meet, I think in some cases, the political correctness of yes, well, we teach abstinence.

If you look at the reality of the ratio, however, of what gets the most attention, that is not what is happening.

Ms. KNOX. Could I respond quickly, as well? Congresswoman Foxx was talking about the statistics we use and the studies that we use. The study that Mr. Weed is referencing I believe was a study that looked at how many times the word abstinence was mentioned on a page of comprehensive sex education curricula. Now, that is just the word abstinence. That is how they got that statistic.

When the Federal Government does their abstinence PSAs, public service announcements, they don't use the word abstinence. They use wait for sex until marriage. So I think that we have to re-look at the studies that we are using, and I just want to point that out there to correct the congressional record.

Mr. BURTON. I think this has been a very interesting hearing. You know, when you represent 700,000 people, like we do, and you see some positive results in a program in your District, and it is irrefutable as far as the statistics are concerned in my District, it sounds like to me, at least in my District, and I think across the country, as well, but at least in my District abstinence programs specifically designed for that do work. They have reduced by 34 and 28 percent the pregnancy rates and the rates of communicable diseases. I think that is something that we should continue to support.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Burton.

I am going to take my time.

My view is that if the local area wants to try something that they think is best, let them spend their money on it; but if we are going to use Federal dollars, I want to be sure those Federal dollars are being used for a program that works and is successful. If we have had studies showing they are not successful, as we have with the abstinence-only programs, then I think we ought to let the local governments decide whether they are going to pay for it.

Dr. Weed, there is one thing I wanted to ask you about. In explaining the evidence for some of these abstinence-only programs, you referred to them in your testimony as abstinence-centered programs. One of the studies has an abstract that states, "The intervention is not an abstinence-until-marriage intervention. The target behavior is abstaining from sexual activity until later in life when the adolescent is more prepared to handle the consequences."

Would a program that is not focused on abstinence until marriage qualify for Federal funding under the State or community-based abstinence-only programs?

Mr. WEED. Would it qualify for funding if it did not target abstinence until marriage?

Chairman WAXMAN. Yes.

Mr. WEED. Well, of course, you know how the A3H guidelines are written, but I think one of the things that helps us in this area is that young people who are fairly concrete—

Chairman WAXMAN. I am asking a very specific question, because my understanding is the answer would be no, that teaching abstinence until marriage is the sole and mandatory purpose of these programs. This illustrates some of the concerns I have with the current policy. It isn't just for a committed relationship or later in life, as valuable as I think that might be in and of itself. There are programs that appear to have real success, but they are being excluded from Federal funding because they don't meet this strict ideological test. It has to be until marriage, itself.

Mr. WEED. Well, I guess I don't see that these other programs are being excluded because 68 percent of our school systems are using comprehensive and contraceptive education, as compared to 25 percent who get abstinence education, so I think it is probably a misunderstanding to think that abstinence-centered education is displacing and replacing all this other stuff. I think it is still there. Kids can—

Chairman WAXMAN. It is certainly still there, but it is being funded at the local level, while these abstinence programs are being funded exclusively at the Federal level with over \$1 billion.

Dr. Santelli, did you want to comment?

Dr. SANTELLI. Yes. I think Stan is absolutely wrong on that. I mean, the research we did, which was based again on national data between 1995 and 2002, showed that virtually every 15 to 19-year-old young woman in this society and the young men as well are getting abstinence education. They are getting it. What we found, though, was education about contraception declined sharply, so many fewer. So almost 100 percent of young people are getting abstinence education. It may not be abstinence-only. We don't know whether it is abstinence-only, but they are getting the abstinence message, but only two-thirds are getting the message about contraception, and that is going down.

Chairman WAXMAN. I appreciate that point.

Now, you were asked, all of you, a few minutes ago by Ms. Foxx to give a yes or no answer only to a more complicated question of whether you would support abstinence-only if evidence became available that it was successful, and you had to say yes or no. A number of you said no and you didn't have a chance to explain, but

I presume that you would have said because it is not public health information, it is not the full story.

Dr. Blythe, is that accurate?

Dr. BLYTHE. I totally agree. It was, I felt, like a trick question almost. I think that none of us at this table deny the importance of abstinence as a major part of the message, but it is, again, including all that other information that will help young people develop healthy sexual lives.

Chairman WAXMAN. Thanks. I presume that was also—without responding, because I have very limited time already to go to other questions.

One of the major concerns of opponents of comprehensive sex education is that teaching teens about condoms and other contraceptives will encourage them to have sex. The suggestion is that teaching about contraception will delude or confuse an abstinence message.

Dr. Benjamin, is there any scientific evidence that comprehensive sex education encourages sexual activity?

Dr. BENJAMIN. The answer is to the contrary, that it does not.

Chairman WAXMAN. Dr. Weed, do you think it encourages sexual activity to talk about more comprehensive approach than just the abstinence-only?

Mr. WEED. I haven't seen evidence that addresses that directly. We are currently doing a study where both messages are combined in the classroom. It is very early, but the evidence looks like that the impact of the program gets minimized when the combination is in place.

Chairman WAXMAN. OK. Well, let me ask the two young people, Shelby and Max. In your experiences now as young adults who speak with young people, what is your understanding—does comprehensive sex education cause teens to have sex, or is this kind of education effective in encouraging teens to delay sexual activity?

Ms. KNOX. I would say once again umbrellas don't cause rain. Young people are smart enough to make responsible decisions when they are given all the information. Myself, the young people that I talk to, we actually are encouraged to make more responsible decisions when we understand about contraception, when we understand about using condoms, when we are not confused, when we don't have misinformation, then we are more likely to make responsible decisions.

Chairman WAXMAN. Thank you very much.

Mr. SIEGEL. I would assert that when we are being told that condoms and contraceptions do not work we are less likely to use them if we do choose to go about that path.

Chairman WAXMAN. Thanks.

Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman. I am sorry I was away. I was speaking on the floor of the House and then I was meeting with a mother whose daughter was raped allegedly by a Marine and then killed. I was meeting with that family, with her, talking about that issue.

I know Mr. Burton has one quick thing he wants to say and I will yield to him for that purpose.

Mr. BURTON. Real briefly, I think one of the reasons the Peer program in Indiana has been successful is they are training students to work with students, and peer to peer I think really has a tremendous impact on the attitudes of these young people. I think that is why these statistics show some dramatic results.

I thank the gentleman for yielding.

Mr. SHAYS. What I am struck with is that young people learn from TV, the movies, the books they read, the magazines they read, they learn from the Internet, they learn things from their peers. I think that there is a natural interest on the part of young people to know about things about sex. They are going to learn it. The question is: are they only learning part of it, and what part are they learning?

Dr. Weed, where I have my problem is that you would object to them having the armor they need in the daily battle of life. You want to tell them one way, one kind of armor, but you don't want to protect them, it seems to me, in all the other ways.

Would you agree that some young people are going to not practice abstinence?

Mr. WEED. Yes. Some will not, and I would say that the armor is great, but if it is flawed armor we don't give them the kind of help you need.

Mr. SHAYS. You tell them it is flawed, but you tell them risks and you tell them information, so what you are doing is basically saying if you are going to abstain you are going to be protected, but if you do anything else you are on your own. It seems to me that borders on cruelty, and the young man to your left dealing with HIV is one of the outcomes. That is tragic.

I just don't get it. I don't understand why it has to be only. Why only? Tell me why only?

Mr. WEED. I think that maybe you weren't here when I mentioned this. I think that is a poor definition of abstinence education programs.

Mr. SHAYS. It is an accurate one.

Mr. WEED. No, it is not. Abstinence-centered is a very different picture than abstinence-only.

Mr. SHAYS. Let me just say why. You can't rest on the laurels of saying the States do it and someone else will tell you the rest of the story. The reason why my State chooses not to be part of it is they think it is going to ultimately result in young people being deprived of knowledge that could save their lives.

Mr. WEED. We do have a premise, sir, that if we give kids more and better information they are going to be better decisionmakers. The recent research in the last 5 to 10 years on the adolescent brain makes us rethink that conventional wisdom. It is a whole different kind of picture that is happening with young people.

Mr. SHAYS. Isn't it an interesting concept. Really what you are saying is abstinence-only works better if they don't know all the information, so we are going to deprive them. But you know what? Some of them are going to then try to find it on their own and it is going to be incomplete information, it is going to be from the wrong places. It seems to me it would be better that they get the right information from the right place.

Mr. WEED. That is part of the misunderstanding, that abstinence-only, as we use that label, assumes that they don't learn anything else. The fact is they do.

Mr. SHAYS. Yes, but they learn it from the wrong places.

Mr. WEED. I am saying within an abstinence program, a good abstinence program isn't that narrow kind of definition that you—

Mr. SHAYS. Is there anyone on the panel that would disagree with that? And tell me why? Do you agree that Dr. Weed is correct when he says that they are going to learn all that they need to know—

Mr. WEED. I didn't say all. I said that it is not narrow the way you have defined it.

Mr. SHAYS. Well, if they are not going to learn all they need to know, then your comment to me is disingenuous.

Mr. WEED. I don't think they are going to learn all they need to know in any program, including a comprehensive sex education program. And, as we have seen, as I have shared with you, we don't have any program yet that has shown a reduction in STD rates that is a comprehensive education program.

Mr. SHAYS. Well, even if that were true—

Mr. WEED. And it is. Yes.

Mr. SHAYS. Even if it were true, I would say to you that at least we gave them the information. So if Mr. Siegel decides to do something and he takes risk, at least he did it with the knowledge that he was taking the risk and that he wasn't ignorant of it.

Mr. WEED. And I think good abstinence programs do that.

Mr. SHAYS. Well, all that I have read about it would totally refute that.

Mr. WEED. You know, I have been there in them. I have watched them. I have observed them. I have interviewed thousands of kids. It is not this narrow kind of—

Mr. SHAYS. Could I just make one more point.

Mr. WEED [continuing]. Perspective that we are hearing here.

Mr. SHAYS. If you are telling me that an abstinence-only program is compromised by telling them about other ways to deal with the issue of sex and not having a pregnancy and not having an illness, if you are telling me that then encourages them to do it, you have this conflict, because you are telling me on one hand that weakens the program, and then you are telling me the program does it.

Mr. WEED. I am saying that you can do both if you do it right and if you do it well. But most of the time, as we have seen in a lot of these programs that are now on the CDC Web site as being effective and proven, the information that is in both programs I think is going to be harmful to kids, not helpful.

Mr. SHAYS. Thank you.

Chairman WAXMAN. The gentleman's time has expired.

Mr. Souder.

Mr. SOUDER. Thank you.

Mr. Siegel and Ms. Knox, were the programs at your school funded by the Federal Government?

Ms. KNOX. Yes.

Mr. SIEGEL. I believe so. I am not certain.

Ms. KNOX. I believe so.

Mr. SOUDER. What years were they?

Mr. SIEGEL. Sorry?

Mr. SOUDER. What year were you in the program?

Mr. SIEGEL. What year was I in the program? It must have been 12 years ago. I believe—

Mr. SOUDER. There was not abstinence education—

Ms. KNOX. I was in the program from 2001 to 2004, so it was within the funding.

Mr. SOUDER. And you are sure that your school—

Ms. KNOX. I cannot say absolutely sure, but I can get the information to find out.

Mr. SOUDER. And we would like that for the record, because a description that you had of your program, that a church came in, did an independent program, is not likely a Federal program.

Ms. KNOX. Can I just make the clarification? That was a secular program. It was done by a local pastor. He was operating within a secular capacity within the school. That was made sure of by the school district.

Mr. SOUDER. Because most likely that your two programs—you have both been very articulate, very passionate—but are mostly irrelevant to this debate, because, in fact, what you are advocating is what everybody on the Republican and Democratic side said is that these should be State and local decisions, and abstinence education programs coming out of Washington, abstinence-centered, which I agree with Dr. Weed, have to meet certain criteria. They go through certain bid process, and they generally aren't random at a local level. Most likely you are dealing with something that, were it done out of the Federal Government, you wouldn't have had the experiences that you had at your school.

In response to Mr. Jordan, one of the questions, if we are going to get into this, how much do we decentralize and wind up with all sorts of variations, or how much do we centralize. This is an interesting debate back and forth, but for the most part your experiences, if they were Federal funded, none of us would have ever supported, and that really weren't relevant.

Further, you had a major factual error, Ms. Knox, and Chairman Waxman and I have been going around this. It is incorrect to say that the Federal Government funds no programs. The Federal Government plans—a statement that Dr. Weed made and was debated—12 times as much money goes into family planning. Not all of that goes into schools. I use the figure 2-to-1 into the schools. In addition, I know from my own home town that displacement of other funds go—for example, in safe and drug-free schools—if you get your money for drug-free schools from other programs, that you can then use the money for other health programs, which then they use for a comprehensive sex education and health care program in the schools with direct Government funding, because under our Education Committee rules, if you cover one category then it becomes fungible funding for the school.

It is absolutely false to assert that no Federal money is in. The only question is whether it is twice as much in the so-called comprehensive or twelve times as much, but clearly far more is spent of Federal dollars in this category, and it is important that the record shows that.

We are going to try to sort out exactly how that funding goes, but that is just not true.

Ms. KNOX. Can I ask you for a minute to respond, as well, about the—

Mr. SOUDER. There is not really a response to that.

And let me say one thing else, Mr. Chairman. We have six witnesses on the majority side and one on the minority side.

Dr. Weed, I would take you in any battle with me to do a course with six people, but this is as stacked a panel as I have ever experienced as a staffer or Member in the House to only have one person on one side and six.

Furthermore, this was represented as a scientific panel. Mr. Siegel and Ms. Knox have been very articulate, but they are not scientists. Out of the others, from what I can tell, Dr. Santelli is a scientist who has worked with it directly, but he is on, as he says in his testimony, he is a senior fellow at the Guttmacher Institute, very tied in with Planned Parenthood. He clearly has a bias, just as others would have a bias.

It isn't clear to me, did you do field research yourself or were you summarizing studies, Dr. Santelli?

Dr. SANTELLI. I have worked in public health for 20 years. I worked in Baltimore for 5 and did a lot of field studies and I worked at CDC for 13 years and was involved in a whole bunch of studies.

Mr. SOUDER. Reclaiming my time, your charts did go to direct questions, while I may not agree with them, may not agree with your summary.

Dr. Fineberg clearly has summarized a group of studies, but did you do any of those yourself? Are you a scientist who has been out in the field and studied this issue?

Dr. FINEBERG. No.

Mr. SOUDER. And Dr. Blythe and Dr. Benjamin basically read ideological statements on the behalf and summarized other people's studies. But this was supposed to be a panel of scientists who were going to show us the true science debate that was occurring, and that has not happened today. It was false representation.

Dr. Weed, I happen to remember you from another life of mine three jobs ago when I was the Republican staff director on the Children and Family Committee, and I believe in the mid-1980's you did a study in Baltimore on teen pregnancy; is that correct?

Mr. WEED. Yes.

Mr. SOUDER. That is how you more or less got started in this field, by showing some of the ineffectiveness of the teen pregnancy programs in Baltimore that was astounding and resulted in programs being put in in Baltimore because their teen pregnancy was totally—it was 90-some percent in some of the schools. I went up there and met with them. You are actually a field researcher.

Mr. WEED. Yes. All my work has been on the ground. I have interviewed thousands of kids. I have personally evaluated over 100 programs. I have data on 500,000 teenagers in my files.

Chairman WAXMAN. The gentleman's time has expired.

The Chair wants to indicate that the witnesses who are here were invited because either they have done the research or they represent organizations. I don't think it is fair to criticize them if

they represent groups like the pediatricians or the OB/GYNs or the American Medical Association or the Institute of Medicine. I also think it is unfair to say that they are not only unbalanced because they represent medical organizations, but that they in some way lack credibility because they represent—and the American Health Association and others—because they represent these organizations. That is why they have been invited.

Second, we have accepted every witness that has been recommended to us from the Republican side of the aisle. Matter of fact, we have never turned down a request from the Republicans on any witness at any hearing.

Third, I just think that an attack on people's views by calling them ideological when they are scientists and they are medical professionals is trying to turn tables by calling them ideological when, in fact, I think that you are attacking them from an ideological perspective.

Do you want to say anything, since I have jumped on you?

Mr. SOUDER. I wasn't questioning the organizations. What I was questioning is that you earlier stated this was a scientific panel, and I was trying to establish that you only have two people who appear to have done scientific research; others were summarizing or giving their personal opinions. In fact, Dr. Weed was criticized for being ideological. I certainly criticized a number of people here for being ideological—making the point again that this is not really a scientific debate but a heavily ideological one.

Chairman WAXMAN. OK.

Well, we have the positions set out.

Dr. Santelli, we are going to have to move on. We have a third panel waiting. Yes?

Dr. SANTELLI. I just spent 2 days, because I am here the 3rd day missing part of the meetings. The American Public Health Association and the Academy of Pediatrics, I have served on committees on both of them, spend a lot of time trying to review scientific evidence. I mean, they also filter it through their clinical wisdom. Maggie is a great example of combining the two. All the professional medical groups in the country are very attuned to the science and try to represent the best science.

Chairman WAXMAN. I think that is an important statement to make.

I want to thank all of you very much for your presentation to us and your willingness to answer questions from members of the committee. Thank you very much.

Our third panel, I want to call forward Charles Keckler, who is the Acting Deputy Assistant Secretary for Policy at Administration for Children and Families at the Department of Health and Human Services. His department coordinates the two largest Federal abstinence-only programs.

Dr. Marcia Crosse is the director for the Healthcare Group in the U.S. Government Accountability Office. She has been with GAO's Healthcare Group since 1996, and since then has led a variety of assignments on public health issues.

I want to welcome you to our hearing today. Your prepared statements will be in the record in full. We would like to ask if you would to limit your oral presentation to 5 minutes.

It is the policy of this committee that all witnesses be sworn in before they testify, although it was pointed out to me that perhaps that didn't happen with the last panel, but I am not sure. But we will continue the practice with you two, if you would please rise and raise your right hands.

[Witnesses sworn.]

Chairman WAXMAN. The record will indicate that both witnesses answered in the affirmative.

Mr. Keckler, why don't we start with you?

STATEMENTS OF CHARLES KECKLER, ACTING DEPUTY ASSISTANT SECRETARY FOR POLICY, ADMINISTRATION FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND MARCIA CROSSE, PH.D., DIRECTOR, HEALTHCARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF CHARLES KECKLER

Mr. KECKLER. Mr. Chairman and members of the committee, thank you for the opportunity to discuss abstinence education programs administered by the Department of Health and Human Services.

The administration continues to support abstinence education programs as one among several methods to address the continuing problems created by adolescent sexual activity, the result of which includes unacceptably high rates of non-marital child-bearing and sexually transmitted diseases among America's youth. Remarkable progress has occurred in this area over the last 15 to 20 years. Pregnancy among 15 to 17-year-old girls declined over 20 percent since the early 1990's, although it remains above the rates for other industrialized nations.

Teenage sexual activity and non-marital child-bearing have serious consequences for teens, their families, their communities, and our society. The two greatest risk factors for teen pregnancy and transmission of STDs are age at first onset and number of partners. In other words, if a teen delays the onset of sexual activity and reduces the number of partners, they are much less likely to become pregnant or get someone pregnant.

By definition, abstinence education programs aim to address these two risk factors. Abstinence is the only 100 percent effective method to prevent pregnancy and sexually transmitted diseases. Through education, mentoring, and peer support, abstinence education helps teens delay the onset of sexual activity and reduce the number of sexual partners they have. In addition to the serious risks of disease, early child-bearing often limits later opportunities for both the parents and the children involved, creating risks of a fragile family structure, poverty, and welfare dependence.

HHS' abstinence education programs are part of a broader strategy to combat teen pregnancy and STDs. Over the last 5 years, the Department estimates that it has expended billions of dollars toward this effort.

HHS funds a variety of interventions, both primary models, which include a risk avoidance message provided through abstinence education programs, as well as secondary models, which in-

clude a risk reduction message. These interventions provide information about the risks of sexual activity and the ways to eliminate or reduce these risks, with the goal of altering adolescent attitude and behaviors in ways that lead to healthier outcomes.

Other interventions can provide direct health services to adolescents, including administering contraception and providing information about its proper use. Beyond abstinence education, the Department provides at least \$300 million annually to administer a variety of pregnancy prevention or STD/HIV prevention and awareness programs. Some of these programs may include information about abstinence or encouraging delayed sexual activity, but are not subject to the Title V, Section 510 A-H definition of abstinence education in the Social Security Act.

Curriculum often called abstinence-plus or comprehensive sex education could be supported under these funding streams. Additionally, the Department provides hundreds of millions annually in family planning services to adolescents through a variety of programs. Of the total Federal resources devoted to combatting teen pregnancy and STD prevention, abstinence education accounts for a fraction.

As a general matter, health education interventions have a record of mixed success. While the majority of studies have shown a limited impact on sexual behavior, some programs have shown evidence for effectiveness. This became increasingly apparent during the 1990's, as studies showed certain programs had effects of delaying the age at first intercourse and sometimes reducing the frequency of sexual activity or the number of partners involved.

The use of abstinence education curricula as such has a shorter history of evaluation, but the results have been similar. Some peer reviewed research has shown an effect in delaying intercourse among program participants. Other studies have shown some effect on partner number, even if intercourse is not delayed.

We are using the results of these studies to identify the characteristics that distinguish effective from ineffective implementations. There is no strong evidence for a decline in the use of contraception as a consequence of these programs.

The administration believes that the abstinence education program sends the healthiest message, as it is the only certain way to avoid out-of-wedlock pregnancy and sexually transmitted diseases. The great majority of American parents agree. A 2007 poll conducted by the National Campaign to Prevent Teen Pregnancy found that 90 percent of teens age 12 to 19 and 93 percent of adults agree that it is important for teens to be given a strong message that they should not have sex until they are at least out of high school.

The administration appreciates the opportunity to update the committee on the progress we are making in this important area of adolescent health and remains committed to providing accurate information that effectively assists young people to make healthy and responsible choices as they mature toward adulthood.

I would be pleased to take any questions that you may have.

[The prepared statement of Mr. Keckler follows:]



STATEMENT BY
CHARLES KECKLER
ACTING DEPUTY ASSISTANT SECRETARY
FOR POLICY AND EXTERNAL AFFAIRS
ADMINISTRATION FOR CHILDREN AND FAMILIES
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

April 23, 2008

Mr. Chairman and Members of the Committee, thank you for providing me with the opportunity to discuss the abstinence education programs administered by the Department of Health and Human Services. The Administration continues to support abstinence education programs, as one among several methods used by educators to address the continuing problems created by adolescent sexual activity, the result of which includes unacceptably high rates of non-marital childbearing and sexually transmitted diseases among America's youth. Remarkable progress has occurred in this area over the last 15-20 years. Teenage pregnancy among 15-17 year-old girls declined over 20% since the early 1990s, although it remains substantially above the rates recorded for other industrialized nations. Teenage sexual activity and non-marital childbearing have serious consequences for teens, their families, their communities and our society. The two greatest risk factors for teen pregnancy and transmission of STDs are the age at first onset, and the number of partners. In other words, if a teen delays the onset of sexual activity and reduces the number of partners, they are much less likely to become pregnant or get someone pregnant compared to those who don't.

By definition, abstinence education programs aim to do just that. Abstinence is the only 100 percent effective method to prevent pregnancy and sexually transmitted diseases. Through education, mentoring, counseling and peer support, abstinence education services help teens delay the onset of sexual activity and reduce the number of sexual partners they have. The ideal of abstinence programs is to encourage individuals to wait to experience sexual relations within the context of a healthy marriage. Abstaining until you get married also has another beneficiary. There is a wide body of social science literature showing more positive outcomes across a variety of measures for

children raised in 2-parent married households when compared to their peers in unmarried households.

In addition to the serious risks of disease, early childbearing very often limits later opportunities for both the parents and the children involved, creating greatly enhanced risks of a fragile family structure, poverty and welfare dependence. The State Abstinence Education Program and the Community-Based Abstinence Education (CBAE) Program of the Administration for Children and Families, together with the Adolescent and Family Life Program from the Office of Population Affairs, provide useful tools to help parents, schools, communities and States guide our Nation's youth away from these devastating outcomes. As requested by the Committee, my testimony will provide background on these programs and discuss what we know and what we are seeking to learn about their effectiveness. I also would like to take this opportunity to discuss recent steps we have taken to improve administration of the programs and increase our knowledge of their operation. However, before I describe the abstinence education programs, evaluation efforts, and efforts to improve program administration, I will first provide some background on HHS' comprehensive strategy to combat teen pregnancy and sexually-transmitted diseases.

Background: HHS' Comprehensive Strategy

HHS' abstinence education programs are part of a broader strategy to combat teen pregnancy and STDs. Over the last five years, the Department estimates that it has expended billions of dollars towards this effort. HHS funds a variety of interventions, both primary models which include a risk-avoidance message provided through

abstinence education programs, as well as secondary models, which include a risk-reduction message. These interventions provide information about the risks of sexual activity and the ways to eliminate or reduce these risks, with the goal of altering adolescent attitudes and behaviors in ways that lead to healthier outcomes. Other interventions can provide direct health services to adolescents, including administering contraception and providing information about its proper use. Beyond abstinence education, the Department provides at least \$300 million annually to administer a variety of pregnancy prevention or STD/HIV prevention and awareness programs. Some of these programs may include information about abstinence or encouraging delayed sexual activity, but are not subject to the Title V, Section 510 A-H definition of abstinence education in the Social Security Act. Curriculum often called “abstinence-plus” or “comprehensive sex education” could be supported under these funding streams. Additionally, the Department provides hundreds of millions annually in family planning services to adolescents through a variety of programs. Of the total federal resources devoted to combating teen pregnancy and STD prevention, abstinence education accounts for a fraction. The majority of departmental funding devoted to this effort includes family planning services, pregnancy prevention activities, and other STD or HIV prevention and awareness activities for adolescents.

Abstinence education, unlike a comprehensive sex education message, has been given a detailed statutory definition by Congress in Title V of the Social Security Act, as part of the Personal Responsibility and Work Opportunity Reconciliation Act enacted in 1996 during the Administration of President Clinton. However, because comprehensive sex education curricula may include information about abstinence, although to varying

degrees, these approaches in practice exist along a continuum of approaches rather than as two completely distinct approaches. The main difference is that comprehensive sex education programs, in addition to abstinence education, also provide instruction about the use of various forms of contraceptive devices. In other words, abstinence education programs do not provide detailed instructions on how to use contraceptive devices, although some provide information about the relative effectiveness of contraceptive devices in preventing pregnancy and disease. This is because the statute requires using federal funds for the “exclusive purpose” of teaching abstinence. In epidemiological terms, both interventions are oriented toward risk prevention; abstinence education is fully focused on risk prevention using a primary public health intervention. Comprehensive sex education mixes the risk-prevention message with a risk-reduction component, using a secondary public health model. By contrast, a pure risk-reduction program could, for example, involve simply distributing contraceptives to adolescents and demonstrating their proper use.

Background: Abstinence Education Programs

HHS’ Administration for Children and Families is responsible for administering the State Abstinence Education program. This program was first authorized in 1998 to provide up to \$50 million per year in grants to States by Title V of the Social Security Act. Funds are allocated to States and territories according to a pro-rata method based on the ratio of the number of low-income children in each State to the total number of low-income children in all States. States must match every four dollars they receive in federal abstinence education funds with three non-federal dollars. In FY 2007, approximately

\$39 million dollars was awarded to 40 States, the District of Columbia, and three territories.

The Administration for Children and Families also administers the Community-Based Abstinence Education (CBAE) program. This program was first funded in FY 2001 to support public and private entities for implementation of abstinence education programs for adolescents ages 12 through 18. Annual appropriations language also references the statutory definition of abstinence education program in Title V, Section 510 of the Social Security Act for administering CBAE. These programs are focused on educating young people and creating an environment within communities that supports adolescent decisions to postpone sexual activity until marriage. Grantees include public and private entities such as community-based and faith-based organizations, hospitals, health centers, school systems and other youth services agencies. In FY 2008, Congress appropriated \$113 million for the CBAE program. These funds will be used to support approximately 188 new start and continuation grants, as well as fund technical assistance, evaluation, research, and public education campaign. The FY 2009 Budget requests an increase of \$28 million for CBAE.

The final abstinence education program administered by HHS is the Adolescent Family Life (AFL) program. This program is administered by the Office of Population Affairs within the Office of Public Health and Science and supports two types of demonstration grants: (1) Prevention (abstinence education) that promotes and evaluates abstinence from sexual activity among adolescents; and (2) care demonstration grants that provide and evaluate comprehensive health and social services for pregnant and parenting adolescents. The prevention demonstrations are abstinence education projects

that have been tied by legislative language in the annual appropriation bill to the statutory definition of abstinence education program in Title V, Section 510 of the Social Security Act. These demonstrations aim to find effective means of reaching preadolescents and adolescents before they become sexually active and to encourage them to abstain from sexual activity and other risky behaviors. The care demonstrations attempt to identify ways to minimize the consequences of this sexual activity by supporting projects for pregnant and parenting teens, their infants, their partners and their families. The abstinence education component of AFL is funded in FY 2008 at \$13 million and supports 37 competitively awarded grants to public or private organizations. The FY 2009 Budget continues to request \$13 million for this program.

Together, the three abstinence education programs reach more than two million youth every year. Countless other youth and families are reached through a national media campaign. The Parents Speak Up National Media Campaign, developed through a partnership with the Office of Public Health and Science, provides public service announcements encouraging parents to talk to their preteens and teens about waiting to have sex, and to share their values and expectations for their children's future. The campaign has developed and distributed media messages, established a website, and developed strategies for targeting Hispanic, African American and Native American communities.

Abstinence education is an important preventive component of an overarching federal strategy designed to protect youth from the physical, psychological and economic consequences associated with teenage sexual activity and non-marital childbearing. Teenage pregnancy among 15-17 year-old girls declined over 20% since the early 1990s,

although it remains substantially above the rates recorded for other industrialized nations. This decline in teenage pregnancy has been driven by both declines in early sexual activity and by more consistent use of contraception among teens, although there is an on-going debate in the research community about the relative contribution of these trends.

Evaluation of Abstinence Education Programs

Increasing abstinence among early adolescents cannot be wholly or directly attributed to health education interventions, including abstinence education. The current research questions surrounding the effectiveness of abstinence education programs are largely focused on the following: Are abstinence education programs equally or more effective in promoting abstinence than comprehensive sex education programs and does the absence of an explicit risk-reduction element in abstinence education cause participants to be less likely to use contraception if they engage in intercourse?

As a general matter, health education interventions have a record of mixed success. While the majority of studies have shown a limited impact on sexual behavior, some programs have shown evidence for effectiveness. Increasingly evident during the 1990s, studies showed certain programs had some effect on delaying the age at first intercourse, and in reducing the frequency of sexual activity or the number of partners involved. The use of abstinence education curricula, as such, has a shorter history of evaluation, but the results have been similar. Some peer-reviewed research has shown a significant effect in delaying intercourse among program participants. Other studies have shown some effect on partner number even if intercourse is not delayed. We are using

the results of these studies to identify the characteristics that distinguish effective from ineffective implementations. There is no strong evidence for a decline in the use of contraception as a consequence of these programs.

Recently, the Department reported the final results of a years-long longitudinal study by Mathematica Policy Research of five projects among the first group of abstinence education programs created by Title V and overseen by the State grantees. Some of these projects were effective in increasing participants' knowledge of sexually-transmitted diseases, and in the short-term, increasing pro-abstinence attitudes and the support of an individual's peers for abstinence. Both of these psychosocial traits were predictive of later abstinence; but the positive effects created by the intervention eroded rapidly in the intervening teen years. By the time of the last data collection four to six years later, behavioral and biological outcomes such as rates of sexual activity and pregnancy were not statistically distinct from a control population that had received the usual services available in that area. An important additional result of the study was that there was no additional risk of unprotected sex among abstinence education participants, contrary to the concern that lack of a contraception instruction component could create additional risk in this regard.

From a policy perspective, a key question is whether the relevant biological and behavioral outcomes differ systematically between abstinence education and comprehensive sex education programs, where both are available. Put simply, when we have the option to provide either type of curricula, is it possible to show that one is better than another in preventing disease transmission and teen pregnancy? This question was not addressed in the recent Mathematica research, nor has such a comparison ever been

made in any other major abstinence or comprehensive sex education evaluation to date. Currently, the Department is funding a long-term study in collaboration with the University of Texas Health Sciences Center that has randomly assigned students to the two different types of treatments, or to a control group. This type of experimental study design should provide us important new evidence that allows direct comparison between the two types of treatments. Data collection from this study, funded primarily by the Centers for Disease Control and Prevention and also ACF, is expected to be complete in May, 2010. At the current time, there is no reason to believe that programs involving abstinence education cannot be designed to be more effective with the available curricular alternatives in encouraging delays or reductions in adolescent sexual activity, and such programs do not appear to cause any decrease in the use of contraception by participants who choose not to abstain.

The Administration believes that the abstinence education program sends the healthiest message as it is the only certain way to avoid out-of-wedlock pregnancy, and sexually transmitted diseases. The great majority of American parents agree: a 2007 poll conducted by the National Campaign to Prevent Teen Pregnancy found that 90 percent of teens aged 12-19 and 93 percent of adults agree that it is important for teens to be given a strong message that they should not have sex until they are at least out of high school.

Also, the Health Education Guidelines used by many States and local school districts require use of abstinence education curricula. Likewise, many current grantee organizations would likely no longer apply to participate in providing health education programs if they were required to give instruction in contraceptive techniques. These jurisdictions and grantees have such constraints for a variety of reasons. For instance,

some have concerns that comprehensive sex education curricula do not fulfill their stated goal of making abstinence the primary message. Because abstinence education curricula must comply with Congress's statutory criteria, they represent a safe harbor for those agencies and entities seeking assurance that the curricula they choose comports with their requirements. Consequently, the abstinence education service option expands the range of possible providers, as well as the populations they can serve.

Progress in Administration of Abstinence Education Programs

In October 2006, the Government Accountability Office released a report on assessing the accuracy and effectiveness of federally funded abstinence education programs. Since this report was released, HHS has taken steps to improve the administration of abstinence education programs. Specifically, HHS' efforts have focused on heightened program oversight and strengthened expectations of our grantees.

HHS requires abstinence education grantees to comply fully with Section 317P of the Public Health Service Act. Section 317P requires mass-produced educational materials that are specifically designed to address sexually transmitted diseases to contain medically accurate information about condom effectiveness. Although abstinence education grantees do not always use materials that are subject to Section 317P's requirements, when they do, they are required to adhere to Section 317P by discussing condom effectiveness or ineffectiveness in the disease transmission context in a medically accurate way.

Compliance with 317P is part of HHS's broader commitment to scientific accuracy in abstinence education, a concern that has been expressed by the GAO and the

Committee, and which the Department fully shares. First, in FY 2007 ACF implemented GAO's recommendation to require Community-Based Abstinence Education and State Abstinence Education grantees to sign a written assurance in their grant applications stating that education materials are factually accurate. Additionally, ACF attached a special condition requiring that each grantee correct any medical inaccuracies identified by ACF in the proposed curriculum. Failure to provide satisfactory resolution to all medical accuracy issues raised by ACF will result in the withholding of funds and/or termination of the project, or both.

Also as recommended by GAO, curricula used by grantees in the Community-Based Abstinence Education program are now reviewed by an independent panel of medical professionals. When considering CBAE grantee plans, the proposed curriculum is reviewed by a research analyst who notes any statements of fact that are not referenced and obtains source documents, when available, of all references that are given. The curriculum is then reviewed by a medical professional (a doctor or nurse in the field of obstetrics and gynecology) to compare the information in the curriculum to the information in the sources, which are themselves assessed for scientific validity. In tandem with these efforts, ACF also requires States to provide their strategies for ensuring accuracy of medical and scientific information in the State Abstinence Education program.

In addition to increasing assurance of accuracy, the Department is also committed to making the changes necessary to increase program effectiveness. CBAE grantees are required to spend a minimum of 15 percent of funds on evaluation of their programs, and there is now an increased emphasis on standardized evaluations that will allow us to

aggregate data from multiple grantees to conduct program-wide analyses with large sample sizes. This will also greatly increase our ability to compare grantees with one another by identifying best practices in efficiency and effectiveness as well as those grantees that are underperforming. For example, grantees are required to report quantitative data on the number of youth served, the hours of service per youth, and the proportion of youth that complete the program. We are also requiring a new standardized survey that will be administered by CBAE grantees to all youth served both before and after service delivery, and a follow-up survey 6-12 months upon the completion of the intervention. The questions will measure initiation and discontinuation of sexual intercourse as well as evidence-based predictors of age at first intercourse, such as sexual attitudes and behavioral intentions. Combined, these data sources will help us to track how grantees are using their funds, and which ones are efficiently achieving meaningful change in adolescent sexual behavior.

In its report, GAO also expressed the expectation that certain ongoing research projects such as the Mathematica evaluation, when completed, should provide direction to our efforts in abstinence education. I am pleased to report that the final results of the Mathematica research study, released in April and August 2007, have already begun to be incorporated into programmatic changes as part of the Department's emphasis on evidence-based policy development. The results of the Mathematica study indicate that targeting abstinence education to youth only in their early adolescent years may not be sufficient, and the programs may be more effective if interventions occur more closely in time to heightened risks of sexual activity in the high school years or are at least sustained up until that time. Based on these findings, preferences will be given to grant

applications that show their programs include high school aged youth. The Mathematica study also indicated that the programs heighten pro-abstinence attitudes and friends' support for abstinence and are significant predictors of future abstinence, but that both frequently erode over the years following the intervention. We now have specific criteria that encourage grantees to focus on developing and sustaining peer networks among adolescent participants, which is expected to create mutual support for abstinence education and to increase the probability of favorable biological and behavioral outcomes in the long-term.

The Administration appreciates the opportunity to update the Committee on the progress we are making in this important area of adolescent health and remains committed to providing accurate information that effectively assists young people to make healthy and responsible choices as they mature towards adulthood.

I would be pleased to answer any questions that you have.

Chairman WAXMAN. Thank you very much.
Dr. Crosse.

STATEMENT OF MARCIA CROSSE

Ms. CROSSE. Mr. Chairman and members of the committee, I am pleased to be here today as you examine abstinence education programs.

My testimony is based on GAO's report on this topic that we prepared for you and other congressional requesters in October 2006, and we have updated certain information for today's hearing. You asked that we examine efforts to assess the scientific accuracy of materials used in abstinence education programs and efforts to assess the effectiveness of these programs.

I will also discuss a Public Health Service Act requirement regarding medically accurate information about condom effectiveness that may be relevant for abstinence education materials.

We reported 18 months ago that efforts by HHS and States to assess the scientific accuracy of materials used in abstinence education programs have been limited. At the time, HHS' Administration for Children and Families [ACF], did not review its grantees' education materials for scientific accuracy in either the State or the community-based programs, nor did it require the grantees in either program to do so. Further, not all States that received funding from ACF had chosen to review the accuracy of their program materials.

In contrast to ACF, HHS' Office of Population Affairs [OPA], had reviewed the scientific accuracy of its grantees' proposed education materials and any inaccuracies that were found had to be corrected before those materials were used.

The extent to which federally funded abstinence education materials are inaccurate wasn't known, but both OPA and some States reported finding inaccuracies. For example, one State official described an instance in which abstinence education materials incorrectly suggested that HIV can pass through condoms because the latex used in condoms is porous.

To address concerns about the scientific accuracy of materials used in these programs, we recommended in our report that the Secretary of HHS develop procedures to help assure the accuracy of such materials. In response to our recommendation, ACF is currently implementing a process to review the accuracy of community-based grantees' curricula and has required those grantees to sign assurances that the materials they propose using are accurate. HHS reported to us that in the future State program grantees' will also have to sign written assurances and provide ACF with descriptions of their strategies for reviewing the accuracy of their programs.

We also examined efforts to assess the effectiveness of abstinence education programs. At the time of our report, we found that HHS, States, and researchers had made a variety of efforts to assess effectiveness. For example, ACF analyzed national data on adolescent birth rates and the proportion of adolescents who report having had sexual intercourse. Additionally, 6 of the 10 States in our review worked with third party evaluators to assess the effectiveness of their programs.

However, the conclusions that can be drawn from these efforts are limited because most of the efforts to evaluate program effectiveness have not met certain minimum criteria, such as random assignment of participants and sufficient followup periods and sample sizes that are necessary for such assessments to be scientifically valid.

Further, the results of some efforts that do meet such criteria have varied. Since our report was issued, a key HHS-funded study has been completed which found few differences on a variety of measures of sexual activity between youth who participated in abstinence education programs and control group youth.

Finally, while conducting work for our 2006 report we identified a legal matter that required the attention of HHS. A section of the Public Health Service Act, Section 317 P, requires certain educational materials to contain medically accurate information about condom effectiveness. At the time of our review, an ACS official reported that materials prepared by abstinence education grantees were not subject to this provision. However, we concluded that this requirement does apply to abstinence education materials prepared and used by Federal grant recipients, depending on their substantive content. In other words, for materials that meet the statutory criteria, HHS' grantees are required to include information on condom effectiveness, and that information must be medically accurate. Therefore, we recommended that HHS adopt measures to ensure that, where applicable, abstinence education materials comply with this requirement.

HHS has told us that they have accepted our recommendation. The fiscal year 2007 community-based program announcement provides information about the applicability of this requirement, and future State program announcements will also include information on this requirement.

In conclusion, when we reported to you 18 months ago on this topic we identified several concerns and information gaps in HHS' abstinence education programs and made recommendations to the Department. HHS has now begun to make changes in response to our recommendations which could improve the accuracy of the materials used in these programs.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other members of the committee may have.

[The prepared statement of Ms. Crosse follows:]

United States Government Accountability Office

GAO

Testimony
Before the Committee on Oversight and
Government Reform, House of
Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Wednesday, April 23, 2008

ABSTINENCE EDUCATION

Assessing the Accuracy and Effectiveness of Federally Funded Programs

Statement of Marcia Crosse
Director, Health Care



April 23, 2008

ABSTINENCE EDUCATION

Assessing the Accuracy and Effectiveness of Federally Funded Programs


Highlights

Highlights of GAO-08-664T, a testimony before the Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

Among the efforts of the Department of Health and Human Services (HHS) to reduce the incidence of sexually transmitted diseases and unintended pregnancies, the agency provides funding to states and organizations that offer abstinence-until-marriage education.

GAO was asked to testify on the oversight of federally funded abstinence-until-marriage education programs. This testimony is primarily based on *Abstinence Education: Efforts to Assess the Accuracy and Effectiveness of Federally Funded Programs*, GAO-07-87 (Oct. 3, 2006). In this testimony, GAO discusses efforts by (1) HHS and states to assess the scientific accuracy of materials used in abstinence-until-marriage education programs and (2) HHS, states, and researchers to assess the effectiveness of abstinence-until-marriage education programs. GAO also discusses a Public Health Service Act requirement regarding medically accurate information about condom effectiveness.

GAO focused on the three main federally funded abstinence-until-marriage programs and reviewed documents and interviewed HHS officials in the Administration for Children and Families (ACF) and the Office of Population Affairs (OPA). To update certain information, GAO contacted officials from ACF and OPA.

To view the full product, including the scope and methodology, click on GAO-08-664T. For more information, contact Marcia Crosse at (202) 512-7114 or crossm@gao.gov.

What GAO Found

Efforts by HHS and states to assess the scientific accuracy of materials used in abstinence-until-marriage education programs have been limited. As of October 2006, HHS's ACF—which awards grants under two programs that account for the largest portion of federal spending on abstinence education—did not review its grantees' education materials for scientific accuracy, nor did it require grantees of either program to do so. Not all states that receive funding from ACF had chosen to review their program materials for scientific accuracy. OPA reviewed the scientific accuracy of grantees' proposed education materials, and any inaccuracies found had to be corrected before those materials could be used. The extent to which federally funded abstinence-until-marriage education materials are inaccurate was not known, but OPA and some states reported finding inaccuracies. GAO recommended that the Secretary of HHS develop procedures to help assure the accuracy of abstinence-until-marriage education materials. An ACF official reported that ACF is currently implementing a process to review the accuracy of Community-based grantees' curricula and has required those grantees to sign assurances that the materials they propose using are accurate. The official also reported that, in the future, state grantees will have to provide ACF with descriptions of their strategies for reviewing the accuracy of their programs.

As of August 2006, HHS, states, and researchers had made a variety of efforts to assess the effectiveness of abstinence-until-marriage education programs, but a number of factors limit the conclusions that can be drawn about the programs' effectiveness. ACF and OPA have required their grantees to report on various outcomes used to measure program effectiveness. To assess the effectiveness of its grantees' programs, ACF has analyzed national data on adolescent birth rates and the proportion of adolescents who report having had sexual intercourse. Additionally, 6 of the 10 states in GAO's review worked with third-party evaluators to assess the effectiveness of abstinence-until-marriage programs in their states. However, the conclusions that can be drawn are limited because most of the efforts to evaluate program effectiveness have not met certain minimum criteria that experts have concluded are necessary for such assessments to be scientifically valid. Additionally, the results of some efforts that do meet such criteria have varied.

While conducting work for its October 2006 report, GAO identified a legal matter that required the attention of HHS. Section 317P(c)(2) of the Public Health Service Act requires certain educational materials to contain medically accurate information about condom effectiveness. GAO concluded that this requirement would apply to abstinence education materials prepared and used by federal grant recipients, depending on their substantive content, and recommended that HHS adopt measures to ensure that, where applicable, abstinence education materials comply with this requirement. The fiscal year 2007 program announcement for the Community-based Program provides information about the applicability of this requirement, and future State and Community-based Program announcements are to include this information.

Mr. Chairman and Members of the Committee

I am pleased to be here today as you examine federally funded abstinence-until-marriage education programs. Reducing the incidence of sexually transmitted diseases (STD) and unintended pregnancies among adolescents has been an important objective of the Department of Health and Human Services (HHS). Among its efforts to do so, HHS funds abstinence-until-marriage education programs. These programs are delivered by a variety of entities, including schools, human service agencies, and faith-based organizations. Studies have raised concerns about the accuracy of the educational materials that are incorporated into these programs, as well as the effectiveness of the programs themselves. My remarks today are primarily based on our October 2006 report on the oversight of federally funded abstinence-until-marriage programs, *Abstinence Education: Efforts to Assess the Accuracy and Effectiveness of Federally Funded Programs* (GAO-07-87).¹ In that report, we recommended that the Secretary of Health and Human Services develop procedures to help assure the accuracy of such materials. Today, I will discuss findings from our report on (1) efforts by HHS and states to assess the scientific accuracy of materials used in abstinence-until-marriage programs, and (2) efforts by HHS, states, and researchers to assess the effectiveness of abstinence-until-marriage education programs as well as updates on selected information. I will also discuss a legal matter that came to our attention during the course of our work regarding the applicability of section 317P(c)(2) of the Public Health Service Act to Abstinence Education programs. We recommended in a letter dated October 18, 2006, that HHS adopt measures to ensure that, where applicable, abstinence-until-marriage education materials comply with the requirement that educational materials specifically designed to address STDs contain medically accurate information about condom effectiveness in preventing the STDs the materials were designed to address.²

¹GAO, *Abstinence Education: Efforts to Assess the Accuracy and Effectiveness of Federally Funded Programs*, GAO-07-87 (Washington, D.C.: Oct. 3, 2006). This report is available online at <http://www.gao.gov>.

²42 U.S.C. § 247b-17(c)(2) (2000); see GAO, *Abstinence Education: Applicability of Section 317P of the Public Health Service Act*, B-308128 (Washington, D.C.: Oct. 18, 2006). This letter is available online at <http://www.gao.gov>.

For our assessment of the accuracy and effectiveness of abstinence-until-marriage education programs, we focused our review on the three main federally funded abstinence-until-marriage programs: the Abstinence Education Program (State Program), the Community-Based Abstinence Education Program (Community-Based Program), and the Adolescent Family Life (AFL) Program. The State Program and the Community-Based Program are both administered by HHS's Administration for Children and Families (ACF); AFL is administered by HHS's Office of Population Affairs (OPA). According to HHS, funding for the three abstinence-until-marriage programs was about \$165 million in fiscal year 2007.

In order to describe the efforts to assess the scientific accuracy of program materials, we reviewed published reports, program announcements, *Federal Register* notices, agency Web sites, and other documents related to abstinence-until-marriage education. We did not assess the criteria used to determine the scientific accuracy of education materials or the quality of the reviews. We interviewed officials from ACF and OPA. We also interviewed officials from the 10 states that received the largest share of federal funding (together accounting for 51 percent of the total funding in fiscal year 2005) through the State Program for abstinence-until-marriage education.³

To describe efforts by HHS, states, and researchers to assess the effectiveness of abstinence-until-marriage education programs, we focused on efforts that examined the extent to which these programs achieved their program goals. In general, these goals include teaching adolescents to abstain from sexual activity until marriage in order to avoid unintended pregnancies, STDs, and related health problems. As part of our review, we compared these efforts to the design characteristics that experts have identified as important for a scientifically valid study of

³The 10 states that received the largest share of funding in fiscal year 2005 through the State Program were Arizona, Florida, Georgia, Illinois, Louisiana, Michigan, New York, North Carolina, Ohio, and Texas.

program effectiveness.⁴ We reviewed journal articles and other published reports, agency budget submissions, program announcements, agency and grantee performance reports, *Federal Register* notices, agency Web sites, and other documents related to abstinence-until-marriage education.⁵ We also interviewed officials from ACF, OPA, the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and 10 states that received the largest share of federal funding for abstinence-only education through the State Program in fiscal year 2005. We focused our review on efforts to assess the scientific accuracy of materials and the effectiveness of the programs during fiscal year 2006. We conducted this work from October 2005 through September 2006 and during April 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

To assess the applicability of section 317P(c)(2) of the Public Health Service Act to abstinence-until-marriage education programs, we reviewed the statute, pertinent legislative history, and relevant program guidance. In addition, we solicited the views of HHS officials on this issue.

In summary, we found that efforts by HHS and states to assess the scientific accuracy of materials used in abstinence-until-marriage education programs had been limited. ACF did not review its grantees' education materials for scientific accuracy and did not require that

⁴See Douglas Kirby, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Washington, D.C.: National Campaign to Prevent Teen Pregnancy, 2001). The experts identifying the design characteristics of a scientifically valid study for the National Campaign to Prevent Teen Pregnancy were drawn from institutions that include the National Institutes of Health, the Medical Institute for Sexual Health, the Alan Guttmacher Institute, the Institute for Research and Evaluation, and various universities. See David Satcher, *The National Consensus Process on Sexual Health and Responsible Sexual Behavior: Interim Report* (Atlanta: Morehouse School of Medicine, 2006). The panel convened by former Surgeon General David Satcher included experts from a variety of organizations, including the Medical Institute for Sexual Health, the Alan Guttmacher Institute, and the American Academy of Pediatrics. In addition, characteristics of a scientifically valid study have been identified by other experts in the field of evaluation research. For example, see Carol H. Weiss, *Evaluation* (Upper Saddle River: Prentice Hall, 1998).

⁵For a more detailed description of our literature review methodology, see GAO-07-87.

grantees of either the State Program or the Community-Based Program do so. In addition, not all states that received funding through ACF's State Program chose to review their program materials for scientific accuracy. Five of the 10 states in our review conducted such reviews. In contrast to ACF, OPA did review the scientific accuracy of AFL grantees' proposed educational materials and any inaccuracies found had to be corrected before the materials could be used. While we reported that the extent to which federally funded abstinence-until-marriage education materials are inaccurate was not known, in the course of their reviews OPA and some states reported that they had found some inaccuracies in abstinence-until-marriage education materials. For example, one state official described an instance in which abstinence-until-marriage materials incorrectly suggested that HIV can pass through condoms because the latex used in condoms is porous. To address concerns about the scientific accuracy of materials used in abstinence-until-marriage programs, we recommended that the Secretary of HHS develop procedures to help assure the accuracy of such materials, and HHS agreed to consider this recommendation. In April 2008, an ACF official reported that, in response to our recommendation, ACF began requiring in fiscal year 2007 that community-based grantees sign written assurances that the materials they propose using are accurate. This official also reported that, starting in fiscal year 2008, grantees of the State Program will also be required to sign these written assurances. In addition, this official reported that ACF is implementing a process to review the accuracy of the proposed curricula of fiscal year 2007 Community-based grantees. The ACF official reported that the curricula will be reviewed by a research analyst to ensure that all statements are referenced to source documents, and then by a healthcare professional who will compare the information in the curricula to information in the source documents. The official also reported that, in the future, ACF will require states to provide the agency with descriptions of their strategies for reviewing the accuracy of their abstinence-until-marriage education programs.

HHS, states, and researchers have made a variety of efforts to assess the effectiveness of abstinence-until-marriage education programs; however, a number of factors limit the conclusions that can be drawn about the effectiveness of abstinence-until-marriage education programs. To assess the effectiveness of their abstinence-until-marriage education programs, ACF and OPA have required their grantees to report on various outcomes. For example, as of fiscal year 2006, states that received funding through the State Program were required to report annually on four measures of the prevalence of adolescent sexual behavior in their state, such as the rate of pregnancy among adolescents aged 15 to 17 years. To assess the

effectiveness of both its State and Community-Based Programs, ACF also analyzed trends in adolescent behavior, as reflected in national data on birth rates among teens and the proportion of surveyed high school students reporting that they have had sexual intercourse. OPA required grantees of the AFL Program to develop and report on outcome measures that demonstrated the extent to which grantees' programs are having an effect on program participants. Further, 6 of the 10 states in our review that received funding through the State Program worked with third-party evaluators to assess the effectiveness of abstinence-until-marriage education programs in their states. Several factors, however, limit the conclusions that can be drawn about the effectiveness of abstinence-until-marriage education programs. Most of the efforts to evaluate the effectiveness of abstinence-until-marriage education programs that we described in our report did not meet certain minimum criteria—such as random assignment of participants and sufficient follow-up periods and sample sizes—that experts have concluded are necessary in order for assessments of program effectiveness to be scientifically valid.

During the course of our work on abstinence-until-marriage education, we identified a legal matter that required the attention of HHS. Section 317P(c)(2) of the Public Health Service Act requires educational materials specifically designed to address STDs to contain medically accurate information about condom effectiveness in preventing the diseases the educational materials are designed to address. We concluded that this requirement would apply to abstinence-until-marriage education materials prepared by and used by federal grant recipients, depending upon the substantive content of those materials. In other words, in materials otherwise meeting the statutory criteria, HHS' grantees are required to include information on condom effectiveness, and that information must be medically accurate. At the time of our review, an ACF official reported that materials prepared by abstinence-until-marriage education grantees were not subject to section 317P(c)(2). Therefore, we recommended in a letter dated October 18, 2006, that HHS reexamine its position and adopt measures to ensure that, where applicable, abstinence-until-marriage education materials comply with this requirement. The fiscal year 2007 Community-Based Program announcement states that mass produced materials that as their primary purpose are specifically about STDs are required to contain medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the STDs the educational materials are designed to address. An ACF official also told us that future State and Community-Based Program announcements would include this language.

Background

Statistics reported by CDC show that many high school students engage in sexual behavior that places them at risk for unintended pregnancy and STDs. In 2005, 46.8 percent of high school students reported that they have had sexual intercourse, with 14.3 percent of students reporting that they had had sexual intercourse with four or more persons. CDC also has reported that the prevalence of certain STDs—including the rate of chlamydia infection, the most frequently reported STD in the United States—peaks in adolescence and young adulthood.

At the time of our 2006 report, HHS's strategic plan included the objectives to reduce the incidence of STDs and unintended pregnancies and to promote family formation and healthy marriages. These two objectives supported HHS's goals to reduce the major threats to the health and well-being of Americans and to improve the stability and healthy development of American children and youth. Abstinence-until-marriage education programs were one of several types of programs that supported these objectives. The State Program, the Community-Based Program, and the AFL Program provide grants to support the recipients' own efforts to provide abstinence-until-marriage education at the local level. These programs must comply with the statutory definition of abstinence education (see table 1).⁶

⁶42 U.S.C. § 710(b)(2). This definition is also referred to as the A-H definition. This statutory provision defines abstinence education for purposes of the State Program. Annual appropriations acts and program announcements have extended this definition to the Community-Based and AFL Programs. See, e.g., Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2006, Pub. L. No. 109-149, 119 Stat. 2833, 2855-56.

Table 1: Definition of Abstinence Education

Abstinence education refers to an educational or motivational program that:	
A.	has, as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
B.	teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
C.	teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
D.	teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
E.	teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
F.	teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
G.	teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
H.	teaches the importance of attaining self-sufficiency before engaging in sexual activity.

Source: Social Security Act, § 510(b)(2) (codified at 42 U.S.C. § 710(b)(2)).

The State Program, administered by ACF, provides funding to its grantees—states—for the provision of abstinence-until-marriage education to those most likely to have children outside of marriage.⁷ States that receive grants through the State Program have discretion in how they use their funding to provide abstinence-until-marriage education. Funds are allotted to each state that submits the required annual application based on the ratio of the number of low-income children in the state to the total number of low-income children in all states. States are required to match every \$4 they receive in federal money with \$3 of nonfederal money and are required to report annually on the performance of the abstinence-until-marriage education programs that they support or administer. In fiscal year 2007, 40 states, the District of Columbia, and 3 insular areas were awarded funding.

⁷Funds are also provided through the State Program to the District of Columbia and insular areas, which include U.S. territories and commonwealths. In this statement, we refer to U.S. territories and commonwealths as "insular areas." When we refer to "states," we are referring to all grantees of the State Program—including states, insular areas, and the District of Columbia.

The Community-Based Program, which is also administered by ACF, is focused on funding public and private entities that provide abstinence-until-marriage education for adolescents from 12 to 18 years old. The Community-Based Program provides grants for school-based programs, adult and peer mentoring, and parent education groups. For fiscal year 2007, 59 grants were awarded to organizations and other entities. Grantees are required to report to ACF, on a semiannual basis, on the performance of their programs.

The AFL Program also supports programs that provide abstinence-until-marriage education.⁸ Under the AFL Program, OPA awards competitive grants to public or private nonprofit organizations or agencies, including community-based and faith-based organizations, to facilitate abstinence-until-marriage education in a variety of settings, including schools and community centers. In fiscal year 2007, OPA awarded funding to 36 grantees. Grantees are required to conduct evaluations of certain aspects of their programs and report annually on their performance.

Five organizational units located within HHS—ACF, OPA, CDC, ASPE, and NIH—have responsibilities related to abstinence-until-marriage education. ACF and OPA administer the three main federal abstinence-until-marriage education programs. CDC supports abstinence-until-marriage education at the national, state, and local levels. CDC, ASPE, and NIH are sponsoring research on the effectiveness of abstinence-until-marriage programs.

⁸See 42 U.S.C. § 300z et seq. In this statement, when we use the term AFL Program, we are referring only to the abstinence-until-marriage component of the AFL Program. The AFL Program also supports other projects for pregnant and parenting adolescents, their infants, male partners, and family members. The purpose of these projects is to improve the outcomes of early childbearing for teen parents, their infants, and their families.

Federal and State Efforts to Assess the Scientific Accuracy of Materials Used in Abstinence-until-Marriage Education Programs Have Been Limited

In October 2006 we reported that efforts by HHS and states to assess the scientific accuracy of materials used in abstinence-until-marriage education programs had been limited.⁹ ACF—whose grants to the State and Community-Based Programs accounted for the largest portion of federal spending on abstinence-until-marriage education—did not require its grantees' education materials for scientific accuracy and did not require grantees of either program to review their own materials for scientific accuracy. In addition, not all states funded through the State Program chose to review their program materials for scientific accuracy. In contrast to ACF, OPA reviewed the scientific accuracy of grantees' proposed educational materials and corrected inaccuracies in these materials.

ACF Neither Reviewed Nor Required Grantees to Review Program Materials for Scientific Accuracy, Although Some State Grantees Had Conducted Such Reviews

As of October 2006, there had been limited efforts to review the scientific accuracy of educational materials used in ACF's State and Community-Based Programs—the two programs that accounted for the largest portion of federal spending on abstinence-until-marriage education. ACF did not review materials for scientific accuracy in either reviewing grant applications or in overseeing grantees' performance. Prior to fiscal year 2006, State Program and Community-Based Program applicants were not required to submit copies of their proposed educational materials with their applications. While ACF required grantees of the Community-Based Program—but not the State Program—to submit their educational materials with their fiscal year 2006 applications, ACF officials told us that grantee applications and materials were only reviewed to ensure that they addressed all aspects of the scope of the Community-Based Program, such as the A-H definition of abstinence education.¹⁰ Further, documents provided to us by ACF indicated that the agency did not review grantees' educational materials for scientific accuracy as a routine part of its oversight activities. In addition, ACF also did not require its grantees to review their own materials for scientific accuracy.

While not all grantees of the State Program had chosen to review the scientific accuracy of their educational materials, officials from 5 of the 10 states in our review reported that their states chose to do so. These five states used a variety of approaches in their reviews. For example, some

⁹See GAO-07-87.

¹⁰HHS officials told us that if ACF finds inaccurate statements during this more general review process or if inaccuracies are brought to their attention at any time during the grant period, ACF officials work with the grantees to take corrective action.

states contracted with medical professionals—such as nurses, gynecologists, and pediatricians—to serve as medical advisors who review program materials and use their expertise to determine what is and is not scientifically accurate. One of the states required that all statistics or scientific statements cited in a program's materials be sourced to CDC or a peer-reviewed medical journal. Officials from this state told us that if statements in these materials could not be attributed to these sources, the statements were required to be removed until citations were provided and materials were approved.

As a result of their reviews, officials from two of the five states reported that they had found inaccuracies. One state official cited an instance where materials incorrectly suggested that HIV can pass through condoms because the latex used in condoms is porous. State officials who have identified inaccuracies told us that they informed their grantees of inaccuracies so that they could make corrections in their individual programs. Some of the educational materials that states reviewed were materials that were commonly used in the Community-Based Program.

While there had been limited review of materials used in the State and Community-Based Programs, grantees of these programs had received some technical assistance designed to improve the scientific accuracy of their materials. For example, ACF officials reported that the agency provided a conference for grantees of the Community-Based Program in February 2006 that included a presentation focused on medical accuracy.

**OPA Reviewed Materials
Used by AFL Program
Grantees for Scientific
Accuracy**

As of 2006, in contrast to ACF, OPA reviewed for scientific accuracy the educational materials used by AFL Program grantees, and it did so before those materials were used. OPA officials said that after grants were awarded, a medical education specialist (in consultation with several part-time medical experts) reviewed the grantees' printed materials and other educational media, such as videos. OPA officials explained that the medical education specialist must approve all proposed materials before they are used. On many occasions, OPA grantees had proposed using—and therefore OPA has reviewed—materials commonly used in the Community-Based Program. For example, an OPA official told us that the agency had reviewed three of the Community-Based Program's commonly used curricula and was also currently reviewing another curriculum commonly used by Community-Based Program grantees.

OPA officials stated that the medical education specialist had occasionally found and addressed inaccuracies in grantees' proposed educational materials. OPA officials stated that these inaccuracies were often the result of information being out of date because, for example, medical and statistical information on STDs changes frequently. OPA addressed these inaccuracies by either not approving the materials in which they appeared or correcting the materials through discussions with the grantees and, in some cases, the authors of the materials. In fiscal year 2005, OPA disapproved of a grantee using a specific pamphlet about STDs because the pamphlet contained statements about STD prevention and HIV transmission that were considered incomplete or inaccurate. For example, the pamphlet stated that there was no cure for hepatitis B, but the medical education specialist required the grantee to add that there was a preventive vaccine for hepatitis B. In addition, OPA required that a grantee correct several statements in a true/false quiz—including statements about STDs and condom use—in order for the quiz to be approved for use. For example, the medical education specialist changed a sentence from "The only 100% effective way of avoiding STDs or unwanted pregnancies is to not have sexual intercourse." to "The only 100% effective way of avoiding STDs or unwanted pregnancies is to not have sexual intercourse and engage in other risky behaviors."

While OPA and some states had reviewed their grantees' abstinence-until-marriage education materials for scientific accuracy, these types of reviews have the potential to affect abstinence-until-marriage education providers more broadly, perhaps creating an incentive for the authors of such materials to ensure they are accurate. As of October 2006, the company that produced one of the most widely used curricula used by grantees of the Community-Based Program had updated its curriculum. A representative from that company stated that this had been done, in part, in response to a congressional review that found inaccuracies in its abstinence-until-marriage materials.

To address concerns about the scientific accuracy of materials used in abstinence-until-marriage education programs, we recommended that the Secretary of HHS develop procedures to help assure the accuracy of such materials used in the State and Community-Based Programs.¹¹ We recommended that in order to provide such assurance, the Secretary could consider alternatives such as (1) extending the approach currently used by

¹¹See GAO-07-87.

OPA to review the scientific accuracy of the factual statements included in abstinence-until-marriage education to materials used by grantees of ACF's Community-Based Program and requiring grantees of ACF's State Program to conduct such reviews or (2) requiring grantees of both programs to sign written assurances in their grant applications that the materials they propose using are accurate. In its written comments on a draft of our report, HHS stated that it would consider requiring grantees of both ACF programs to sign such written assurances to the accuracy of their materials. In April 2008, an ACF official reported that, in response to our recommendation, ACF began requiring in fiscal year 2007 that community-based grantees sign written assurances that the materials they propose using are accurate. This official also reported that, starting in fiscal year 2008, grantees of the State Program will also be required to sign these written assurances. In addition, this official reported that ACF is implementing a process to review the accuracy of the proposed curricula of fiscal year 2007 Community-based grantees. The ACF official reported that the curricula will be reviewed by a research analyst to ensure that all statements are referenced to source documents, and then by a healthcare professional who will compare the information in the curricula to information in the source documents. The official also reported that, in the future, ACF will require states to provide the agency with descriptions of their strategies for reviewing the accuracy of their abstinence-until-marriage education programs.

**A Variety of Efforts
Were Made to Assess
the Effectiveness of
Abstinence-until-
Marriage Education
Programs, but a
Number of Factors
Limit the Conclusions
That Can Be Drawn**

HHS, states, and researchers have made a variety of efforts to assess the effectiveness of abstinence-until-marriage education programs; however, a number of factors limit the conclusions that can be drawn. ACF and OPA have required their grantees to report on various outcomes used to measure the effectiveness of grantees' abstinence-until-marriage education programs. To assess the effectiveness of the State and Community-Based Programs, ACF has analyzed national data on adolescent birth rates and the proportion of adolescents who report having had sexual intercourse. As of October 2006, other organizational units within HHS were funding studies designed to assess the effectiveness of abstinence-until-marriage education programs in delaying sexual initiation, reducing pregnancy and STD rates, and reducing the frequency of sexual activity. Despite these efforts, several factors limit the conclusions that can be drawn about the effectiveness of abstinence-until-marriage education programs. Most of the efforts to evaluate the effectiveness of abstinence-until-marriage education programs that we reviewed have not met certain minimum criteria that experts have concluded are necessary in order for assessments of program effectiveness to be scientifically valid, in part because such designs can be

expensive and time-consuming to carry out. In addition, the results of some efforts that meet the criteria of a scientifically valid assessment have varied.

HHS, States, and Researchers Have Made a Variety of Efforts to Assess the Effectiveness of Abstinence-until-Marriage Education Programs

ACF has made efforts to assess the effectiveness of abstinence-until-marriage education programs funded by the State Program and the Community-Based Program. One of ACF's efforts has been to require grantees of both programs to report data on outcomes, though the two programs have different requirements for the outcomes grantees must report.¹² As of fiscal year 2006, State Program grantees were required to report annually on four measures of the prevalence of adolescent sexual behavior in their states, such as the rate of pregnancy among adolescents aged 15 to 17 years, and compare these data to program targets over 5 years. States also were required to develop and report on two additional performance measures that were related to the goals of their programs.¹³ Also as of fiscal year 2006, ACF required Community-Based Program grantees to develop and report on outcome measures designed to demonstrate the extent to which grantees' community-based abstinence-until-marriage education programs were accomplishing their program goals.¹⁴ In addition to outcome reporting, ACF required grantees of the Community-Based Program to report on program "outputs," which measure the quantity of program activities and other deliverables, such as the number of participants who are served by the abstinence-until-marriage education programs.

¹²This reporting is a part of ACF's efforts to collect evaluative information about these programs. These efforts include both performance measurement—the ongoing monitoring and reporting of program accomplishments toward pre-established goals—and program evaluation—individual systematic studies to assess how well a program is working.

¹³For example, in fiscal year 2002, state grantees developed such measures as the percentage of teens surveyed who show an increase in participating in structured activities after school hours; the percentage of live births to women younger than 18, fathered by men age 20 and older; the percentage of program participants proficient in refusal skills; the percentage of high school students who reported using drugs or alcohol before intercourse; and the percentage of high school students who had sexual intercourse for the first time before age 13.

¹⁴The fiscal year 2006 program announcement for the Community-Based Program provided examples of outcome measures that grantees could use, including increased knowledge of the benefits of abstinence, the number of youths who commit to abstaining from premarital sexual activity, and increased knowledge of how to avoid high-risk situations and risk behaviors.

As of October 2006, OPA also had made efforts to assess the effectiveness of the AFL Program. Specifically, OPA required grantees of the AFL Program to develop and report on outcome measures, such as participants' knowledge of the benefits of abstinence and their reported intentions to abstain from sexual activity, that were used to help demonstrate the extent to which grantees' programs were having an effect on program participants. To collect data on outcome measures, OPA required grantees to administer, at a minimum, a standardized questionnaire to their program participants, both when participants begin an abstinence-only education program and after the program's completion. OPA officials told us that they were planning to aggregate information from certain questions in the standardized set of questionnaires in order to report on certain performance measures as part of the agency's annual performance reports; the agency expected to begin receiving data from grantees that were using these questionnaires in January 2007.

To help grantees measure the effectiveness of their programs, both ACF and OPA required that grantees use independent evaluators and have provided assistance to grantees in support of their program evaluation efforts. ACF and OPA required their grantees to contract with third-party evaluators, such as university researchers or private research firms, who were responsible for helping grantees develop the outcome measures they were required to report on and monitoring grantee performance against those measures. Unlike ACF, OPA required that these third-party evaluations incorporate specific methodological characteristics, such as control groups of individuals that did not receive the program and sufficient sample sizes to ensure that any observed differences between the groups were statistically valid. Both ACF and OPA have provided technical assistance and training to their grantees in order to support grantees' own program evaluation efforts.

ACF also analyzed trends in adolescent behavior, as reflected in national data on birth rates among teens and the proportion of surveyed high school students reporting that they have had sexual intercourse.¹⁵ ACF used these national data as a measure of the overall effectiveness of its State and Community-Based Programs, comparing the national data to

¹⁵Data on teen birth rates and adolescents' reported sexual behavior are contained in the National Vital Statistics System and the Youth Risk Behavior Surveillance System, respectively. The former is a national data set of public health statistics reported by states to CDC, and the latter is a national data set based on nationwide surveys administered to high school students by CDC.

program targets. In its annual performance reports, the agency has summarized the progress being made toward lowering the rate of births to unmarried teenage girls and the proportion of students (grades 9-12) who report having ever had sexual intercourse.

Some states have made additional efforts to assess the effectiveness of abstinence-until-marriage education programs. Specifically, we found that 6 of the 10 states in our review that received funding through ACF's State Program had made efforts to conduct evaluations of selected abstinence-until-marriage programs in their state. All 6 of the states worked with third-party evaluators, such as university researchers or private research firms, to perform the evaluations, which in general measured self-reported changes in program participants' behavior and attitudes related to sex and abstinence as indicators of program effectiveness. Four of these states had completed third-party evaluations as of February 2006, and the results of these studies varied.¹⁶ Among those 4 states, 3 states required the abstinence programs in their state to measure reported changes in participants' behavior as an indicator of program effectiveness—both at the start of the program and after its completion. The 3 states required their programs to track participants' reported incidence of sexual intercourse. Additionally, 2 of the 4 states required their programs to track biological outcomes, such as pregnancies, births, or STDs. In addition, 6 of the 10 states in our review required their programs to track participants' attitudes about abstinence and sex, such as the number of participants who make pledges to remain abstinent.

Besides ACF and OPA, other organizational units within HHS have made efforts to assess the effectiveness of abstinence-until-marriage education programs. As of 2006, ASPE was sponsoring a study of the Community-Based Program and a study of the State Program. The study of the State Program was conducted by Mathematica Policy Research, Inc. (Mathematica) and completed in 2007. It examined the impact of five programs funded through the State Program on participants' attitudes and

¹⁶See, for example, LeCroy & Milligan Associates, Inc., *Abstinence Only Education Program: Fifth Year Evaluation Report*, a report prepared for the Arizona Department of Health Services (2003); Patricia Goodson et al., *Abstinence Education Evaluation: Phase 6*, a report prepared for the Texas Department of State Health Services (2005); MGT of America, *Evaluation of Georgia Abstinence Education Programs Funded Under Title V, Section 510*, a report prepared for the Georgia Department of Human Resources (2005); Thomas E. Smith, *It's Great to Wait: An Interim Evaluation*, a report prepared for the Florida Department of Health (2001).

behaviors related to abstinence and sex.¹⁷ Like ASPE, CDC has made its own effort to assess the effectiveness of abstinence-until-marriage education by sponsoring a study to evaluate the effectiveness of two middle school curricula—one that complies with abstinence-until-marriage education program requirements and one that teaches a combination of abstinence and contraceptive information and skills. The agency expects to complete the study in 2009. Likewise, NIH has funded studies comparing the effectiveness of education programs that focus only on abstinence with the effectiveness of sex education programs that teach both abstinence and information about contraception. As of October 2006, NIH was funding five studies, which in general were comparing the effects of these two types of programs on the sexual behavior and related attitudes among groups of either middle school or high school students.

In addition to the efforts of researchers working on behalf of HHS and states, other researchers—such as those affiliated with universities and various advocacy groups—have made efforts to study the effectiveness of abstinence-until-marriage education programs. This work includes studies of the outcomes of individual programs and reviews of other studies on the effectiveness of individual abstinence-until-marriage education programs. In general, research studies on the effectiveness of individual programs have examined the extent to which they changed participants' demonstrated knowledge of concepts taught in the programs, declared intentions to abstain from sex until marriage, and reported behavior related to sexual activity and abstinence. As of October 2006, the efforts to study and build a body of research on the effectiveness of most abstinence-until-marriage education programs had been under way for only a few years, in part because grants under the two programs that account for the largest portion of federal spending on abstinence-until-marriage education—the State Program and the Community-Based Program—were not awarded until 1998 and 2001, respectively.

¹⁷The five abstinence-until-marriage education programs studied were *My Choice, My Future!* in Powhatan, Virginia; *ReCapturing the Vision* in Miami, Florida; *Teens in Control* in Clarksdale, Mississippi; *Families United to Prevent Teen Pregnancy* in Milwaukee, Wisconsin; and *Heritage Keepers* in Edgefield, South Carolina.

Several Factors Limit the Conclusions That Can Be Drawn about the Effectiveness of Abstinence-until-Marriage Education Programs

Most of the efforts of HHS, states, and other researchers to evaluate the effectiveness of abstinence-until-marriage education programs included in our review have not met certain minimum criteria that experts have concluded are necessary in order for assessments of program effectiveness to be scientifically valid. In an effort to better assess the merits of the studies that have been conducted on the effectiveness of sexual health programs—including abstinence-until-marriage education programs—scientific experts have developed criteria that can be used to gauge the scientific rigor of these evaluations. The reports of two panels of experts,^{18,19} as well as the experts we interviewed in the course of our previous work, generally agreed that scientifically valid studies of a program's effectiveness should include the following characteristics:

- *An experimental design that randomly assigns individuals or schools to either an intervention group or control group, or a quasi-experimental design that uses nonrandomly assigned but well-matched comparison groups.* According to the panel of scientific experts convened by the National Campaign to Prevent Teen Pregnancy, experimental designs or quasi-experimental designs with well-matched comparison groups have at least three important strengths that are typically not found in other studies, such as those that use aggregated data: they evaluate specific programs with known characteristics, they can clearly distinguish between participants who did and did not receive an intervention, and they control for other factors that may affect study outcomes. According to scientific experts, studies that include experimental or quasi-experimental designs should also collect follow-up data for a minimum number of months after subjects receive an intervention. In addition, experts have reported that studies should have a sample size of at least 100 individuals for study results to be considered scientifically valid.
- *Studies should assess or measure changes in biological outcomes or reported behaviors instead of attitudes or intentions.* According to scientific experts, biological outcomes—such as pregnancy rates, birth rates, and STD rates—and reported behaviors—such as reported initiation and frequency of sexual activity—are better measures of the effectiveness

¹⁸See Kirby. This panel included experts from NIH, the Medical Institute for Sexual Health, the Alan Guttmacher Institute, the Institute for Research and Evaluation, and various universities.

¹⁹See Satcher. This panel included experts from a variety of organizations, including the Medical Institute for Sexual Health, the Alan Guttmacher Institute, and the American Academy of Pediatrics.

of abstinence-until-marriage programs, because adolescent attitudes and intentions may or may not be indicative of actual behavior.

Many of the efforts by HHS, states, and other researchers that we identified in our review lack at least one of the characteristics of a scientifically valid study of program effectiveness. Most of the efforts to assess the effectiveness of these programs have not used experimental or quasi-experimental designs with sufficient follow-up periods and sample sizes. For example, ACF used, according to ACF officials, grantee reporting on outcomes in order to monitor grantees' performance, target training and technical assistance, and help grantees improve service delivery. However, because the outcomes reported by grantees have not been produced through experimentally or quasi-experimentally designed studies, such information cannot be causally attributed to any particular abstinence-until-marriage education program. Further, none of the state evaluations we reviewed that had been completed included randomly assigned control groups. Similarly, some of the journal articles that we reviewed described studies to assess the effectiveness of abstinence-until-marriage programs that also lacked at least one of the characteristics of a scientifically valid study of program effectiveness. In these studies, researchers administered questionnaires to study participants before and after they completed an abstinence-until-marriage education program and assessed the extent to which the responses of participants changed.²⁰ These studies did not compare the responses of study participants with a group that did not participate in an abstinence-until-marriage education program.

Like the lack of an experimental or quasi-experimental design, not measuring changes in behavioral or biological outcomes among participants limits the conclusions that can be drawn about the effectiveness of abstinence-until-marriage education programs. Most of the efforts we identified in our review used reported intentions and attitudes in order to assess the effectiveness of abstinence-until-marriage programs. For example, as of 2006, neither ACF's community-based grantees nor OPA's AFL grantees were required to report on behavioral or biological outcomes, such as rates of intercourse or pregnancy. Similarly, the journal articles we reviewed were more likely to use reported attitudes and

²⁰See, for example, S. M. Fitzgerald et al., "Effectiveness of the Responsible Social Values Program for 6th Grade Students in One Rural School District," *Psychological Reports*, vol. 91 (2002), and J. E. Barnett and C. S. Hurst, "Abstinence Education for Rural Youth: An Evaluation of the Life's Walk Program," *The Journal of School Health*, vol. 73, no. 7 (2003).

intentions—such as study participants' reported attitudes about premarital sexual activity or their reported intentions to remain abstinent until marriage—rather than their reported behaviors or biological outcomes to assess the effectiveness of abstinence-until-marriage programs.

According to scientific experts, HHS, states, and other researchers face a number of challenges in applying either of these criteria. According to these experts, experimental or quasi-experimental studies can be expensive and time-consuming to carry out, and many grantees of abstinence-until-marriage education programs have insufficient time and funding to support these types of studies. Moreover, it can be difficult for researchers assessing abstinence-until-marriage education programs to convince school districts to participate in randomized intervention and control groups, in part because of sensitivities to surveying attitudes, intentions, and behaviors related to abstinence and sex. Similarly, experts, as well as state and HHS officials, have reported that it can be difficult to obtain scientifically valid information on biological outcomes and sexual behaviors. For example, experts have reported that when measuring a program's effect on biological outcomes—such as reducing pregnancy rates or birth rates—it is necessary to have large sample sizes in order to determine whether a small change in such outcomes is the result of an abstinence-until-marriage education program.

Among the assessment efforts we identified are some studies that meet the criteria of a scientifically valid effectiveness study. However, results of these studies varied, and this limits the conclusions that can be drawn about the effectiveness of abstinence-until-marriage education programs. Some researchers have reported that abstinence-until-marriage education programs have resulted in adolescents reporting having less frequent sexual intercourse or fewer sexual partners.²¹ For example, in one study of middle school students, participants in an abstinence-until-marriage education program who had sexual intercourse during the follow-up period were 50 percent less likely to report having two or more sexual partners when compared with their nonparticipant peers.²² In contrast,

²¹See E. A. Borawski et al., "Effectiveness of Abstinence-only Intervention in Middle School Teens," *American Journal of Health Behavior*, vol. 29, no. 5 (2005). See also T. L. St. Pierre et al., "A 27-Month Evaluation of a Sexual Activity Prevention Program in Boys & Girls Clubs Across the Nation," *Family Relations*, vol. 44, no. 1 (1995).

²²See Borawski et al., "Effectiveness of Abstinence-only Intervention in Middle School Teens,"

other studies have reported that abstinence-until-marriage education programs did not affect the reported frequency of sexual intercourse or number of sexual partners.²³ For example, one study of middle school students found that participants of an abstinence-until-marriage program were not less likely than nonparticipants at the 1 year follow-up to report less frequent sexual intercourse or fewer sexual partners.²⁴ Experts with whom we spoke emphasized that there were still too few scientifically valid studies completed as of 2006 that could be used to determine conclusively which, if any, abstinence-until-marriage programs are effective.

We identified two key studies that experts anticipated would meet the criteria of a scientifically valid effectiveness study. Experts and federal officials we interviewed stated that they expected the results of these two federally funded studies to add substantively to the body of research on the effectiveness of abstinence-until-marriage education programs. One of these key studies—the final Mathematica report, contracted by ASPE, on the State Program—has been completed.²⁵ In this report, the researchers found that youth who participated in the abstinence-until-marriage education programs were no more likely than control group youth to have abstained from sex, and among those who reported having had sex, they had similar numbers of sexual partners and had initiated sex at the same average age. The youth in abstinence-until-marriage education programs also were no more likely to have engaged in unprotected sex than control group youth. The second key study we identified is CDC's research on middle school programs, which is still ongoing. In addition, since October 2006, a third key report was released, presenting the 2007 analysis of the

²³See N. G. Harrington et al., "Evaluation of the All Stars Character Education and Problem Behavior Prevention Program: Effects on Mediator and Outcome Variables for Middle School Students," *Health Education & Behavior*, vol. 28, no. 5 (2001). See also J. B. Jemmott III, L. S. Jemmott, and G. T. Fong, "Abstinence and Safer Sex HIV Risk-Reduction Interventions for African American Adolescents: A Randomized Controlled Trial," *Journal of the American Medical Association*, vol. 279, no. 19 (1998).

²⁴See Harrington et al., "Evaluation of the All Stars Character Education and Problem Behavior Prevention Program: Effects on Mediator and Outcome Variables for Middle School Students."

²⁵See Trenholm et al., *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report*, a report prepared for ASPE, 2007. According to several scientific experts, Mathematica's study is an important one, in part because of its sound design: the study randomly assigns and compares control groups with groups receiving abstinence-until-marriage education and uses surveys to follow up with program participants for several months after their completion of a program.

National Campaign to Prevent Teen and Unplanned Pregnancy of the available research on abstinence-until-marriage education programs. This report stated that studies of abstinence programs have not produced sufficient evidence of effectiveness, and that efforts should be directed toward further evaluation of these programs.²⁶

Statutory Requirement to Include Information on Condom Effectiveness Would Apply to Certain Abstinence-until-Marriage Education Materials

During the course of our work on abstinence-until-marriage education, we identified a federal statutory provision—section 317P(c)(2) of the Public Health Service Act—relevant to the grants provided by HHS's State Program, Community-Based Program, and AFL Program.²⁷ This provision requires that educational materials prepared by HHS's grantees, among others, that are specifically designed to address STDs, contain medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the diseases the materials are designed to address.

At the time of our review, an ACF official reported that materials prepared by abstinence-until-marriage education grantees were not subject to section 317P(c)(2). However, we concluded that this requirement would apply to abstinence-until-marriage education materials prepared by and used by federal grant recipients, depending upon the substantive content of those materials. In other words, in materials specifically designed to address STDs, HHS's grantees are required to include information on condom effectiveness, and that information must be medically accurate. Therefore, we recommended in a letter dated October 18, 2006, that HHS reexamine its position and adopt measures to ensure that, where applicable, abstinence education materials comply with this requirement.²⁸

²⁶See Douglas Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases* (Washington D.C.: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007).

²⁷42 U.S.C. § 247b-17(c)(2). Section 317P(c)(2) states that ". . . educational and prevention materials prepared and printed . . . for the public and health care providers by the Secretary (including materials prepared through the Food and Drug Administration, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration) or by contractors, grantees, or subgrantees thereof, that are specifically designed to address STDs . . . shall contain medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the STD the materials are designed to address. Such requirement only applies to materials mass produced for the public and health care providers, and not to routine communications."

²⁸See GAO, B-308128, Oct. 18, 2006.

In a letter to us dated January 16, 2007, ACF responded that it would take steps to “make it clear to grantees that when they mass produce materials that as a primary purpose are specifically about STDs those materials are required by section 317P(c)(2) of the Public Health Service Act to contain medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the sexually transmitted disease the materials are designed to address.” The fiscal year 2007 Community-Based Program announcement states that mass produced materials that as their primary purpose are specifically about STDs are subject to this requirement. The announcement also states that mass produced materials are considered to be specifically designed to address STDs if more than 50 percent of the content is related to STDs. An ACF official also told us that future State and Community-Based Program announcements would include this language.²⁹

Mr. Chairman, this completes my prepared remarks. I will be happy to answer questions you or other Committee Members may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact Marcia Crosse at (202) 512-7114 or crossem@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Major contributors to this report were Kristi Peterson, Assistant Director; Kelly DeMots; Cathleen Hamann; Helen Desaulniers; and Julian Klazkin.

²⁹OPA reported that, as a matter of policy, it has required since 1993 that AFL Program materials that include information regarding STDs contain medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the STDs addressed in the materials. Further, OPA reported that, since November 2006, OPA has taken additional steps to inform grantees about OPA’s policy and the need to be compliant with the requirements of Section 317P(c)(2) of the Public Health Service Act.

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Chairman WAXMAN. Thank you very much for your presentation to us and the hard work that you have done at our request.

Mr. Keckler, I have some questions about your characterization of the evidence on abstinence-only programs. You acknowledge that the data supports the effectiveness of teen sex education programs in delaying sex and reducing sexual frequency or the number of partners. You then said that "the use of abstinence education curricula has a shorter history of evaluation, but the results have been similar."

But this isn't the view of medical experts. The American Medical Association, the American Public Health Association, the American Academy of Pediatrics have all looked at abstinence-only programs and found that they are not as effective as comprehensive sex education. Why is it that what you are telling us is so different from the expert medical bodies? You are drawing one conclusion, and they look at the same evidence and draw a completely different conclusion.

Mr. KECKLER. Thank you for the question, Mr. Chairman.

Well, I think that we need to be, when we say one works better than the other, that comparison has never been done. We have a study ongoing that will compare the two treatments side by side. But some of these statements and some of the collections of studies which were referred to earlier are something else. They are accumulations of studies of, on the one hand, studies that have been done of comprehensive sex education over the years, and some studies that have been done on abstinence until marriage.

Chairman WAXMAN. Well, OMB, for example, the Office of Management and Budget at the White House, does program assessments of different Government programs called PART assessments.

Mr. KECKLER. Yes.

Chairman WAXMAN. In its assessment of the abstinence-only programs, OMB gave the program a very low score of 33 out of 100 for program results and accountability. The answer to, "Has the program demonstrated adequate progress in achieving its long-term goals" was "small extent." The answer to whether the program achieves its annual performance goals was "no," because the programs won't even set baselines until March 2009, so basically we have no idea if individual programs are having any impact on participant behavior and health. Why are we continuing to fund programs where even OMB is saying there is virtually no evidence of effectiveness?

Mr. KECKLER. Mr. Chairman, with regard to the OMB PART assessment, the PART assessment ultimately of these programs was ranked as adequate with the conditions that we make certain evaluation changes that OMB recommended. We are making those changes, which include standardized reporting from CBA grantees on the outputs of their programs and, starting in the upcoming year, standardized survey of participants, which will include outcomes of the programs, including whether or not the participants are having sexual activity.

Chairman WAXMAN. Let me ask Dr. Crosse about that evaluation. Do you think the administration is doing enough to establish baselines and other measurement goals for these programs so we can measure them and see whether they are succeeding?

Ms. CROSSE. Well, they are currently funding some well-designed studies, and the one study that I cited that had been completed since our report was issued was one of the studies that the Department funded that did meet the standards for a scientifically valid study that was a situation where they had random assignment.

I think some of our concerns are some of the measures that the Department has been using are ones that cannot be clearly linked back specifically to the program. The national rates of pregnancy is not something where you can say that the impact on that is specifically because of the program, because you don't have any information about the differences in the rates between those who have received that information and those who didn't.

Chairman WAXMAN. Let me get into another question.

Mr. Keckler, we know some teens are going to have sex. We can talk to them about abstinence until marriage, but let's say a young person comes to you and says, I put a lot of thought into it, but I am going to go have sex. I have reached a point that I am going to do this. The question comes to you, Should I use a condom? What would you say to him or her?

Mr. KECKLER. Well, I am not sure that my personal response to a teen in my life is germane, but I think—

Chairman WAXMAN. What do you think somebody running a program should say to that individual?

Mr. KECKLER. Well, I can tell you what they will say in the CBA programs, which is that if somebody is in need of other services, our grantees are asked and encouraged to give them referrals to other services. Our grantees, of course, are bound by the A through H requirements to focus on abstinence, but they will make referrals for other services, and that is what they would say.

Chairman WAXMAN. I find that nonsense, nonsensical. If somebody is coming to you and asking in one of these programs, admitting that they are going to be sexually active—which probably means they already are sexually active—to tell them, I am going to refer you to someone else will probably mean that, if they go to someone else, it will be after they have already had enough sexual contact where they might have contracted HIV or some other sexually transmitted disease. That is one of the big problems I have with this separation. We can only talk about abstinence. We can't talk about the rest of the information that is pertinent.

I just know, if the Members will forgive me—and I will allow them a little extra time, as well—I know a lot of people have said over the years we ought to let States and local governments make the decision. Maybe we ought to just have a block grant. Let the States and local governments decide if they want an abstinence-only program or if they want to use the money for a broader comprehensive program. But here we have Washington, DC, saying, "We know what is best, and if you want money for sex education in the schools, you have to use abstinence-only funds."

When we hear about these other programs being funded, most of them are at the local level. The others are extrapolations of Medicaid funding for family planning services—they are not going to schools, they are not going to teenagers. They're funding for Title X clinics, well, they are clinics. They are not in the schools. They may have some relationship. The Indian Health Services and some

of these others, I think that is being used to say we have a lot more dollars going to these other programs. Well, they are not Federal dollars for the most part.

Is that an accurate statement, Dr. Crosse? Have you looked at the funding mechanisms?

Ms. CROSSE. My understanding is that the only Federal money that specifically is targeted for sex education programs is through these programs that we focused on, these three big programs at the Department—the State program, the community-based program [CBA] program, and the adolescent family life program. There may be small amounts in other areas, but the targeted areas for sex education are abstinence-only ones.

Chairman WAXMAN. Thank you.

I have used 7.4 minutes, but I am going to yield to the gentleman and each of the other gentleman on the panel 8 minutes so we will be fair. They don't have to use it all, but each will get 8.

Mr. SOUDER. It won't be entirely fair because it is two against one again.

Chairman WAXMAN. Well, I haven't used the full 8.

Mr. SOUDER. First, let me say sometimes I get in trouble for this, and I have complained about a number of hearings that we have had here, including today, but I find the chairman very fair. We have a good personal relationship. It concerns some of my colleagues that I speak highly of him many times, but, in fact, he attempts to be fair. Sometimes liberals have a tough time understanding our perspective enough to what we consider fair or not, but I believe he is genuine in his ability to desire to do that.

Chairman WAXMAN. Time's up. [Laughter.]

Mr. SOUDER. Mr. Keckler, we have had a lot of discussion today about the Federal funding for sex education. I would appreciate your getting back to the committee with the specifics here. You chose your words carefully. You said that the Federal Government funds money for Planned Parenthood, family planning, and other types of things. What we really need here is how much of that actually goes to schools. Dr. Crosse picked her words very carefully there, said the dedicated stream. But, in fact, we all know these programs are in the schools, have been in the programs for many years. They are funded through the Federal Government, through the family planning that comes through. There are also health grants that come through that may not be in your area, but if you could break that out. I mentioned Safe and Drug-Free Schools because I wrote that section and allowed it to be fungible funding, and I know that in school districts people use it there. But we need some kind of a read with this, because this has, in my opinion, been a false track that we got off to. I think it is a legitimate debate that the chairman said should any be specifically dedicated. That is a fair debate.

But partly what Dr. Crosse, whose recommendation seemed pretty reasonable, has suggested is that when we, the Federal Government, give the funds without any guidelines, then we get charges like came up from the two younger people here today that clearly those wouldn't have met Federal standards to do a program like that.

It would be very helpful if you can get us a funding stream, not only of this much goes in family planning, but to see if we can do a down-stream track of where that funding breaks out. I don't know whether this is a school survey working with the Department of Education, but I think it is very important for us to understand how these programs are funded in the schools.

Mr. KECKLER. I agree with you, Congressman, and the problem has been that, because the other forms of comprehensive sex education and prevention programs are folded into, sometimes they are block grants, they are folded in throughout the Department of Health and Human Services in a variety of ways, and some of them are also directed both to young adults and to adolescents in order to get a real apples-to-apples comparison.

There is some work that needs to be done with our budget people, but we will be happy to get you firmer estimates along those lines.

Mr. SOUDER. Because without that it is hard for anybody to allege scientific comparisons if, in fact, we don't even know what Federal funding is where. I support block grants, but I also have historically believed there should be accountability. We have run into huge problems with the No Child Left Behind with this, because then nobody likes the accountability measures and we argue over the accountability measures. But the fact is that if the Federal Government is going to be tasked with raising the taxes and spending the funding, we shouldn't dictate how a local district meets it, but there ought to be requirements that meet basic standards so that we know tax dollars are being spent.

If you are a Libertarian and don't want the Federal Government to do it, that is one thing, but if the Federal Government is going to do it, in the day and age of the computer reporting system it seems like this would be not that hard to put a designation on a form for the data to come back of did this go into school, how many dollars went to the school, the schools to report back. I mean, they already deal with mounds of reports, and I understand that, but if we are going to have—how are people alleging scientific comparisons here, because there are controlled programs and non-controlled programs.

I heard data thrown out today not comparing, when they were comparing abstinence programs, comparing it to the universe rather than the schools around it, may have had an alternative program, which in science would have been mandatory. What is the universe? What is the comparison? What are the control groups?

One of the most famous early studies in the 1980's was in Minnesota, where a school that had a family planning program said they reduced teen pregnancy. A quick check showed that every other school in Minneapolis went down more, because there were cultural variables and other things happening in the community, not just that program. So you have to have multiple control groups.

We are having this debate today sounding like the science is in one direction when, as Dr. Crosse has pointed out, and I think fairly, that there should be factual information in any abstinence program. They shouldn't be able to put out false information. There ought to be accountability to it.

One other question I had that was raised by—I forget her name, the young girl on the first panel—she said, as I understood her to say—Shelby—it was a secular program and a pastor came in as part of that. In these programs, are they allowed to invite guest speakers in? And if guest speakers come in, are they held to any accountable standards, which is something else that ought to be looked at. Did you look at that, Dr. Crosse?

Ms. CROSSE. We did not look at the specifics of the structures. And our recommendations are to the general information that are distributed for the programs. There is certainly always the possibility that someone can come in and write something up on a blackboard that would not be under any kind of control or review.

Mr. SOUDER. Because when we are dealing with these social, controversial issues, often somebody will be invited in from a local church, or somebody will be invited in from the other side. If, in fact, it is a religious community they will invite somebody in from Planned Parenthood to present that. The question is: how fact-based are we going to have this? Is there an accountability procedure? But I would think we should at least know in the presentation of a grantee whether they intend to do that, because otherwise it becomes hard. Do you know whether that is done now?

Mr. KECKLER. Well, there are a variety of methods. I think Dr. Fineberg talked about the great variety of methods that people are using, and we as a Department are going through this process to try to identify best practices, along with many other people in the field. So could somebody come in and speak? Yes. The grantee, however, is responsible under our current rules for ensuring medical accuracy, and when we make a site visit there, either because we think there are good practices there or we have heard some problems with the grantee, medical accuracy is looked at, as well. So it is their assurance and their responsibility to maintain medical accuracy.

Our efforts on that have been welcomed by all the grantees. They want to be medically accurate. They appreciate our help.

Mr. SOUDER. I need to get another factual question on the record here. We have heard about the 17 States opting out, 33 are in. Have you had a drop-off in application rates?

Mr. KECKLER. The CBA grants have not shown any particular drop-off in that program. There have been this year fewer States applying for the State funds.

Mr. SOUDER. But there is still more demand than there is money?

Mr. KECKLER. Oh, yes. The CBA grants are probably the most competitive grant program that is currently making grants in ACF. In the last 3 years—

Mr. SOUDER. You are saying of all the programs—

Mr. KECKLER. In ACF, all the grant programs.

Mr. SOUDER. So the demand for this is huge.

Mr. KECKLER. Right. We have funded between 8 and 14 percent of grant applications in the last 3 fiscal years, so there is tremendous unmet demand.

Chairman WAXMAN. Thank you, Mr. Souder.

Mr. Shays.

Mr. SHAYS. Thank you.

I don't intend to use my full 8 minutes, given I missed a good chunk of this hearing, but I want to ask you an ethical question, both of you. I think it clearly matters if a program is successful or not, and we determine success based on certain outcomes. I guess the first outcome, are young people having premarital sex or not. The outcomes disease, pregnancy, emotional issues, as well.

But the ethical question for me is let's just say that an abstinence program was equal to, in terms of outcome, as one that was more comprehensive. Let me even say it this way. Let's just say an abstinence program was even better. Don't young people have a right to know the truth? And it seems to me that we are almost suggesting that if we can just focus on abstinence-only and leave out the rest of the story, because if we leave out the rest of the story they may have more sex, so we leave out the rest of the story.

But it seems to me that is unethical. It seems to me maybe when you are talking to a 6th grade kid I don't know, but it seems to me by the time a young people is a junior in high school they just deserve to know the truth, whatever the truth is. And you try to have impact on their young minds to do what we as adults thinks is responsible.

The irony, I was speaking to some of my colleagues here and asked them if they had premarital sex. They said they did. And when they started to talk about it, it was almost like it was a good thing. I mean, the irony, the hypocrisy of this is kind of interesting, too. So I am just asking you about the ethics of denying people information. Do they not deserve to know it? Or if they do know it, do you think they are going to do the wrong thing, so they shouldn't have it?

Chairman WAXMAN. Before you answer that question I want to indicate for the record that the gentleman did not ask me that question. [Laughter.]

Mr. KECKLER. Well, Congressman Shays, that is a very important question. Clearly, teens need to know the truth about their lives and about this area. The question, though, is do they need to know it all at once and in the same place. The Department supports a risk avoidance message and a risk reduction message. There is important programmatic and practical reasons why we should have the capacity to be able to keep those messages distinct. There is a lot of jurisdictions and there is a lot of grantees that want to help and want to give the risk avoidance message but they don't want to be compelled to include with that a risk reduction message.

So being able to deliver those separately is useful from a programmatic context. There are hypotheses out there on both sides of whether it is more effective to deliver a focused, pure risk avoidance message or whether it might be more effective some way combining it. As I have mentioned, that direct comparison of whether it is better to put them together or keep them separate has never fully been done, but it is important that both messages be out there and that both messages be accurate.

Ms. CROSSE. Just for the record, GAO has no position on this, but I will answer your question in that I think it is important and it is ethical for students, teenagers to be given complete information. I think it is a policy question where they get that information.

I think the heart of the ethical issue that we spoke to in our work is whether they be given any misleading information, and that clearly we have taken a position would not be ethical, and certainly not that the Federal Government would be supporting the dissemination of the information that is not accurate to these teenagers in the programs.

Mr. SHAYS. I thank both of you.

Mr. SOUDER. Mr. Chairman, very briefly?

Do you favor the same policy for cigarettes, that low-tar cigarettes, that we would show kids the level of nicotine and tar in the cigarettes between the different brands so that, since a high percentage of them smoke anyway, we can give them better information on which cigarettes would be better to smoke?

Mr. SHAYS. I would do this. I would make sure they had total knowledge, because if a young person is going to smoke, then I want to make sure that they have a sense of the degrees of harm they are causing themselves, so in that answer, yes, but I would be working overtime to have them understand that it would be a pretty bad thing to smoke.

Chairman WAXMAN. Does the gentleman yield back the balance of his time?

Mr. SHAYS. I do yield back.

Chairman WAXMAN. I thank you very much. I thank the two of you for your presentation.

Without objection, we are going to keep the record open for an additional 7 days so that Members may ask all the witnesses or any of the witnesses additional questions and get a response in writing, and then others may be able to submit additional information for the record.

Thank you very much. This hearing is adjourned.

[Whereupon, at 1:50 p.m., the committee was adjourned.]

[Additional information submitted for the hearing record follows:]

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Committee on Oversight and Government Reform

Statement of
The American Association of Sexuality Educators, Counselors and Therapists
Assessing Evidence with Domestic Abstinence-Only Programs
April 23, 2008

Submitted by:

Stephen Conley, PhD
Executive Director

AASECT supports comprehensive sexuality education because it is based upon standard scientific principles and it is effective. We are pleased to see the Committee on Oversight and Government Reform of the U.S. House of Representatives continue to analyze the failures of the abstinence-only until married educational fiasco, simply because it has no evidence proving it effective in any area of youth behavior. In fact, some independent studies have found the various abstinence-only approaches to be harmful to youth (Bruckner & Bearman, 2005).

The creation of the abstinence-only programs in 1996 was done under darkness without debate in Congress in the midst of omnibus welfare reform. The program was written and designed at the Heritage Foundation, not by health educators or prevention experts, but by ideologues intent upon promoting and funding a political agenda for sympathizers who were

July 29, 2008

tangentially related to the fields of health and education. The effort succeeded in creating a program that has now wasted over \$1.5 billion in US tax dollars. When matching funds required of the states under Title V are included, the figure becomes even more astounding. It is no wonder that a dozen years down this road that more than seventeen states have decided to refuse these "funds to nowhere."

Earlier work by this committee has shown disturbing practices within a majority of these federally-financed programs. Many of the curricula used in abstinence-only programs are medically inaccurate. Many contain "false, misleading or distorted information." A 2004 investigation by the minority staff of the House Government Reform Committee reviewed 13 commonly used abstinence-only curricula taught to millions of school-age youth. The study concluded that two of the curricula were accurate but that 11 others, used by 69 organizations in 25 states, blurred religion and science, and contained unproven claims and subjective conclusions or outright falsehoods regarding the effectiveness of contraceptives, gender traits, and when life begins. Among the misconceptions and outright falsehoods:

- A 43-day-old fetus is a "thinking person."
- HIV can be spread via sweat and tears.
- Half of gay male teenagers in the United States have tested positive for HIV.
- Pregnancy can result from touching another person's genitals.
- Condoms fail to prevent HIV transmission as often as 31 percent of the time in heterosexual intercourse.
- Women who have an abortion "are more prone to suicide."
- As many as 10 percent of women who have an abortion become sterile. (Committee on Government Reform, 2004)

Abstinence-only-until-married programs are of little value to sexually active teens and, by definition, discriminate against lesbian, gay, bisexual, and transgender youth. Adolescents are often reluctant to acknowledge sexual activity, seek out contraception, and/or discuss sexuality, even in the most

open settings. Abstinence-only programs do **not** provide a much-needed forum in which sexually active adolescents can address critical issues – such as safer sex, the benefits of contraception, legal rights to health care, and ways to access reproductive health services. Instead, abstinence-only programs allow discussions only within the narrow limits developed by those who wrote the original law with its narrow definitions, and then managed to have it adopted by their supporters in Congress.

The abstinence-only initiatives also discriminate against all youth in such programs who are in nontraditional families, including single-parent households or those whose parents are gay, lesbian, bi-sexual or transgender.

When Congress originally funded the abstinence-only initiatives, no funding was included for evaluation. After considerable outcry from the public health sector expected to administer the funds, Mathematic Policy Research was granted funding to do an assessment. It took them eleven years to finally publish a very damning report.

Here a description of their findings as reported on the web by the Kaiser Family Foundation's Women's Daily Health Report:

“Abstinence-only sex education programs are not effective in preventing or delaying teenagers from having sexual intercourse, according to a report released on Friday by Mathematica Policy Research, the Washington Post reports (Sessions Stepp, *Washington Post*, 4/14). The report, which was commissioned by Congress, followed 2,057 U.S. teenagers in late elementary and middle school who participated in four abstinence programs, as well as students in the same grades who did not participate in such programs. The study was conducted in Clarksdale, Miss.; Miami; Milwaukee; and Powhatan, Va. The average age of the students who participated in abstinence education was 11 to 12 when they entered the programs in 1999, and they participated in the programs for one to three years, the AP/Boston Globe reports. The students were an average age of 16.5 when Mathematica conducted a follow-up study in 2005 and early 2006. About half of the students who received abstinence education and about half of those who did not reported that they abstained from sex, according to the study (Freking, *AP/Boston Globe*, 4/16). Teenagers who were sexually active reported having had sex for the first time when they were about 15 years old, the findings showed. More than one-third

July 29, 2008

of both groups had two or more sexual partners, the study found (*Washington Post*, 4/14). Twenty-three percent of both groups reported having had sex and always using a condom; 17% of both groups reported having had sex and only sometimes using a condom; and 4% of the students in both groups reported having had sex and never using a condom, according to the report.”
http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=44263)

With the absence of evidence of effectiveness in programs this lacking after this many years and this much funding, no programs of this type should continue to receive funding. It is time for Congress to fund effective comprehensive sexuality education that leads to healthy, positive sexual beings in our nation. Our youth deserve no less.

Thank you for the opportunity to comment.

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U.S. House of Representatives, Committee on Government Reform. The content of federally funded abstinence-only education programs, prepared for Rep. Henry A. Waxman. Washington, DC: author, 2004.

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The American Civil Liberties Union

Written Statement
For a Hearing on

Domestic Abstinence-Only Programs: Assessing the Evidence

Submitted to the House Committee on Oversight and Government Reform

Wednesday, April 23, 2008

Caroline Fredrickson, Director
ACLU Washington Legislative Office

Vania Leveille, Legislative Counsel
ACLU Washington Legislative Office

On behalf of the American Civil Liberties Union (ACLU), a nonpartisan public interest organization dedicated to protecting the constitutional rights of individuals, and its hundreds of thousands of members, activists, and 53 affiliates nationwide, we would like to thank Chairman Waxman, Ranking Member Davis, and the esteemed Committee on Oversight and Government Reform for the opportunity to submit a statement for the record of this hearing on “Domestic Abstinence-Only Programs: Assessing the Evidence.”

Since 1996, Congress has appropriated more than a billion dollars for educational programs that focus exclusively on abstinence and censor other information that can help young people make responsible, healthy, and safe decisions about sexual activity. While federal funding for abstinence-only-until marriage programs has increased steadily to more than \$176 million annually, there are no federal funds dedicated to supporting sexuality education programs that teach both abstinence and contraceptive use.

We applaud the Committee’s timely and appropriate scrutiny of abstinence-only-until-marriage programs. Scientific evidence has accumulated over the past years that casts serious doubts upon the effectiveness of these programs and calls into question the wisdom of a substantial federal investment exceeding one billion dollars. Indeed, the evidence points to but one conclusion: abstinence-only programs represent a failed and ideologically-based policy. They are not based on science or on good public health policy. Most troubling, they represent a purposeful campaign to mislead, distort, stifle and censor; they encourage a disturbing trend to politicize science; and they express a disdain for knowledge and the free exchange of ideas that stands at the heart of our democracy and historical traditions.

Let us be clear: where local communities choose to offer young people instruction and guidance about human sexuality, abstinence should be an important component of that educational program. However, federally funded programs focusing exclusively on abstinence work against good public health policy and also raise serious civil liberties concerns. Congress ought not to support programs that censor information, reinforce gender stereotypes, provide inaccurate and misleading information, promote religion in the classroom, serve a narrow ideological agenda, and jeopardize the well-being of young people. Funding for abstinence-only programs should end immediately.

Some Abstinence-Only Programs Impermissibly Promote Religion

In violation of First Amendment guarantees, some federally funded abstinence-only programs contain religious teachings about proper sexual behavior and values.

The Supreme Court has made clear that religion is impermissibly advanced, and the Constitution violated, when government aid is used to fund “specifically religious activit[ies]” even within “an otherwise substantially secular setting.” *Bowen v. Kendrick*, 487 U.S. 589,621 (1988) (internal quotation and citation omitted). Indeed, it was in *Bowen*, a case challenging the constitutionality of the Adolescent Family Life Act and its appropriation of funds for abstinence-only education, that Justice O’Connor emphasized, “any use of public funds to promote religious doctrines violates the Establishment Clause.” *Id.* at 623 (O’Connor, J. concurring).

Although federal funding guidelines do not permit abstinence-only grantees to convey overt religious messages or to impose religious viewpoints, in practice, many of these programs do precisely that. For example, in *ACLU v. Leavitt*, the ACLU showed how federal dollars were supporting an overtly religious abstinence-only program called The Silver Ring Thing, which had been awarded more than \$1 million dollars in federal money in the prior three years.

During the Silver Ring Thing's flagship three-hour program, members testified that accepting Jesus Christ improved their lives, quoted Bible passages, and urged audience members to ask the Lord Jesus Christ to come into their lives. As a result of the ACLU's lawsuit, federal officials suspended federal funding of the Silver Ring Thing. And, in February 2006, the ACLU announced a settlement with HHS, under which HHS agreed that it would not fund the program as currently structured.

Most recently, in May 2007, the ACLU expressed concern to HHS about the misuse of abstinence-only funds by two grantees funded by the federal Community Based Abstinence Education Program (CBAE). Specifically, one Oregon grantee created the *Stop and Think* abstinence program and contracted with another grantee to teach the program in various venues across the country. In order to use the program, the second grantee had to sign a contract containing the following conditions:

- 1) The presenter and supervisor
 - a) possess an authentic relationship with Jesus Christ
 - b) possess knowledge of the word of God, and the ability to communicate it's [sic] truth
 - c) exhibit a loving and merciful spirit
 - d) attend a Bible believing local church or fellowship

This contract was provided to HHS as part of the second grantee's application for CBAE funding. Moreover, an advertisement by one of the grantees for a full-time abstinence director "responsible for overall implementation of the *Stop & Think* [program]" directed applicants to send a resume and "letter of Christian testimony."

A direct grant of government dollars violates the Constitution when it is used to fund specifically religious activities. In the cited circumstances, one grantee required, and another agreed, that all presenters of the federally funded *Stop and Think* program hold particular religious beliefs. Additionally, proselytization was an essential component of the *Stop and Think* program and the program contained religious or sectarian messages. As a result of the ACLU's complaint, HHS conducted investigations of both grantees and reported that the Oregon grantee would require "all abstinence education program staff to sign a statement of understanding that they may not proselytize while working with any federally funded program." In addition, HHS found that though the other grantee, which had been organizing "purity balls," "took steps to separate [religious and non-religious] programs, the separation between the two events could in the future be strengthened."

Abstinence-only Programs Censor Information

Statistics reveal that teens need information about contraception and sexual health: nearly two-thirds of all high school seniors in the U.S. have had sexual intercourse; approximately 822,000 pregnancies occurred among 15-19 year old women in 2000; and each year, approximately 9.1 million 15-24 year olds are infected with sexually transmitted infections.

However, recipients of abstinence-only funds are censored in the information they can provide to students. Federal funding can be used solely to offer programs with the “exclusive purpose” of teaching the benefits of abstinence programs. In the context of these programs, grantees may not provide a participating adolescent with any information that is inconsistent with the narrow eight-point definition of abstinence-only education. These programs thus leave teens without information critical to protecting their health and preventing pregnancy.

The government’s mandate thus censors the transmission of vital information about human sexuality and reproduction. And in the schools, this funding serves to force many teachers to avoid providing educational information they consider valuable to teens. A 1999 nationally representative survey of 7th-12th grade teachers in the five specialties most often responsible for sex education found that a strong majority believed sexuality education courses should cover birth control methods (93.4%), factual information about abortion (89%), where to go for birth control (88.8%), the correct way to use a condom (82%), and sexual orientation (77.8%), among other topics.

The federal government should not censor educational programs concerning the communication of vital information to young people.

Abstinence-only Programs Provide Inaccurate and Misleading Information

Many federally funded abstinence-only programs present teens with inaccurate information. A study conducted by the House of Representatives Committee on Government Reform found that 11 of the 13 abstinence-only curricula used by CBAE programs “contain major errors and distortions about public health information,” including HIV and other STD prevention, pregnancy prevention, and condom effectiveness. The problems have not gone away.

Most recently, the ACLU conducted investigations into HHS violations of a federal law relating to medical accuracy of educational materials. Specifically, by letter dated April 25, 2007, the ACLU called on HHS to take immediate action to remedy its ongoing violations of 42 U.S.C. § 247b-17(c)(2), a federal statute that requires that a broad category of educational materials must include medically accurate information about the effectiveness of condoms in preventing STDs.

In that letter, and other supporting documents, we addressed a number of abstinence-only materials that are covered by 247b-17(c)(2), but failed to meet its requirements. Instead, they omitted vital information about condom effectiveness and contained inaccuracies suggesting that condoms fail to protect against infection, when in fact they are highly effective at doing so. Following that initial complaint, the ACLU communicated over the course of several months

with officials at ACF in order to ensure that particularly problematic curricula identified in its letter were either corrected or no longer funded. While the entity that produced one of those curricula, *Teen-Aid Inc.*, is no longer a CBAE grantee, the other, *Why kNOw*, continues to receive federal funds. Some improvements to the *Why kNOw* materials were made after our complaint. But, as we have advised HHS, serious inaccuracies remain—despite HHS’s assurances that it reviews for, and demands, medical accuracy in all grantees’ educational materials. Thus, it is clear that HHS is unable, or simply unwilling, to ensure that abstinence-only grantees satisfy minimum standards of scientific and medical accuracy.

Congress should not support the dissemination of medically inaccurate and misleading information. Rather, it should fund programs that provide teens with medically accurate and complete information about abstinence as well as contraceptives.

Abstinence-Only Programs are Ineffective

There is no conclusive evidence that abstinence-only programs, which teach students to abstain from sex until married and generally only teach about contraceptive failure, reduce the rate of unintended pregnancy or STDs.

Moreover, studies show that most abstinence-only programs do not help teens delay having sex, and some show evidence that these programs actually deter teens who become sexually active from protecting themselves from unintended pregnancy or STDs.

In April 2007, a long-awaited study by Mathematica Policy Research Inc., on behalf of HHS, showed that abstinence-only programs don’t work. This congressionally commissioned study, *Impacts of Four Title V, Section 510 Abstinence Education Programs*, evaluated several federally funded programs and found that teens who participated in them were just as likely to have sex as teens who did not participate. Specifically, the report concluded that, “[f]indings indicate that youth in the program group were no more likely than control group youth to have abstained from sex and, among those who reported having had sex, they had similar numbers of sexual partners and had initiated sex at the same mean age.”

In light of recent research highlighting the lack of medical accuracy of these programs, and at a time when the Administration emphasizes accountability in funding only programs with demonstrated success, the continued funding of unproven programs is deeply troubling.

Many Abstinence-Only Programs are Hostile to Gay and Lesbian Youth

Federally funded abstinence-only programs marginalize gay and lesbian students and stigmatize homosexuality by requiring programs to teach that a “mutually faithful monogamous relationship in [the] context of marriage is the expected standard of human sexual activity.” Such a message rejects the idea of sexual intimacy for lesbians and gays, ignores their need for critical information about protecting themselves from STDs in same-sex relationships, and creates a hostile learning environment.

Indeed, a study of Ohio abstinence-only programs concluded, “one of the greatest flaws of abstinence programs is their inherent exclusion of [lesbian, gay, bisexual, and transgender] youth.” A recent review of the leading abstinence-only curricula found that most address same-sex sexual behavior only within the context of promiscuity and disease, and several are overtly hostile to lesbians and gay men.

For example, in its parent-teacher guide, an abstinence-only program called “Facing Reality” instructs educators to teach students that homosexuals with AIDS are now suffering for the “choices” they made regarding their sexual orientation. Materials from an abstinence-only program used recently in Alabama state that “same sex ‘union’ cannot provide an adequate means of achieving a genuine physical relationship with another human being because this type of ‘union’ is contrary to the laws of nature.”

By positioning sexual relations within a heterosexual marriage as the “standard” for sexual activity and teaching that STDs are a form of moral punishment for homosexuality, abstinence-only programs undermine efforts to educate students about protecting their health and create a hostile learning environment for lesbian and gay students or the children of lesbian, gay and/or single parents.

Federal funding of such programs should not be tolerated.

Conclusion

The ACLU applauds the Committee’s examination of abstinence-only programs and urges continued action to bring this failed policy to an end.



Statement of

Kenneth Noller, MD, FACOG
President, American College of Obstetricians and Gynecologists (ACOG)

Hearing on
Abstinence-Only Education Programs
Submitted for the Hearing Record

House Committee on Oversight and Government Reform

April 23, 2008

Chairman Waxman, Ranking Member Davis, and members of the Committee, thank you for holding this hearing. I am submitting this statement on behalf of the American College of Obstetricians and Gynecologists (ACOG), representing 51,000 physicians and partners in women's health.

Sexual development and sexual health are integral parts of human health and development. As such, sexuality education is a necessary part of comprehensive health education, the goal of which is to help children and adolescents become healthy adults with responsible health behaviors. Sexuality education is often a part of "family life education," which encompasses a broad range of topics that prepare young people for marriage, parenthood, and family responsibilities.

Despite fears to the contrary, careful and objective scholarly research during the last two decades has shown that sexuality education does not increase rates of sexual activity among teenagers. Rather, sexuality education increases knowledge about sexual behavior and its consequences and increases prevention behaviors among those who are sexually active.

Sexuality education/family life education is valuable in its ability to truthfully educate young people about sex and its risks, to provide them with knowledge to protect themselves from unwanted pregnancy and sexually transmitted diseases, including HIV infection. Young people must have accurate and sufficient information to make responsible choices and to become responsible adults. Teaching correct information about sexuality or any other topic in school does not prevent any parent from teaching and modeling values and expectations in the home, rather it should assist parents in providing opportunities for family communication.

ACOG long has supported comprehensive, age-appropriate sexuality education for children of all ages.

Medically Accurate and Scientific-Based Curricula

Abstinence-only programs restrict information about condoms and contraception — critical information that protects the health of young people and can prevent unplanned pregnancy, HIV infection, and other sexually transmitted diseases. Withholding lifesaving information from young people is unacceptable.

A 2004 report by the House Committee on Government Reform, requested by Congressman Henry Waxman, found that many federally-funded abstinence-only programs distort public health data and misrepresent the effectiveness of contraception. The report found instances where programs erroneously stated that 5% to 10% of women who have legal abortions will become sterile, denied condoms help prevent the spread of STDs, and suggested that sweat and tears are risk factors for HIV transmission. All federally-funded sexuality education, family life education, abstinence education, comprehensive health education and character education programs should provide medically accurate information. Anything less leaves young people vulnerable to unintended pregnancy and STDs.

An October 2006 GAO report corroborates Waxman's finding. GAO found that HHS is not reviewing all abstinence-only programs for scientific accuracy or requiring that state grant recipients review materials. Of the materials that have been reviewed, some contain serious inaccuracies, such as suggesting that HIV can pass through condoms because latex is porous.

The inaccuracies found in some abstinence-only curricula severely undermine adolescent health. It is essential that programs funded by Congress and introduced into school are medically and scientifically accurate. Anything less leaves young people vulnerable to unintended pregnancy and STDs.

Comprehensive Sexuality Education is Needed to Combat Teen Pregnancy and STDs

The most comprehensive and authoritative study to date on abstinence-only programs has shown that they have no impact. An April 2007 multi-year, experimentally-based impact study conducted by Mathematica Policy Research for the U.S. Department of Health and Human Services found that abstinence-only programs supported by Title V, Sec. 510 had no impact. Youth in abstinence-only education programs were no more likely to have abstained from sex than those in a control group with no sexuality education. Among those who reported having sex, they had a similar number of sexual partners, initiated sex at the same age, had the same rates of unprotected sex, and had the same level of knowledge on unprotected sex risks and the consequences of STDs. The Mathematica Policy Research study is especially important today with the new study released by the Centers for Disease Control and Prevention that found 1 in 4 teenage girls have a sexually transmitted disease.

Conversely, comprehensive sex education programs have shown positive effects. According to a report by the National Campaign to Prevent Teen Pregnancy, *Emerging Answers 2007 Research Findings on Programs to Reduce Teen Pregnancy*, found that two-thirds of the 48 comprehensive programs that supported both abstinence and the use of condoms and contraceptives for sexually active teens had positive behavioral effects. Specifically, over 40% of the programs delayed the initiation of sex, reduced the number of sexual partners, and increased condom or contraceptive use; almost 30% reduced the frequency of sex (including a return to abstinence); and more than 60% reduced unprotected sex. Furthermore, nearly 40% of the programs had positive effects on more than one of these behaviors.

Emerging Answers 2007 clearly showed that comprehensive sex and HIV education programs did not increase sexual activity, hasten the onset of sex, increase the frequency of sex, or increase the number of sexual partners. To the contrary, some sex and HIV education programs delay the onset of sex, reduce the frequency of sex, or reduce the number of sexual partners. The study found that the two most important messages for an effective program are: (1) being clearly focused on sexual behavior and contraceptive use; and (2) delivering a clear message about abstaining from sex as the safest choice for teens and using protection against STDs and pregnancy if a teen is sexually active.

Dedicated Funding for Comprehensive Sex Education

ACOG firmly believes that sexuality education should promote age-appropriate and scientifically accurate information about the effective use of contraception, as part of a comprehensive sexuality education curriculum. ACOG proposes funding comprehensive sexuality education at the federal level to respond to the approximately 750,000 teen pregnancies every year, including the 82% of those unintended teen pregnancies. With the research showing that eighty-six percent of the decline in cases of teen pregnancy from 1995-2002 was attributed to the use of contraception, ACOG believes that providing a federal program for comprehensive sexuality education is paramount for our nation's public health.

Unfortunately, there are no federal programs dedicated to supporting comprehensive sexuality education, yet there are three federal programs dedicated to funding abstinence-only education. With growing discontent from the public in regards to unproven abstinence-only education programs, which includes 17 states rejecting Title V funding and 82% of adults supporting programs that teach students about both abstinence and other methods of preventing pregnancy and sexually transmitted diseases, it is time to shift the funding to more appropriate sources like comprehensive sexuality education programs.



Comprehensive Sexuality Education

Evidence on the Value of Factual and Scientific-Based Curricula

April 2008

Sexuality education is a major component of comprehensive health education, the goal of which is to help children and adolescents avoid teen pregnancies and become healthy adults with responsible health behaviors. ACOG supports promoting abstinence from sexual intercourse as the preferred responsible behavior for adolescents, supports comprehensive sex education that includes age appropriate curriculum and medically accurate information about contraception.

Careful and objective scholarly research during the last two decades has shown that comprehensive sexuality education does not increase rates of sexual activity among teenagers. Rather, it promotes prevention behaviors among sexually active young people by giving them factual information about the consequences of sexual behavior.

Sexuality education, sometimes included in family life education, helps teenagers postpone sexual activity in a number of ways. Comprehensive sexuality education helps teens develop skills to resist pressures to become sexually active; provides training in decision-making skills related to dating, sexuality, contraception, abortion, childbearing, and parenthood; and helps them understand that abstinence from intercourse is the surest way to prevent STDs and pregnancy.

ACOG Supports Comprehensive Sexuality Education Programs that:

- Encourage parental involvement in their children's sexuality education.
- Promote healthy lifestyles for adolescents and their families.
 - Promoting abstinence from sexual intercourse as the preferred responsible behavior for adolescents;
 - Increasing rates of effective use of contraceptives, including condoms, by sexually active adolescents; and
 - Supporting increased availability of confidential reproductive health services, including family planning and services for the prevention, diagnosis, and/or treatment of STDs.
- Provide scientifically accurate information about sexuality, STDs, contraception, and preventive health care.
- Ensure ongoing rigorous evaluation of the effectiveness of all sexuality education programs to determine their effect on sexual behavior and on unintended pregnancy and abortion rates.

Current Federal Funding

- There are no federal programs dedicated to supporting comprehensive sexuality education. The three federal abstinence-only education programs are Community-Based Abstinence Education (CBAE), Title V, Section 510(b) of the Social Security Act (Title V), and Adolescent Family Life Act (AFLA). In Fiscal Year 2008, CBAE was funded at \$113 million, Title V at \$50 million, and AFLA at \$13 million.

Rates of Teen Pregnancy and STDs Must be Reduced

- There are approximately 750,000 teen pregnancies every year, and 82% of which are unintended.¹

- 86% of the decline in teen pregnancy from 1995-2002 is due to increased use of contraceptives, 14% is attributed to teens delaying sex or having sex less often.²
- A study by the Centers for Disease Control and Prevention (CDC) found that 1 in 4 teenage girls have a sexually transmitted disease.³

Abstinence-Only Education is Ineffective

- **The most comprehensive and authoritative studies to date show that abstinence-only programs do not accomplish their goals.** An April 2007 multi-year, experimentally-based impact study conducted by Mathematica Policy Research for the U.S. Department of Health and Human Services found that abstinence-only programs supported by Title V, Sec. 510 had no impact. Youth in abstinence-only education programs were no more likely to have abstained from sex than those in a control group with no sexuality education. Those who reported having sex had a similar number of sexual partners, initiated sex at the same age, had the same rates of unprotected sex, and had the same level of knowledge on unprotected sex risks and the consequences of STDs as the control group.⁴
- A study of Postponing Sexual Involvement (PSI) in Atlanta, Georgia measured the impact of an “abstinence-plus” intervention that combined abstinence and a discussion of contraception, and found that the programs delayed the initiation of sex. When PSI was implemented in California as an abstinence-only program, without the unit on contraception, a rigorous evaluation found that it did not delay the initiation of sex.⁵
- **Despite grant requirements, many abstinence-only programs fail to conduct a rigorous review of their programs’ effectiveness.** An October 2006 Government Accountability Office (GAO) report found that the reviewed programs have not met the minimum scientific criteria to draw valid conclusions.⁶

Comprehensive Sexuality Education Works

- According to a report by the National Campaign to Prevent Teen Pregnancy, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, a large body of research clearly showed that sex and HIV education programs can delay the onset of teen sex, reduce the frequency of sex, or reduce the number of sexual partners. The programs did not increase sexual activity – they did not hasten the onset of sex, increase the frequency of sex, or increase the number of sexual partners.
 - The study found that the two most important messages for an effective program are: (1) being clearly focused on sexual behavior and contraceptive use; and (2) delivering a clear message about abstaining from sex as the safest choice for teens and using protection against STDs and pregnancy if a teen is sexually active.⁷
- *Emerging Answers 2007* found that two-thirds of the 48 comprehensive programs that supported both abstinence and the use of condoms and contraceptives for sexually active teens had positive behavioral effects. Specifically, over 40% of the programs delayed the initiation of sex, reduced the number of sexual partners, and increased condom or contraceptive use; almost 30% reduced the frequency of sex, including a return to abstinence; and more than 60% reduced unprotected sex. Nearly 40% of the programs had positive effects on more than one of these behaviors.⁸
- An April 2008 national study assessed the impact of formal sexuality education programs on teen sexual health. The study found that comprehensive sexuality education programs were significantly associated with reducing the risk of teen pregnancy. Comprehensive sexuality programs were also marginally associated with a decreased likelihood of becoming sexually active. In contrast, the study found that abstinence-only programs had no significant impact on delaying the initiation of sexual activity or reducing the risk for teen pregnancy and STDs.⁹

Medically Accurate and Scientific-Based Curricula

- A 2004 report by the House Committee on Government Reform, requested by Congressman Henry Waxman, found that many federally-funded abstinence-only programs distort public health data and misrepresent the effectiveness of contraception.¹⁰ The report found instances where programs erroneously stated that 5% to 10% of women who have legal abortions will become sterile, denied condoms help prevent the spread of STDs, and suggested that sweat and tears are risk factors for HIV transmission. All federally-funded sexuality education, family life education, abstinence education, comprehensive health education and character education programs should provide medically accurate information. Anything less leaves young people vulnerable to unintended pregnancy and STDs.¹¹
- An October 2006 GAO report backed up Waxman's findings, showing that HHS does not review abstinence-only programs for scientific accuracy or review grant-recipient materials. In reviewing some program materials, GAO found serious inaccuracies, such as suggestions that HIV can pass through condoms.¹²

States Refuse Abstinence-Only Funding

- At least 17 states have explicitly rejected funding for federal abstinence-only education or are not expected to apply for Title V, Section 510 funds because of the strict abstinence-only rules that they must follow.¹³ These rules require programs to adhere to a strict eight-point definition of abstinence-only education. The curriculum's exclusive purpose must be "teaching the social, psychological, and health gains to be realized by abstaining from sexual activity." They must also teach that "sexual activity outside of marriage may have harmful psychological and physical effects." The programs may not discuss contraceptives, except in the context of failure rates.¹⁴
- Arizona Governor Janet Napolitano said that she accepted Title V abstinence-only funding in previous years "in part to see whether it worked," but added that every recent study has shown that abstinence-only programs do not delay the onset of sexual behavior or decrease teen pregnancy rates. Napolitano said she believes in education that "strongly promotes abstinence" but will only accept federal funding again if it can be used for a "curriculum that provides comprehensive and medically accurate sexuality education."
- New York State Health Commissioner Dr. Richard F. Daines stated, "The Bush administration's abstinence-only program is an example of a failed national healthcare policy directive..." and that the policy was "...based on ideology rather than on sound scientific-based evidence that must be the cornerstone of good public healthcare policy."

The Public Supports Comprehensive Sexuality Education

- 93% of parents of junior high school students and 91% of parents of high school students believe that it is very important or somewhat important to have sexuality education as part of the school curriculum.¹⁵
- 95% of parents of junior high school students and 93% of parents of high school students believe that birth control and methods of preventing pregnancy are appropriate topics for middle school and high school students.¹⁶
- 82% of adults support programs that teach students about both abstinence and other methods of preventing pregnancy and sexually transmitted diseases.¹⁷
- 72% of parents of junior high school students and 65% of parents of high school students believe that federal government funding "should be used to fund more comprehensive sexuality education programs that include information on how to obtain and use condoms and other contraceptives."¹⁸

- ¹ Guttmacher Institute, *U.S. Teenage Pregnancy Statistics: National and State Trends and Trends by Race and Ethnicity*, 2006, <<http://www.guttmacher.org/pubs/2006/09/11/USTPstats.pdf>>, accessed Nov. 20, 2007; Finer LB et al., Disparities in rates of unintended pregnancy in the United States, 1994 and 2001, *Perspectives on Sexual and Reproductive Health*, 2006, 38(2):90–96.
- ² Santelli JS et al., Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use, *American Journal of Public Health*, 2007, 97(1):1–7.
- ³ Sara Forhan, MD, CDC. John Douglas Jr., MD, director, CDC division of STD prevention. Elizabeth Alderman, MD, Children's Hospital at Montefiore, New York, chairwoman, Executive Committee, Section of Adolescent Health, American Academy of Pediatrics.
- ⁴ Christopher Trenholm et al., *Impacts of Four Title V, Section 510 Abstinence Education Programs*, Princeton: Mathematica Policy Research, Inc., April 2007.
- ⁵ Kirby D. Do Abstinence-Only Programs Delay the Initiation of Sex Among Young People and Reduce Unintended Pregnancy? National Campaign to Prevent Teen Pregnancy; October 2002.
- ⁶ GAO — Government Accountability Office. (2006a). *Abstinence Education: Efforts to Assess the Accuracy and Effectiveness of Federally Funded Programs*. Washington, DC: Government Accountability Office.
- ⁷ Kirby D. Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy: National Campaign to Prevent Teen Pregnancy; May 2001.
- ⁸ Kirby D. Emerging Answers 2007: National Campaign to Prevent Teen Pregnancy; November 2007.
- ⁹ Kohler PK, Manhart LE, Lafferty WE. Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *J Adolesc Health* 42(4), 2008.
- ¹⁰ U.S. House of Representatives Committee on Government Reform, Minority Staff Special Investigations Division, *The Content of Federally Funded Abstinence-Only Education Programs*, prepared for Representative Henry A. Waxman, December 2004.
- ¹¹ U.S. House of Representatives Committee on Government Reform, Minority Staff Special Investigations Division, *The Content of Federally Funded Abstinence-Only Education Programs*, prepared for Representative Henry A. Waxman, December 2004.
- ¹² GAO — Government Accountability Office. (2006a). *Abstinence Education: Efforts to Assess the Accuracy and Effectiveness of Federally Funded Programs*. Washington, DC: Government Accountability Office.
- ¹³ Stein, Rob. "Abstinence Programs Face Rejection." *The Washington Post*. Sunday December 16, 2007: A03.
- ¹⁴ SIECUS, *A Brief History of Abstinence-Only-Until Marriage Funding*, 2005 <<http://www.nomoremoney.org/history.html>>, accessed January 7, 2008.
- ¹⁵ *Sex Education in America: General Public/Parents Survey* (Washington, DC: National Public Radio, Kaiser Family Foundation, Kennedy School of Government, 2004).
- ¹⁶ *Sex Education in America: General Public/Parents Survey* (Washington, DC: National Public Radio, Kaiser Family Foundation, Kennedy School of Government, 2004).
- ¹⁷ Bleakley A, Hennessy M, Fishbein M. Public opinion on sex education in US schools. *Arch Pediatr Adolesc Med*. 2006;160:1151-1156.
- ¹⁸ *Sex Education in America: General Public/Parents Survey* (Washington, DC: National Public Radio, Kaiser Family Foundation, Kennedy School of Government, 2004).



Executive Summary

Science and Success, Second Edition: Sex Education and Other Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections

Until recently, teen pregnancy and birth rates had declined in the United States. Despite these declines, US teen birth and sexually transmitted infection (STI) rates remain among the highest in the industrialized world. Given the need to focus limited prevention resources on effective programs, Advocates for Youth undertook exhaustive reviews of existing research to compile a list of those programs proven effective by rigorous evaluation. Nineteen programs appeared in *Science and Success* when it was first published in 2003; seven additional programs are included in *Science and Success, Second Edition*.

Criteria for Inclusion—The programs included in this document all had evaluations that:

- Were published in peer-reviewed journals (a proxy for the quality of the evaluation design and analysis);
- Used an experimental or quasi-experimental evaluation design, with treatment and control / comparison conditions;
- Included at least 100 young people in treatment and control / comparison groups.

Further, the evaluations either:

- Continued to collect data from both groups at three months or later after intervention

And

- Demonstrated that the program led to at least two positive behavior changes among program youth, relative to controls:
 - Postponement or delay of sexual initiation;
 - Reduction in the frequency of sexual intercourse;
 - Reduction in the number of sexual partners / increase in monogamy;
 - Increase in the use, or consistency of use, of effective methods of contraception and/or condoms;
 - Reduction in the incidence of unprotected sex.

Or:

- Showed effectiveness in reducing rates of pregnancy, STIs, or HIV in intervention youth, relative to controls.

Program Effects—Twenty-six programs met the criteria described above. These 26 programs were able to affect the behaviors and/or sexual health outcomes of youth exposed to the program.

Risk Avoidance Through Abstinence—Fourteen programs demonstrated a statistically significant delay in the timing of first sex among program youth, relative to comparison / control youth. One of these programs is an intervention for elementary school children and their parents. The other 13 programs target middle and high school youth and all include information about both abstinence and contraception, among other topics and/or services. (See Table A, Page 3-4)

Risk Reduction for Sexually Active Youth—Many of the programs also demonstrated reductions in other sexual risk-taking behaviors among participants relative to comparison / control youth. (See Table A, Page 3-4)

- 14 programs helped sexually active youth to increase their use of condoms.
- 9 programs demonstrated success at increasing use of contraception other than condoms.
- 13 programs showed reductions in the number of sex partners and/or increased monogamy among program participants.
- 7 programs assisted sexually active youth to reduce the frequency of sexual intercourse.
- 10 programs helped sexually active youth to reduce the incidence of unprotected sex.

Reduced Rates of Teenage Pregnancy or Sexually Transmitted Infections—Thirteen programs showed statistically significant declines in teen pregnancy, HIV or other STIs. Nine demonstrated a statistically significant impact on teenage pregnancy among program participants and four, a reduced trend in STIs among participants when measured against comparison / control youth. (See Table A, Page 3-4)

Increased Receipt of Health Care or Increased Compliance with Treatment Protocols—Six programs achieved improvements in youth's receipt of health care, and/or compliance with treatment protocols. (See Table A, Page 3-4)

Program Content—Of the 26 effective programs described here, 23 included information about abstinence *and* contraception within the context of sexual health education. Of the three that did not include sexual health education, two were early childhood interventions and one was a service-learning program.

Following is a brief description of each of the 26 programs. For more detailed descriptions, please see *Science and Success, Second Edition*, Advocates for Youth, 2008, or visit www.advocatesforyouth.org/programsthatwork/.

Table A. Effective Programs: Impact on Adolescents' Risk for Pregnancy, HIV & STIs

School-Based Programs
 Community-Based Programs
 Clinic-Based Programs

	<i>Delayed Initiation of Sex</i>	<i>Reduced Frequency of Sex</i>	<i>Reduced Number of Sex Partners</i>	<i>Increased Monogamy</i>	<i>Reduced Incidence of Unprotected Sex</i>	<i>Increased Use of Condoms</i>	<i>Increased Use of Contraception</i>	<i>Increased Use of Sexual Health Care: Treatment Compliance</i>	<i>Reduced Incidence of STIs</i>	<i>Decreased Number or Rate of Teen Pregnancy: Birth</i>
1. AIDS Prevention for Adolescents in School			★	★		★			★	
2. Get Real about AIDS			★			★				
3. Postponing Sexual Involvement (Augmenting a Five-Session Human Sexuality Curriculum)	★	★					★			
4. Postponing Sexual Involvement: Human Sexuality & Health Screening	★						★			
5. Reach for Health Community Youth Service	★	★				★	★			
6. Reducing the Risk	★				★		★			
7. Safer Choices	★				★	★	★	★		
8. School / Community Program for Sexual Risk Reduction among Teens	★					★				★
9. Seattle Social Development Project	★		★			★				★
10. Self Center (School-Linked Reproductive Health Care)	★				★		★	★		★
11. Teen Outreach Program										★
12. Abecedarian Project										★
13. Adolescents Living Safely: AIDS Awareness, Attitudes & Actions		★	★			★				

Note: Blank boxes indicate either 1) that the program did not measure nor aim at this particular outcome/impact or 2) that the program did not achieve a significant positive outcome in regard to the particular behavior or impact.

Table A. Effective Programs: Impact on Adolescents' Risk for Pregnancy, HIV & STIs

School-Based Programs
 Community-Based Programs
 Clinic-Based Programs

	<i>Delayed Initiation of Sex</i>	<i>Reduced Frequency of Sex</i>	<i>Reduced Number of Sex Partners</i>	<i>Increased Monogamy</i>	<i>Reduced Incidence of Unprotected Sex</i>	<i>Increased Use of Condoms</i>	<i>Increased Use of Contraception</i>	<i>Increased Use of Sexual Health Care Treatment Compliance</i>	<i>Reduced Incidence of STIs</i>	<i>Decreased Number or Rate of Teen Pregnancy / Birth</i>
14. Be Proud! Be Responsible!		★	★			★				
15. Becoming a Responsible Teen	★	★			★	★				
16. California's Adolescent Sibling Pregnancy Prevention Project	★						★			★
17. Children's Aid Society – Carrera Program	★					★	★	★		★
18. Community-level HIV Prevention for Adolescents in Low-Income Developments	★					★				
19. Cudate!		★	★		★	★				
20. Making Proud Choices!	★	★			★	★				
21. Poder Latino: Community AIDS Prevention Program for Inner-City Latino Youth	★		★							
22. HIV Risk Reduction for African American & Latina Adolescent Women			★		★				★	
23. Project SAFE: Sexual Awareness for Everyone			★	★	★			★	★	
24. SHLE			★		★	★			★	★
25. Tailoring Family Planning Services to the Special Needs of Adolescents							★	★		★
26. TLC: Together Learning Choices			★		★			★		

Note: Blank boxes indicate either 1) that the program did not measure nor aim at this particular outcome/impact or 2) that the program did not achieve a significant positive outcome in regard to the particular behavior or impact.

I. School Based Programs

1. AIDS Prevention for Adolescents in School

This HIV/STI prevention curriculum comprises six sessions, delivered on consecutive days, and includes experiential activities to build skills in refusal, risk assessment, and risk reduction. It is recommended for use with African American, Hispanic, white, and Asian high school students in urban settings. *Evaluation found that this program assisted sexually experienced participants to increase monogamy, reduce the number of their drug-using sexual partners, and increase condom use. The program had no significant effect on delaying the initiation of sex. Evaluation found the program to be associated with a favorable trend in the incidence of STIs among participants, relative to controls.*¹

For More Information or to Order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

2. Get Real about AIDS

This HIV risk reduction curriculum comprises 15 sessions delivered over consecutive days. It includes experiential activities to build skills in refusal, communication, and condom use. Other components include activities, such as public service announcements, to reach more youth and reinforce educational messages. It is recommended for use with sexually active, white and Hispanic, urban, suburban, and rural, high school students. *Evaluation found that the program assisted sexually active participants to reduce the number of their sexual partners, increase condom use, and increase condom purchase. The program did not affect the timing of sexual initiation. It did not reduce the frequency of sex among sexually active youth nor their use of drugs and alcohol prior to having sex.*²

For More Information or to Order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

3. Postponing Sexual Involvement (Augmenting a Five-Session Human Sexuality Curriculum)

This five-session, peer-led curriculum is designed to augment a five-session human sexuality curriculum led by health professionals, who also refer sexually active youth for nearby reproductive health care. It is recommended for use with eighth grade, black urban youth, especially those at socioeconomic disadvantage. *Evaluation showed delayed initiation of sexual intercourse and, among sexually experienced participants, reduced frequency of sex and increased use of contraception. When replicated without fidelity (including omission of the five-session human sexuality curriculum), the program led to no changes in sexual behavior among participants relative to comparison youth.*^{3,4,5}

For More Information or to Order Postponing Sexual Involvement to Augment Human Sexuality Education, Contact

- **Marian Apomah, Coordinator, Jane Fonda Center; Emory University School of Medicine:** Building A Briarcliff Campus, 1256 Briarcliff Road, Atlanta, GA, 30306; Phone, 404.712.4710; Fax, 404.712.8739

4. Postponing Sexual Involvement, Human Sexuality & Health Screening

This pregnancy prevention program combines the five-session, peer-led *Postponing Sexual Involvement* curriculum with elements drawn from the *Self Center* (described below), and includes: three classroom sessions on reproductive health, delivered to seventh graders by health professionals and, again the next year, to eighth graders; group discussions; and a full-time health professional from outside the school and working in the school. Other components of the program include individual health risk screening and an eighth grade assembly and contest. The program is recommended for seventh and eighth grade, urban, African American, economically disadvantaged females. *Evaluation found that the program assisted female participants to delay initiation of sexual intercourse and increased the use of contraception by sexually active female participants. Evaluation found no statistically significant impact on the sexual behaviors of male participants.*⁶

For More Information or to Order, Contact

- **Renee R. Jenkins, MD, Dept. of Pediatrics and Child Health, Howard University Hospital:** 2041 Georgia Avenue NW, Washington, DC 20060
- **For Postponing Sexual Involvement—Marian Apomah, Coordinator, Jane Fonda Center; Emory University School of Medicine:** Building A Briarcliff Campus, 1256 Briarcliff Road, Atlanta, GA, 30306; Phone, 404.712.4710; Fax, 404.712.8739
- **For the Self Center—Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

5. Reach for Health Community Youth Service

This program combines a health promotion curriculum (40 lessons per year in each of two years), including sexual health information, with three hours per week of community service. Activities help students reflect on and learn from their community experience. The program is recommended for use with seventh and eighth grade, urban, black, and Hispanic youth, especially those who are economically disadvantaged. *Evaluation showed delayed initiation of sexual intercourse, an effect that continued even through 10th grade. The program also assisted sexually active participants in reducing the frequency of sex and increasing use of condoms and contraception.*^{7,8}

For More Information or to Order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

6. Reducing the Risk (RTR)

Reducing the Risk is a sex education curriculum, including information on abstinence and contraception. In 16, 45-minute sessions, it offers experiential activities to build skills in refusal, negotiation, and communication, including that between parents and their children. Designed for use with high school students, especially those in grades nine and 10, it is recommended for use with sexually inexperienced, urban, suburban, and rural youth—white, Latino, Asian, and black. *Evaluation showed that it was more effective with lower risk, than with higher risk, youth. Evaluations—of the original program and of a replication of the program—each found: increased parent-child communication about abstinence and contraception; delayed initiation of sexual intercourse; and reduced incidence of unprotected sex / increased use of contraception among participants as well.*^{9,10}

For More Information or to Order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>
- **ETR Associates:** Phone, 1.800.321.4407; Fax, 1.800.435.8433; Web, <http://www.etr.org/>

7. Safer Choices

This is an HIV/STI and teen pregnancy prevention curriculum, given in 20 sessions, evenly divided over two years and designed for use with grades nine through 12. The program includes experiential activities to: build skills in communication; delay the initiation of sex; and promote condom use by sexually active participants. Other elements include a school health protection council, a peer team or club to host school-wide activities, educational activities for parents, and HIV-positive speakers. The program is recommended for use with Hispanic, white, African American, and Asian, urban and suburban high school students. *A new evaluation showed that Safer Choices effectively assisted sexually inexperienced youth, especially Hispanics, to delay the initiation of sexual intercourse. It assisted sexually experienced youth to reduce the number of new sex partners, reduce the incidence of unprotected sex, and increase use of condoms and other contraception. Earlier evaluation showed that Safer Choices assisted sexually experienced youth to increase condom and contraceptive use. Earlier evaluation also showed that hearing an HIV-positive speaker was associated with participants' greater likelihood of receiving HIV testing, relative to control youth.*^{11,12,13,14}

For More Information or to Order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>
- **ETR Associates:** Phone, 1.800.321.4407; Fax, 1.800.435.8433; Web, <http://www.etr.org>

8. School/Community Program for Sexual Risk Reduction among Teens

This intensive, school-based intervention integrates sex education into a broad spectrum of courses throughout public education (kindergarten through 12th grade). It includes teacher training, peer education, school-based health clinic services (including contraceptive provision), referral and transportation to community-based reproductive health care, workshops to develop the role modeling skills of parents and community leaders, and media coverage of a spectrum of health topics. The program is recommended for use with black and white rural students (kindergarten through 12th grade). *Evaluation found that this program reduced teen pregnancy rates in the participating community relative to comparison counties. Replication in two counties in another state found that it assisted youth in one county to delay the initiation of sexual intercourse and assisted males in another county to increase their use of condoms, relative to youth in comparison counties.*^{15,16,17}

For More Information or to Order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

9. Seattle Social Development Project

This is a school-based program to provide developmentally appropriate, social competence training to elementary school children. Components include educator training each year and voluntary parenting classes on encouraging children's developmentally appropriate social skills. The program is recommended for use with urban, socio-economically disadvantaged children—white, Asian, and Native American, but especially African American—in grades one through six. *Evaluation when study participants were age 18, and again when they reached 21, found that the program assisted youth who participated in the program as children to significantly delay the initiation of sexual intercourse and, among sexually experienced youth, to reduce the number of sexual partners and increase condom use, relative to comparison youth. By age 21, the program also showed reduced rates of teenage pregnancy and birth in participants, relative to comparison youth. Other long-term positive outcomes for participating youth, relative to comparisons, included increased academic achievement and reduced incidence of delinquency, violence, school misbehavior, and heavy drinking.*^{18,19}

For More Information, Contact

- **Social Development Research Group, University of Washington:** 9725 Third Avenue NE, Suite 401, Seattle, Washington, 98115

(This program is not available for purchase)

10. Self-Center (School-Linked Reproductive Health Center)

This model of the school-linked health center (SLHC) offers free reproductive and contraceptive health care to participating youth from nearby junior and senior high schools. SLHC staff works daily in participating schools, providing sex education lessons once or twice a year in each homeroom and offering daily individual and group counseling in the school health suite. Staff is also available daily in the SLHC to provide students with education and counseling and, for those youth registered with the clinic, reproductive and sexual health care. The program is recommended for use with urban, black, and economically disadvantaged, junior and senior high school students. *Evaluation found that the program assisted participants to delay the initiation of sexual intercourse and to use reproductive health services prior to initiating sex. It also assisted sexually active participants to reduce the incidence of unprotected sex and increase their use of contraception. The program resulted in a reduction in teen pregnancy rates among participants, relative to comparison youth.*^{20,21}

For More Information or to order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

11. Teen Outreach Project (TOP)

This school-based, teen pregnancy and dropout prevention program involves weekly school classes, lasting one hour, that integrate the developmental tasks of adolescence with lessons learned from community service (lasting at least 30 minutes each week). The curriculum focuses on values, human growth and development, relationships, dealing with family stress, and issues related to the social and emotional transition from adolescence to adulthood. The program is recommended for high school youth at risk of teen pregnancy, academic problems, and school dropout, and is most effective with ethnic minority youth, adolescent mothers, and students with academic difficulties, including previous school suspension. *Evaluation of the original program and evaluations of two replications all found that the program reduced rates of pregnancy, school suspension, and class failure among participants, relative to control/comparison youth.*^{22,23,24}

For More Information or to Order, Contact

- **Wyman Teen Outreach Program:** 600 Kiwanis Drive, Eureka, MO 63025; Phone, 636-938-5245; E-mail, teenoutreachprogram@wymancenter.org; Web, <http://www.wymanteens.org>.

Section II. Community-Based Programs**12. Abecedarian Project**

This full-time educational program consists of high quality childcare from infancy through age five, including individualized games that focus on social, emotional, and cognitive development, with a particular emphasis on language. During the early elementary school years, the program works to involve parents in their children's education, using a Home School Resource Teacher to serve as a liaison between school and families. The program

is recommended for use with healthy, African American infants from families that meet federal poverty guidelines. *Evaluation found long-term impacts, including a reduced number of adolescent births and delayed first births as well as increased rates of skilled employment and college education and reduced rates of marijuana use among former participants, relative to controls.*²⁵

For More Information, Contact

- **FPG Child Development Institute, University of North Carolina at Chapel Hill:** www.fpg.unc.edu/~abc/

This program is not available for purchase.

13. Adolescents Living Safely: AIDS Awareness, Attitudes & Actions

This HIV prevention program is designed to augment traditional services available at shelters for runaway youth. The program involves 30 discussion sessions for small groups, each lasting one-and-a-half to two hours and including experiential activities to build cognitive and coping skills. Intensive training of shelter staff and access to health care, including mental health services, are also important components of the program. It is recommended for use with black and Hispanic runaway youth, ages 11 through 18, living in city shelters. *Evaluation found that the program assisted youth to reduce the frequency of sex and numbers of sexual partners, and to increase condom use. The program did not affect the timing of sexual initiation.*²⁶

For More Information or to Order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence:** Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

14. Be Proud! Be Responsible! A Safer Sex Curriculum

This HIV prevention curriculum comprises six sessions, each lasting 50 minutes, and includes experiential activities to build skills in negotiation, refusal, and condom use. It is recommended for use with urban, black, male youth, ages 13 through 18. *Evaluation found that it assisted young men to reduce their frequency of sex, reduce the number of their sexual partners (especially female partners who were also involved with other men), increase condom use, and reduce the incidence of heterosexual anal intercourse.*^{27,28}

For More Information or to Order, Contact

- **Select Media:** Phone, 1.800.707.6334; Web, <http://www.selectmedia.org>
- For educator training, contact **ETR Associates:** Phone, 1.800.321.4407; Fax, 1.800.435.8433; Web, <http://www.etr.org>

15. Becoming a Responsible Teen

This HIV prevention, sex education, and skills training curriculum comprises eight one-and-a-half- to two-hour sessions. It includes experiential activities to build skills in assertion, refusal, problem solving, risk recognition, and condom use and is designed for use in single-sex groups, each facilitated by both a male and a female leader. It is recommended for use with African American youth, ages 14 through 18. *Evaluation found the program assisted participants to delay the initiation of sex and assisted sexually active participants to reduce the frequency of sex, decrease the incidence of unprotected sex (including anal sex), and increase condom use.*²⁹

For More Information or to Order, Contact

- **ETR Associates:** Phone, 1.800.321.4407; Fax, 1.800.435.8433; Web, <http://www.etr.org/>

16. California's Adolescent Sibling Pregnancy Prevention Project

This teen pregnancy prevention program provides individualized case management and care as well as sex education, including information on abstinence and contraception, to the adolescent siblings of pregnant and parenting teens. The program is recommended for economically disadvantaged, Hispanic youth, ages 11 to 17. *Evaluation found that the program assisted female youth to delay the initiation of sexual intercourse and assisted male youth to increase the consistent use of contraception. The program resulted in reductions in teen pregnancy rates among program youth, relative to comparison youth.*³⁰

For More Information, Contact

- **California Department of Health Services, Maternal & Child Health Branch:** 714 P Street, Room 750, Sacramento, CA 95814; Phone: 1.866. 241.0395

This program is not available for purchase.

17. Children's Aid Society—Carrera Program

This multi-component youth development program provides daily after-school activities—including a job club and career exploration, academic tutoring and assistance, sex education that includes information about abstinence and contraception, arts workshops, and individual sports activities. A summer program offers enrichment activities, employment assistance, and tutoring. The program provides year-round, comprehensive health care, including primary, mental, dental, and reproductive health services. The program involves youth's families and provides interpersonal skills development and access to a wide range of social services. The program is recommended for use with urban, black and Hispanic, socio-economically disadvantaged youth, ages 13 through 15. *Evaluation found that the program assisted female participants to delay the initiation of sexual intercourse and resist sexual pressure. It also assisted sexually experienced female participants to increase their use of dual methods of contraception. The program assisted both male and female participants to increase their receipt of health care. Otherwise, evaluation showed no positive, significant behavioral changes in participating males relative to comparison males. The program resulted in reduced rates of teen pregnancy among participants, relative to comparison youth.*³¹

For More Information, Contact

- **Children's Aid Society:** 105 East 22nd Street, New York, NY 10010; Phone, 212.949.4800; Web, <http://www.childrengsaidsociety.org>

18. Community Level HIV Prevention Intervention for Adolescents in Low-Income Developments

This HIV prevention program includes training in refusal, condom negotiation, communication, and condom use for adolescents in low-income housing developments. Workshops are followed by a multi-component community intervention including follow-up sessions; a Teen Health Project Leadership Council; media projects, social events, talent shows, musical performances, and festivals; and HIV/AIDS workshops for parents. The program is recommended for low-income adolescents living in housing projects, urban youth, and multi-ethnic youth ages 12-17. *Evaluation found that the program assisted participants to delay initiation of sex and assisted sexually active participants to increase condom use.*³²

For More Information, Contact

- **Kathleen Sikkema, PhD, Department of Epidemiology and Public Health, Yale University,** 60 College Street, P.O. Box 208034, New Haven CT 06520-8034; e-mail: Kathleen.sikkema@yale.edu

This program is not available for purchase.

19. ¡Cuidate!

This HIV prevention curriculum is tailored for use with Latino adolescents. Its goals are to 1) influence attitudes, beliefs, and self-efficacy regarding HIV risk reduction, especially abstinence and condom use; 2) highlight cultural values that support safer sex practices; 3) reframe cultural values that might be perceived as barriers to safer sex; and 4) emphasize how cultural values influence attitudes and beliefs in ways that affect sexual risk behaviors. It consists of six one-hour modules delivered over consecutive days. The program is recommended for urban Latino youth ages 13-18. *Evaluation found that the program assisted participants to reduce frequency of sex, reduce number of sex partners, reduce incidence of unprotected sex, and increase condom use.*^{33,34}

For More Information, Contact

- **Susan S. Witte, Columbia University**, Room 813, 1255 Amsterdam Avenue, New York, New York 10027; Phone 202-851-2394; e-mail SSW12@columbia.edu

20. Making Proud Choices!

This HIV prevention curriculum emphasizes safer sex and includes information about both abstinence and condoms. It comprises eight, culturally appropriate sessions, each lasting 60 minutes and includes experiential activities to build skills in delaying the initiation of sex, communicating with partners, and among sexually active youth, using condoms. It is recommended for use with urban, African American youth, ages 11 through 13. *Evaluation found the program assisted participants to delay initiation of sex and assisted sexually active participants to reduce the frequency of sex, reduce the incidence of unprotected sex, and increase condom use.*³⁵

For More Information or to Order, Contact

- **Select Media**: Phone, 1.800.707.6334; Web, <http://www.selectmedia.org>
- For information regarding training, contact **ETR Associates**: Phone, 1.800.321.4407; Fax, 1.800.435.8433; Web, <http://www.etr.org>

21. Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth

This community-wide, 18-month program provides peer education workshops on HIV awareness and prevention and peer-led group discussions in various community settings. Peer educators also lead efforts to make condoms available via door-to-door and street canvassing and make presentations at major community events. Radio and television public service announcements, posters in local businesses and public transit, and a newsletter augment the work of the peer educators. The program is designed for use in urban, Latino communities in order to reach the community's adolescents ages 14 through 19. *Evaluation showed that the program assisted the community's male teens to delay the initiation of sexual intercourse and assisted the community's sexually active female teens to reduce the number of their sexual partners. The program did not affect sexually active participants' frequency of sex.*^{36,37}

For More Information or to Order, Contact

- **Sociometrics Program Archive on Sexuality, Health & Adolescence**: Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

Section III. Clinic-Based Programs

22. HIV Risk Reduction for African American & Latina Adolescent Women

This skills-based HIV risk reduction intervention is designed for use in health clinics. Intended for use with African American and Latina young women, ages up to 19, who are at high risk of HIV because they have prior STI infections, the program provides young clients with confidential and free family planning services, teaches them how to use condoms, and provides skill building in relation to partner negotiation and condom use. *Evaluation found that young women who participated in the intervention had a lower incidence of STIs versus comparisons; they also reduced the number of their sexual partners and their incidence of unprotected sex.*³⁸

For More Information or to Order, Contact:

- **Loretta Sweet Jemmott, PhD, FAAN, RN, School of Nursing, University of Pennsylvania**, Room 239 Fagin Hall, 418 Curie Blvd., Philadelphia, Pennsylvania 19104-6096; Phone, 215.898.8287; E-mail, jemmott@nursing.upenn.edu

There is little replication information available for this program.

23. Project SAFE (Sexual Awareness for Everyone)

This gender- and culture-specific behavioral intervention consists of three sessions, each lasting three to four hours. Designed specifically for young African American and Latina women ages 15 through 24, it actively involves participants in lively and open discussion and games, videos, role plays, and behavior modeling. Discussions cover abstinence, mutual monogamy, correct and consistent condom use, compliance with STI treatment protocols, and reducing the number of one's sex partners. Each participant is encouraged to identify realistic risk reduction strategies that she can use in the context of her own life and values. *Evaluation found that participants increased their adherence to monogamy, reduced the number of their sexual partners and the incidence of unprotected sex, reduced the incidence of STIs, and increased their compliance with STI treatment protocols.*^{39,40,41,42}

For More Information or to Order, Contact:

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence**: Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

24. SiHLE

SiHLE is an HIV prevention program especially designed for sexually active African American teenage women. Consisting of four sessions, each lasting four hours, the program is facilitated by trained, African American females—one health educator and two peer educators. Sihle means beautiful or strong young woman, and the program encourages participants to develop ethnic and gender pride as well as self-confidence. It also builds their skills and awareness for sexual risk reduction. *Evaluation found increased condom use and reduced number of new sex partners as well as reduced incidence of unprotected sex; STIs, and pregnancy.*⁴³

For More Information or to order, Contact

- **Sociometrics, Program Archive on Sexuality, Health & Adolescence**: Phone, 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>

25. Tailoring Family Planning Services to the Special Needs of Adolescents

This effective, clinic-based, pregnancy prevention protocol is designed for use in family planning and other reproductive and sexual health clinics. It is particularly designed to meet the special needs of youth under the age of 18. As such, it provides education geared to the adolescent's cognitive development and offers reassurance of confidentiality, extra time for counseling, information and reassurance regarding medical exams, and carefully timed medical services. *Evaluation found that teens that had these specially tailored services were significantly more likely than other teens to increase their use of effective contraception and had a decreased pregnancy rate.*⁴⁴

For More Information or to Order, Contact

- Sociometrics, Program Archive on Sexuality, Health & Adolescence: Phone 1.800.846.3475; Fax, 1.650.949.3299; E-mail, pasha@socio.com; Web, <http://www.socio.com>.

26. TLC: Together Learning Choices

This curriculum is aimed at HIV positive youth in a clinic setting. It consists of 16 sessions of a small group intervention led by trained facilitators. Participants learn skills in solving problems, setting goals, communicating effectively, being assertive, and negotiating safer sex practices. They also improve their self-awareness regarding their feelings, thoughts, and beliefs, especially related to health promotion and positive social interactions. The program can be used with urban, African American or Latino, HIV-positive youth ages 13 through twenty-four. *Evaluation found that the program assisted participants to reduce numbers of sexual partners, reduce incidence of unprotected sex, increase positive lifestyle changes (females only), and increase positive coping actions.*^{45,46}

For More Information, Contact

- A detailed manual for the two sessions is available online at <http://chipts.ucla.edu>
- In addition, this program is a part of CDC's Diffusion of Effective Behavioral Interventions (DEBI) project. For additional information and training visit <http://www.effectiveinterventions.org/go/interventions/together-learning-choices>

Table B. Effective Programs: Settings & Populations Served

	School-Based Programs			Community-Based Programs			Clinic-Based Programs					
	Urban	Suburban	Rural	Elementary School	Middle School	Sr. High	18-24	White	Black	Hispanic/Latino	Asian	Sex
1. AIDS Prevention for Adolescents in School	★					★		★	★	★	★	Both Sexes
2. Get Real about AIDS	★	★	★			★		★		★		Both Sexes
3. Postponing Sexual Involvement (Augmenting a Five-Session Human Sexuality Curriculum)	★				★				★			Both Sexes
4. Postponing Sexual Involvement: Human Sexuality & Health Screening	★				★				★	★		Females
5. Reach for Health Community Youth Service	★				★				★	★		Both Sexes
6. Reducing the Risk	★	★	★			★		★	★	★	★	Both Sexes
7. Safer Choices	★	★				★		★	★	★	★	Both Sexes
8. School / Community Program for Sexual Risk Reduction among Teens			★	★	★	★		★	★			Both Sexes
9. Seattle Social Development Project ⁸	★	★		★				★	★		★	Both Sexes
10. Self Center (School-Linked Reproductive Health Care)	★			★	★	★			★			Females
11. Teen Outreach Program	★	★	★			★		★	★	★		Both Sexes
12. Abecedarian Project	★	★		★					★			Both Sexes
13. Adolescents Living Safely: AIDS Awareness Attitudes & Actions	★			★	★	★	★		★	★		Both Sexes

Table B. Effective Programs: Settings & Populations Served

☐ School-Based Programs ☑ Community-Based Based Programs ☐ Clinic-Based Programs

	Urban	Suburban	Rural	Elementary School	Middle School	Sr. High	18-24	White	Black	Hispanic/Latino	Asian	Sex
14. Be Proud! Be Responsible! A Safer Sex Curriculum	★			★	★	★	★		★			Males
15. Becoming a Responsible Teen	★			★		★	★		★			Both Sexes
16. California's Adolescent Sibling Pregnancy Prevention Project	★	★	★	★	★	★				★		Both Sexes
17. Children's Aid Society—Carrera Program	★			★	★	★			★	★		Females
18. Community-level HIV Prevention for Adolescents in Low-Income Developments	★			★	★	★			★		★	Both Sexes
19. ¡Cuidate!	★			★		★				★		Both Sexes
20. Making Proud Choices	★			★	★				★			Both Sexes
21. Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth	★			★		★	★			★		Both Sexes
22. HIV Risk Reduction for African American and Latina Adolescent Women	★			★	★	★	★		★	★		Females
23. Project Safe – Sexual Awareness for Everyone	★			★		★	★		★	★		Females
24. SIHLE	★	★		★		★	★		★			Females
25. Tailoring Family Planning Services to the Special Needs of Adolescents		★	★	★		★	★	★				Females
26. TLC: Together Learning Choices	★			★	★	★	★		★	★		Both Sexes

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until it's over
AIDS ACTION

The Honorable Henry Waxman
Chairman
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

**RE: AIDS Action Statement on the Public Health and Ethical Concerns with
Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive
Sexuality Education, Submitted for the Record.**

Dear Chairman Waxman,

AIDS Action serves as the national voice for AIDS service organizations, health departments, health educators, and a diverse network of community-based organizations across the country providing services for people living with or affected by HIV/AIDS. On behalf of AIDS Action's diverse membership organizations committed to ending the HIV/AIDS epidemic in the United States, I write to express grave concern with continued federal investment in abstinence-only-until-marriage programs. AIDS Action has long called for the elimination of funding for abstinence-only-until-marriage programs, and instead supports comprehensive prevention and sexual educational programs that are scientifically sound and effective at reducing HIV and STD transmission. The health and education of our nation's young people must become a priority for this Congress, and we commend the Committee for holding an oversight hearing on this most critical issue.

Several federally funded research studies show that abstinence-only-until-marriage education programs are ineffective at best. They do not delay the start of sexual activity or decrease the number of sexual partners. Often they contain medically inaccurate data and do not teach youth how to protect themselves from HIV infection. Most recently, a study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. The \$1 million study found no evidence that abstinence-only programs increases rates of sexual abstinence. The study also found that students enrolled in abstinence-only-until-marriage-education programs were far less likely to know that condoms can lower the risk of sexually transmitted diseases including HIV.

It is imperative that Congress take a hard look at this scientific evidence. It is not only unethical to deny young people life saving information and education, but reprehensible for Congress to continue spending American tax dollars on ideologically based programs that are proven to be unsuccessful. Abstinence-only-until-marriage programs have been funded by the federal government for over 25 years. These programs have received over

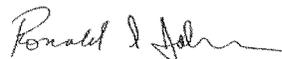
\$1 billion dollars under the Bush administration, all without any legitimate evidentiary support in their favor.

Our government's irresponsible and narrow focus on abstinence-only-until-marriage education has serious consequences. HIV remains a public health crisis in America, now infecting more than 40,000 people annually. Every 13 minutes, a person in the United States is newly infected with HIV. **More than 1 in 10 of them are under the age of 25.** Not only are HIV rates on the rise, America's youth are also facing higher rates of other sexually transmitted diseases and teen pregnancy. As STD rates rise among our nation's youth so does their risk of HIV, as having a sexually transmitted disease makes an individual biologically more susceptible to HIV infection.

There is clearly a true need for evidence-based, comprehensive sexuality education that meets the needs of **all** youth, including HIV positive, lesbian, gay, bisexual, and transgender youth. Congress should fund age-appropriate, comprehensive, and evidenced based sexuality education programs which fully inform youth about HIV prevention-interventions. Abstinence is and should remain a critical component of comprehensive HIV prevention education along with contraception and other life and decision making skills.

AIDS Action urges the Committee to provide the necessary oversight to bring an end to federal funding for abstinence-only-until-marriage programs. We ask Congress to act in the best interest of young people by supporting public health and education policies that are comprehensive and rooted in the best science. Thank you, Chairman Waxman for your leadership and commitment on this issue.

Sincerely,

A handwritten signature in black ink, appearing to read "Ronald Johnson". The signature is fluid and cursive, written in a professional style.

Ronald Johnson
Deputy Executive Director
AIDS Action



Statement of AIDS Alabama on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sex Education

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

AIDS Alabama devotes its energy to helping people with HIV/AIDS live healthy and productive lives and works to prevent the spread of HIV/AIDS. Incorporated in 1986, AIDS Alabama is the largest 501(c)3 organization providing services throughout Alabama.

Our primary service is affordable housing for people with HIV/AIDS, including two specialty housing programs, the Rectory and JASPER House. The Rectory is a residential substance abuse treatment facility that houses up to eleven residents for 90 days and JASPER House is a 14-bed, long-term residential facility for people with mental illness. In addition to those housing facilities, we operate five properties for homeless families and six apartment complexes for transitional and permanent housing needs, as well as scattered homes and facilities across the state.

In addition we offer comprehensive HIV prevention programs to men who have sex with men and African-American women, both adversely affected by HIV. This year we purchased a mobile HIV testing van and are able to provide free, confidential testing throughout the state. Our programs have won the praise of the Alabama Department of Public Health and many other entities.

According to the Alabama Department of Public Health, a growing number of new HIV infections are occurring in persons ages 13 to 24. Teenage pregnancy rates have always been used as a surrogate marker to predict HIV infection. In 2005 the Centers for Disease Control and Prevention recorded that 321,368 girls in Alabama ages 15-19 were pregnant. Every day in Alabama another young person becomes newly infected with HIV. The growing number of HIV cases among youth in Alabama indicates that the abstinence-only curriculum is ineffective. Yet Alabama continues to support and accept funding for abstinence-only curriculum in middle and high schools throughout the state. Ultimately an increase in HIV infections present a growing and persistent public health threat to our youth, particularly those in underserved populations.

While the federal government continues to fund abstinence-only programs, our youth and adolescents continue to participate in unprotected sex and to become HIV infected. The abstinence-only funding must be replaced with comprehensive sexual education, and HIV prevention funding must be increased in order to reduce the spread of the disease. The time has come for those in positions of power to review the research and to determine proven and effective methods of sexual education to fund. Much money is being wasted on ineffectual abstinence-only education, while very little is being invested in curricula with the power to save the lives of many Americans.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for more than 25 years, although no professional study in a peer-reviewed journal has found them to be broadly effective. However, a recent federally-funded study of abstinence-only-until-marriage programs conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services found no evidence that abstinence-only-until-marriage programs have achieved their goal to increase rates of sexual abstinence, which is the purpose of the programs. Additionally 13 states have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful. A report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the growing body of knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs. Where is the accountability?

Every major medical and public health organization supports a comprehensive approach to sexuality education, including the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, the American Public Health Association, the Institute of Medicine, the National Institutes of Health, and the Society for Adolescent Medicine. Several, including the American Public Health Association, the Institute of Medicine, and the Society for Adolescent Medicine, have gone so far as to call for the repeal of current abstinence-only-until-marriage programs and funding.

In November 2007 ten public-health researchers sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid urging Congress to reduce or eliminate federal support for abstinence-only-until-marriage programs, in part because the programs have "multiple scientific and ethical errors." We strongly support the researchers' conclusions that abstinence-only-until-marriage programs withhold "...potentially life-saving information..." The letter focused on the large body of evidence showing that abstinence-only-until-marriage programs are ineffective in getting young people to delay sexual initiation.

Alabama's youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, that are founded in the

best science available, and that reflect mainstream values. The lives of our young people represent our future. Please make that future a healthy one.

Kathie M. Hiers
CEO, AIDS Alabama

In a Position to Know



Youth and Parents Living With HIV
Speak Out on Sexuality Education

**In a Position to Know:
Youth and Parents Living With HIV
Speak Out on Sexuality Education**

by
Rachael D. Dombrowski, MPH
Diana K. Bruce, MPA



AIDS Alliance advances the partnership between consumers and providers—we are the voice of women, children, youth and families living with and affected by HIV and AIDS.

AIDS Alliance for Children, Youth & Families would like to acknowledge the invaluable contributions of the following people and organizations: Shira Saperstein of The Moriah Fund, the Ford Foundation, Nathan Schaefer of GMHC (formerly of AIDS Alliance), Rob Keithan of the Unitarian Universalist Association of Congregations, and Jennifer Heitel Yakush and Maxwell Ciardullo of SIECUS. We especially would like to thank the many young people and parents living with HIV/AIDS who shared their stories with us and inspired us to develop this report.

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Contents

In a Position to Know	1
Background	2
Three Approaches to Sexuality Education in the U.S.	7
Fear- and Shame-Based Abstinence-Only Programs	11
Other Abstinence-Only Approaches	15
Comprehensive Programs	16
What the Research Says	17
Testimonies of Youth and Parents Living with HIV	19
Recommendations	26
Conclusion	27
References	29

In a Position to Know: Youth and Parents Living With HIV Speak Out on Sexuality Education

The sexuality education debate in the U.S. is intense and fiery. It takes place where science and public health intersect with some of our society's most private and deeply felt concerns—family and community values, religion, morality, and human sexuality. The AIDS community—like the majority of American parents—has consistently supported comprehensive, age-appropriate, science-based sexuality education programs for school-aged youth. Opponents of comprehensive sexuality education maintain that sex education programs must be limited to abstinence-only-until-marriage messages, and these groups have been successful in securing significant federal funding for abstinence-only programs. This success is all the more remarkable because most parents and teens alike want programs that teach both abstinence and contraception instead of one or the other (Albert, 2007).

In the midst of this often noisy debate, there are some voices that are rarely heard—youth and parents who are HIV positive. Because their lives are uniquely affected by what policy makers decide about sexuality and HIV prevention education,

AIDS Alliance for Children, Youth & Families created a forum for them to be heard. *In a Position to Know: Youth and Parents Living With HIV Speak Out on Sexuality Education* combines their voices with an analysis of the science underlying both comprehensive and abstinence-only approaches.

AIDS Alliance was founded in 1994 to advocate for women, children, youth, and families living with and affected by HIV. Since our inception, AIDS Alliance has been part of national efforts supporting comprehensive sexuality and HIV prevention education. In 2006, with generous grant support from the Ford Foundation and The Moriah Fund, AIDS Alliance launched the Positive Youth Project to empower HIV-positive youth and parents to speak for themselves. In this first report from the project, AIDS Alliance concludes that abstinence-only approaches endanger youth who are at high risk for HIV infection, further stigmatize youth who are already living with HIV, and fail to support families with parents who are HIV positive and who want their children to have all the information and support they need to stay healthy and make good decisions about their

own behavior. While these concerns have sometimes been incorporated in other analyses of sexuality education, they have yet to serve as the central force behind a policy report.

AIDS Alliance is confident that this perspective will move the national debate forward in support of responsible, science-based, comprehensive HIV prevention and sexuality education for America's youth.

Background

Comprehensive programs teach about abstinence, but they also teach about condoms and contraception, and about the delicacy, complexity, and personal values associated with sexuality in developing youth. All of these are tools that help to slow the spread of HIV. Comprehensive programs have not only demonstrated their efficacy in reducing high-risk behavior among youth but also have provided youth who are HIV positive with essential tools and information so that they can live healthy lives and protect their partners if and when they decide to engage in sexual activity. HIV-positive parents also say that they are supported when comprehensive approaches taught at school mirror what they teach their children at home. Proponents of comprehensive sexuality and HIV prevention education say that this approach protects young people by giving them the information they need to protect themselves if they decide—as most unmarried people in the U.S. do—to become sexually active before committing to a lifetime partner.

Abstinence-only programs teach only abstinence from sexual intercourse until marriage—which the federal government defines as a union between a man and a woman—thus excluding gay and lesbian youth from sexual relationships for life. Absti-

nence-only programs, by definition, do not teach about the benefits of contraception or condom use to prevent HIV infection. Unfortunately, the most widely used abstinence-only curricula also contain significant misinformation about sexuality, HIV disease, and HIV prevention. Proponents of abstinence-only education say that this approach encourages youth to be abstinent and avoids mixed messages.

Federal Funding for Sexuality Education

Studies have shown that when teens receive comprehensive sexuality education they are more likely to delay sexual initiation and to have fewer sexual partners. They are also more likely to use condoms when they do engage in sex (Bearman & Brukner, 2001; Grunseit, Kippax, Aggleton, Baldo, & Slutkin, 1997; Kirby, 2001, 2007). Recent studies also have shown that over 82 percent of U.S. parents support a more comprehensive approach to sexuality education for their children (Bleakley, Hennessy, & Fishbein, 2006). Yet, there is currently no federal funding stream specifically dedicated to these kinds of programs.

In contrast, no reliable data exist to support the effectiveness of abstinence-only programs. Mathematica Policy Research (2007) completed a congressionally mandated, rigorously

designed outcome study of abstinence-only programs in four states. It found that among the over 2,000 students in the study abstinence-only programs had no impact on rates of sexual abstinence, sexual initiation age, or number of sexual partners. A new review by leading sexuality education researcher Douglas Kirby, also found no sound evidence from scientific studies to support the effectiveness of abstinence-only programs (Kirby, 2007). Despite these and other data indicating that such programs do not work, abstinence-only programs are supported by no fewer than three separate federal funding streams, each with its own allocation, distribution method, and regulations:

- Section 510(b) of Title V of the Social Security Act provides \$50 million in federal funding to abstinence-only programs and has done so since 1996. Title V dollars are supplemented with a required 75 percent state match that brings total annual funding to \$87.5 million. States are required to evaluate their programs, and most of these evaluations have found the programs ineffective. Fourteen states, including California, which never accepted the funding, currently reject federal funding for this program.

- The Community Based Abstinence Education (CBAE) program, which was created in 2001 and is the most restrictive of all federal abstinence-only programs, is funded currently at \$113 million.
- The Adolescent Family Life Act (AFLA) abstinence-only program is funded at \$13 million. It began as a \$4 million abstinence-only earmark written into legislation in 1982.

Over \$200 million in federal and state resources support abstinence-only-until-marriage programs each year. Many also receive considerable private funding, which makes total spending on abstinence-only programs largely unknowable. In an era of rising new HIV infections and STDs among youth and huge demands on the federal budget, this massive investment in programs that have failed to have an impact on teens' sexual behavior flies in the face of both science and common sense.

Epidemic Among Youth

Abstinence-only programs are present in schools and communities all across the country, and they often are targeted to the very youth who are at high risk for HIV infection. Yet, despite the extraordinary federal spending on these programs and their widespread presence, sexually transmitted HIV infection among America's youth has increased sub-

stantially since the beginning of the epidemic (Centers for Disease Control and Prevention [CDC], 2007b).

In the early 1990s, approximately 2,000 babies were born HIV positive each year. Thankfully, new treatments for HIV-positive pregnant women and their newborns have reduced that number to fewer than 100 annually (CDC, 2007b). However, this means that thousands of babies born with HIV in the epidemic's early years now are or soon will be sexually active young adults. Many more young people become HIV positive each year through unprotected sex and other high-risk behavior—young people now represent 13 percent of all new HIV/AIDS cases (CDC, 2007b). Our country's sexuality education policies must reflect this reality and act to protect youth from becoming HIV infected and to help young people who are already HIV positive lead healthy lives and avoid transmitting HIV to others. Comprehensive sexuality and HIV prevention education can meet the needs of all youth—including those who are living with the virus themselves or who live in families and communities where the epidemic is a daily fact of life.

Sexuality education also must be culturally competent and able to meet the needs of sexual minority youth and young people of color. According to the Society of Adolescent Medicine (2006), 2.5 percent of high

school students identify as gay, lesbian, or bisexual, and one in 10 struggles with issues of sexual orientation. For a variety of reasons, sexual minority youth—who are defined in this report as gay, lesbian, bisexual, transgender, and questioning youth—are at higher risk for HIV and other STDs than their heterosexual peers. Young people of color, especially blacks and Latinos, also are affected by HIV and STDs far out of proportion to their numbers in the general population. (See Figures 1-2 on page 6.)

Youth and Parents Living With HIV Speak Out

When youth and parents living with HIV speak out, their compelling stories offer a unique perspective. Chelsea Gulden, a young mother who contracted HIV in college, knows first hand what life is like for an HIV-positive youth dealing with abstinence-only education. As an HIV prevention counselor today, she shares her frustrations as she tries to offer information and guidance to youth who come to her for help in a county where she is limited to providing abstinence-only messages. Max Siegel's disappointment is clear as he discusses the lack of information and guidance available for HIV-positive youth in school. Max, who is 23 today, contracted HIV in high school where

he was provided only abstinence messages—and where other HIV-positive youth continue to receive the same messages today. As a mother who has been living with the virus for 15 years, Danielle Warren-Dias wants all kids to learn everything there is to know about protecting themselves, but she especially wants HIV-positive youth to know how to protect themselves and others when they become sexually active. HIV-positive mother Gina Brown explains that she wants the HIV education her daughter is taught in school to match what she is teaching her at home. Finally, Chaneil Scott, a perinatally infected 15-year-old, describes her daily struggle with disclosing her status to her classmates and friends in a society where stigma still runs rampant and where abstinence-only-until-marriage programs further marginalize HIV-positive teens.

Chelsea, Max, Danielle, Gina, Chaneil, and other positive youth and parents that AIDS Alliance interviewed for this report are new voices for comprehensive sexuality education. AIDS Alliance is providing the platform for their stories to be heard—now it is time for stakeholders in the debate to listen and act to change national policy to support the comprehensive sexuality and HIV prevention education for which they so eloquently ask.

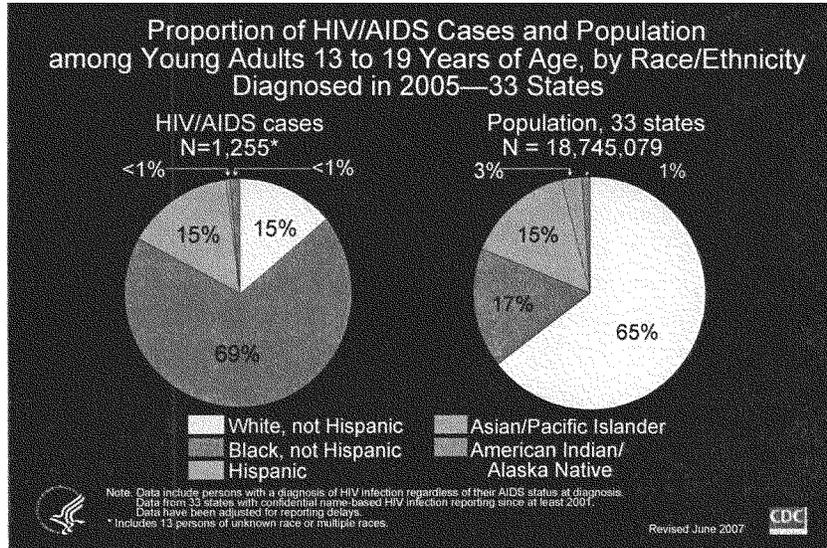


Figure 1: From "HIV/AIDS Surveillance in Adolescents and Young Adults (through 2005)," by the Centers for Disease Control and Prevention, revised June 28, 2007.

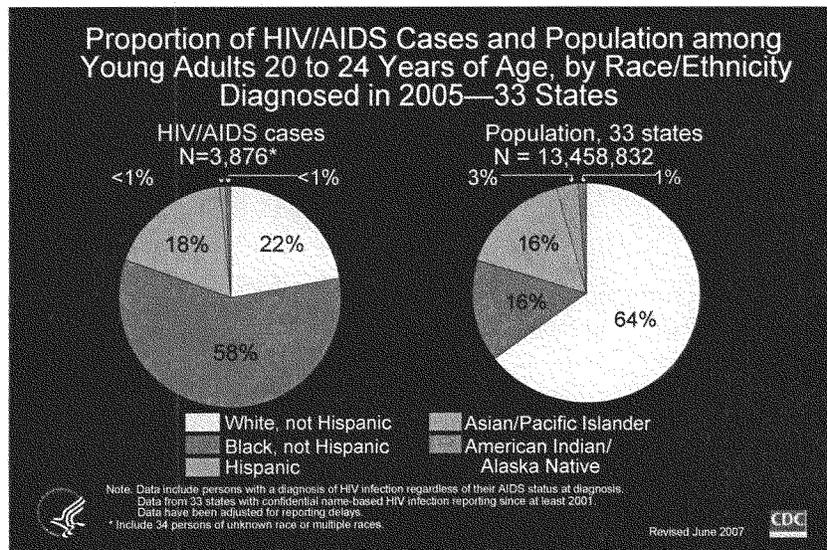


Figure 2: From "HIV/AIDS Surveillance in Adolescents and Young Adults (through 2005)," by the Centers for Disease Control and Prevention, revised June 28, 2007.

Three Approaches to Sexuality Education in the U.S.

Although the public debate centers on abstinence-only versus comprehensive approaches to sexuality education, programs can be usefully analyzed within three categories, two of which are varying approaches to abstinence-only education. Although abstinence-only programs differ considerably on a range of issues, a primary distinction is whether or not a program relies on fear and shame about sex outside marriage as the foundation for its abstinence-only messages. Fear- and shame-based programs have been the most hotly debated and are of most concern to AIDS Alliance and the positive youth and parents interviewed for this report. Unfortunately, many federally funded abstinence-only programs are rooted in fear- and shame-based messaging.

Some abstinence-only programs promote abstinence within the context of self-esteem, decision-making skills, and negotiation within interpersonal relationships. Because such programs teach only about abstinence, however, they fail to provide

young people with essential information about HIV and STD risk reduction, including condom use. These programs are not as heavily funded as the fear- and shame-based programs and are not as widespread.

Comprehensive sexuality education is rooted in the principle that good decisions about sexual behavior are more likely when young people have accurate information about their sexual and reproductive health. Comprehensive programs include discussions of abstinence, contraception, human development and relationships, sexual behavior and health—including condoms as a method to prevent STDs—and interpersonal skills.

Sexuality education programs, whether comprehensive or abstinence only, vary in how they discuss HIV transmission, how they portray individuals living with HIV, and how they portray sexual minority populations. An analysis of these differences demonstrates their relative value or harm for youth living with and at highest risk for HIV infection. (See Table 1 on pages 8-10.)

Table 1: Curricula Comparisons on HIV Portrayal, HIV Transmission, and Sexual Minority Youth

CURRICULUM	Abstinence-Only		Comprehensive	
	Sex Respect	Passions & Principles	Family Life & Sexual Health (F.L.A.S.H.)	Our Whole Lives
HIV PORTRAYAL	<p>Refers to people living with HIV as "AIDS patients" or "AIDS victims" (p. 60).</p> <p>—</p> <p>"While AIDS is fatal and has no cure, the behavior that leads to AIDS can be prevented through high personal standards and strong character" (p. 131).</p> <p>—</p>	<p>"Every number on the die represents a risk some are willing to take. This illustrates that SEX before Marriage will cost! Ask students, 'Do I have any risk takers?' If one of the students in the exercise rolls a four, the leader is supposed to tell the student they have AIDS, followed by, 'You're heading to the grave. No cure' (p. 36).</p> <p>—</p>	<p>"Even though scientists have not found a cure for HIV, there are medicines that people with HIV can take in order to stay healthy" (p. 25-5).</p> <p>—</p>	<p>"People with HIV may live for 10 to 15 years in relatively good health and without serious symptoms" (p. 272).</p> <p>—</p> <p>"For many people, early treatment delays the onset of more serious symptoms" (p. 272).</p> <p>—</p> <p>"Drugs such as AZT have been used successfully to prevent the transmission of HIV from pregnant mothers to infants" (p. 272).</p> <p>—</p>

CURRICULUM	Abstinence-Only		Comprehensive	
	Sex Respect	Passions & Principles	Family Life & Sexual Health (F.L.A.S.H.)	Our Whole Lives
HIV TRANSMISSION	<p>States that HIV is a lentivirus. "That means the virus may be in your body a long time (from a few months to as long as 10 years or more) before it can be detected, either by a test or by physical symptoms" (p. 60).</p> <p>—</p>	<p>"Nearly 1 in 3 will contract AIDS from an infected partner with 100% condom use" (p. 12).</p> <p>—</p> <p>Explains AIDS by saying, "The causative agent, I-UV, is transmitted by body fluids such as blood and semen" (p. 65).</p> <p>—</p>	<p>"For HIV to be transmitted, it has to get directly into the blood. There are 3 ways that HIV can be spread:</p> <ol style="list-style-type: none"> 1. The most common way is during sex, if infected blood, semen, or vaginal fluid passes from one person to another...; 2. HIV infection can also happen when an infected person injects drugs into a vein, then shares the needle with someone else; 3. HIV infection can be passed from an HIV-positive mother to her baby when the mother is pregnant. This can occur during labor and delivery, or through breast-feeding" (p. 25-6). <p>—</p> 	<p>"HIV can be found in blood, semen, vaginal secretions, and breast milk. This virus is very fragile, and it dies very quickly when it is outside the body" (p. 264).</p> <p>—</p> <p>"You can become infected with HIV through either sexual intercourse or sharing needles for any reason. In addition, babies born to infected mothers can be born with the HIV virus" (p. 264).</p> <p>—</p> <p>"Specifically, you can become infected with the HIV virus by:</p> <ol style="list-style-type: none"> 1. Having vaginal, anal, or oral sexual intercourse (penis-vagina, penis-rectum, mouth-rectum, mouth-vagina, mouth-penis) with a person who is infected with HIV. 2. Sharing IV (intravenous) needles or any needles with a person infected with HIV" (p. 264). <p>—</p>

CURRICULUM	Abstinence-Only		Comprehensive	
	Sex Respect	Passions & Principles	Family Life & Sexual Health (F.L.A.S.H.)	Our Whole Lives
SEXUAL MINORITY YOUTH	<p>"Finally, AIDS (Acquired Immune Deficiency Syndrome), the STD most common among homosexuals, bisexuals, and IV drug users, has now made its way into heterosexual circles" (p. 54).</p> <p>—</p> <p>"Homosexual activity involves an especially high risk for HIV transmission" (p. 68).</p> <p>—</p>	<p>"You must teach the students that sex is the glue that ultimately links them to someone for the rest of their lives within a biblical marriage relationship" (p. 26).</p> <p>—</p>	<p>"Neither is it appropriate to condemn homosexual behavior or to suggest that gay, lesbian, or bisexual students should be heterosexual" (p. 7-4).</p> <p>—</p> <p>"This Reference Sheet teaches that labeling one's self, based on other's assumptions, is unnecessary... and that labeling and degrading others is wrong" (p. 7-4).</p> <p>—</p> <p>"Being gay or lesbian has nothing to do with how feminine or masculine you are, or even who you have or haven't had sex with. It has to do with how you feel inside, who you feel most attracted to" (p. 7-8).</p> <p>—</p>	<p>"Everyone has the right to their personal and religious beliefs about homosexuality. However, no one has the right to oppress or treat someone unfairly because of his or her sexual orientation" (p. 85).</p> <p>—</p> <p>Sexual Orientation is "the deep-seated direction of one's romantic and erotic attraction toward the same sex (homosexual), other sex (heterosexual), or both sexes (bisexual)" (p. 92).</p> <p>—</p> <p>"People who view homosexuality as an illness have sought so-called cures, but there is no cure because being gay is not an illness" (p. 89).</p> <p>—</p>

Table 1 is an analysis of examples of widely used abstinence-only curricula and comprehensive curricula on three issues—how they portray people living with HIV, what they teach about HIV transmission, and what they say about sexual minority youth. Note: For full references on *Sex Respect*, *Passions & Principles*, *F.L.A.S.H.*, and *Our Whole Lives* please see Reference List.

Fear- and Shame-Based Abstinence-Only Programs

The cornerstone of fear- and shame-based abstinence-only programs is that a mutually faithful, monogamous relationship in the context of marriage between a man and a woman is the expected standard of all human sexual activity (Title V, Section 510(b) of the Social Security Act, 1996). This principle fails to acknowledge the reality that 63 percent of all teens have had sex by the 12th grade, one in five report having had four or more partners by the time they graduate, and one-quarter of sexually active teens have an STD (CDC, 2006). Fear- and shame-based programs also are replete with inaccuracies, distortions of fact, myths, and gender stereotypes—a congressional report found that over 80 percent of the curricula used by over two-thirds of the federally funded programs reviewed contained false, misleading, and distorted information (U.S. House of Representatives Committee on Government Reform, 2004). Although these programs seek to help students make responsible decisions, they provide no information on prevention methods other than abstinence, make specific moral judgments that parents may not

share, provide medically and scientifically unsound information about human development and reproductive health—including condom efficacy—and fail to address the needs of sexual minority youth. In addition, based on our analysis, none of these programs address the needs of HIV-positive youth in any of their curricula.

HIV Transmission and Prevention

Fear- and shame-based abstinence-only programs fail young people by providing them with inaccurate medical information about HIV and other STDs. HIV exposure rates are discussed in confusing terms, and risks of substances and activities are often exaggerated. For example, *Sex Respect* (Mast, 2001) states:

HIV is a lentivirus, which means that the virus may be in your body a long time (from a few months to as long as 10 years or more) before it can be detected, either by a test or by physical symptoms. (p. 60)

Another fear- and shame-based abstinence-only program, *Reasonable Reasons to Wait*, tells students, “AIDS can be transmitted by skin to skin contact” (Duran, 2003, p. 19).

Condoms. Abstinence-only programs that receive federal funding are permitted by law to mention condoms only in the context of their

failure rates. Many fear- and shame-based programs inflate failure rates in the hope of scaring young people into abstaining from sexual activity. For example, *Passions & Principles* claims that “nearly 1 in 3 will contract AIDS from an infected partner with 100% condom use” (Hughes, 1998, p. 12), indicating a 33 percent failure rate. However, with consistent and correct use, condom failure rates range from 1.6 percent to 3.6 percent, including the combined method failure of both slippage and breakage and contributing factors such as experience in condom use, condom size, and the use of a lubricant (CDC, 2001). The CDC, the National Institutes of Health (NIH), the United States Agency for International Development (USAID), and the Food and Drug Administration (FDA) issued the following statement about the effectiveness of condoms in preventing disease:

Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases (CDC, 2001, p. 2).

Despite the facts about condoms, abstinence-only-until-marriage programs do not discuss with students

the proper way to use this form of contraception, nor do they provide information on any other form of contraception that may help reduce the risk of becoming pregnant or contracting HIV or another STD. The only method discussed is abstaining from sexual activity until marriage.

Views of People Living With HIV

Many fear- and shame-based abstinence-only programs portray HIV-positive people as irresponsible and immoral. *Facing Reality* states:

Many homosexual activists are frustrated and desperate over their own situation and those of loved ones. Many are dying, in part due to ignorance. Educators who struggle to overcome ignorance and instill self-mastery in their students will inevitably lead them to recognize that some people with AIDS are now suffering because of the choices they made (Coughlin, 1998, p. 19).

Similarly, *Sex Respect* teaches that the “behavior which leads to AIDS can be prevented through high personal standards and strong character” (Mast, 2001, p. 131).

These kinds of statements blame and stigmatize people living with HIV and do not belong in a public school curriculum for that reason alone. However, they also display a pro-

found ignorance of the social drivers of HIV infection in youth, including poverty, coerced sex, childhood sexual abuse, ignorance about HIV risk and transmission and about sexuality in general, gender inequality, and uncertainty about sexual feelings and how to handle them. They also fail to acknowledge biological factors such as the greater susceptibility to infection of the immature female genital tract, and the role of mental illness in sexual and other risk taking.

Fear- and shame-based programs also typically portray people living with HIV as victims who are terminally ill. Such a portrait is highly stigmatizing and ignores the fact that HIV disease is now a chronic illness and, as with many other chronic illnesses, with proper treatment people living with HIV can live healthy and productive lives for decades. *Passions & Principles* uses a game to teach distorted information about living with HIV. Students are asked to roll a dice and are told that every number on the dice represents a risk. Rolling a four means that a student has contracted AIDS, and the instructor says, "You're heading to the grave. No cure" (Hughes, 1998, p. 35).

In addition to portraying people living with HIV in negative and stigmatizing ways, these curricula and programs fail HIV-positive youth in a potentially more damaging way. By providing misinformation about

condom efficacy in preventing HIV transmission, such programs are denying them medically accurate information about how to protect their sexual partners now and in the future, including a future spouse.

Views of Sexual Minority Youth

Sexual minority youth are left out of the conversation entirely when it comes to relationships in fear- and shame-based abstinence-only curricula because of the heavy focus on marriage at a time when many state laws forbid marriage between same-sex partners (Frank, 2005). New federal guidance mandates that abstinence-only-until-marriage programs define marriage as follows:

a legal union between one man and one woman as a husband and wife, and the word 'spouse' refers only to a person of the opposite sex who is a husband or a wife (Announcement of Availability of Funds for Adolescent Family Life (AFL) Demonstration Projects, 2007).

This regulation makes it clear that the devaluation of gay and lesbian life partnerships is a deliberate feature of abstinence-only programs.

When fear- and shame-based abstinence-only programs do mention sexual minority youth, they provide negative and false information that

reinforces stigma and stereotypes. For example, *Sex Respect* assigns blame for the epidemic: “AIDS is the STD most common among homosexuals and bisexuals, and has recently made its way into heterosexual circles” (Mast, 2001, p. 54), and *Passions & Principles* suggests that instructors teach students that “sex is the glue that ultimately links them to someone for the rest of their lives within a biblical marriage relationship” (Hughes, 1998, p. 26).

Because a “biblical marriage relationship” is between a man and a woman, sexual minority youth are denied for a lifetime the possibility of love and union with a same-sex partner. References to biblical teachings as the standard for marriage are also inappropriate in a public school curriculum for use with students who may have a different faith or none at all.

Views of Gender and Family

Many fear- and shame-based abstinence-only curricula perpetuate gender and family stereotypes, and girls and young women often are presented as the “controllers” of sexual situations. *Sex Respect* states:

A young man’s natural desire for sex is already strong due to testosterone, the powerful male growth hormone. Females are becoming culturally conditioned to fantasize about sex as well ... yet, because

they generally become physically aroused less easily, girls are still in a good position to slow down the young man and help him learn balance in a relationship (Mast, 2001, p.11-12).

In a section of this curriculum designed to facilitate questions from students, *Sex Respect* poses the question “aren’t there many girls who want to have sex, and so they pressure the guys” and answers it, “yes, there are. This is happening in larger numbers now than in years past, since the pop culture has removed the stigma from non-virgins and displays many role models of provocative women” (Mast, 2001, p. 12). Fear- and shame-based curricula also teach—to an audience that includes many sexually active teens—that sexually active young women are to be considered dirty, scarred, and inferior.

Finally, fear- and shame-based curricula do not acknowledge current family structures, ignoring the fact that many students in the classroom are being raised by parents who did not marry, and that some students may already be parents themselves. Abstinence is presented as the only option for preventing pregnancy and STD infection. Comprehensive information about pregnancy prevention is especially necessary for young women who are HIV positive and who need the opportunity to care-

fully plan any pregnancy and to take advantage of treatments that prevent mother-to-child transmission of HIV. These curricula not only stigmatize young, pregnant women but also fail to provide adequate, comprehensive information to help youth make responsible decisions about their sexual health.

Other Abstinence-Only Approaches

Abstinence-only programs are not all alike. Some programs do not use fear or shame to promote abstinence. Instead, they focus on increasing self-esteem while teaching students decision-making and negotiation skills within interpersonal relationships (SIECUS, 1998a). However, these programs, by definition, do not provide youth with all the information they need to make good choices, stay healthy, and protect themselves if they are or become sexually active, or if they are already HIV positive. They also do not address the needs of sexual minority youth.

Abstinence-only programs that do not rely on fear and shame to control students' sexual behavior can help promote self-esteem while also providing youth with concrete skills for negotiating interpersonal relationships and confronting peer pressure to engage in unwanted sexual activity. While less stigmatizing and negative than fear-based abstinence-only programs, these programs also fail to provide youth with all the information they need to protect themselves and to make healthy decisions if they are or become sexually active, or if they are living with HIV.

Comprehensive Programs

Comprehensive sexuality education promotes accurate information about sexual and reproductive health and includes discussions of abstinence, condoms and contraception, relationships, human development, sexual behavior and health, and interpersonal skills. The comprehensive approach is based on four primary goals: information; attitudes, values, and insights; relationships and interpersonal skills; and responsibility (SIECUS, 1998b). Unlike abstinence-only approaches, comprehensive sexuality education is more likely to provide age- and culturally appropriate, medically accurate information for youth.

Comprehensive approaches vary in their messages and emphasis. Abstinence-plus approaches promote abstinence as the safest form of protection against pregnancy and STDs while also providing information and advice on condoms and contraception (Stammers, 2003). Abstinence-plus curricula recognize the desirability and health benefits of abstinence for young people but also present options for youth who are or will become sexually active. Other comprehensive curricula do not include a strong focus on abstinence, particularly when they are targeting youth who are sexually active. Such curricula acknowl-

edge sexually active youth and prepare them for a lifetime of sexuality. Whatever the differences in emphasis, the tenet of comprehensive programs is to teach young people how to avoid unwanted pregnancies and STDs and how to protect their health and the health of their partners. In contrast, abstinence-only programs simply tell young people not to have sex, despite the clear fact that by the time they are 18 years old, most U.S. teens have had sex (Guttmacher Institute, 2006).

HIV Transmission and Prevention

Comprehensive sexuality curricula use up-to-date, accurate information about HIV disease and risk for transmission. *Our Whole Lives* teaches that “HIV can be found in blood, semen, vaginal secretions, and breast milk. This virus is very fragile, and it dies very quickly when it is outside the body” (Wilson, 1999, p. 264). Along with information about HIV transmission, comprehensive sexuality education provides students with information on how to reduce their risk for HIV and other STDs through abstinence and correct, consistent condom use.

Views of People Living With HIV

Some comprehensive curricula, such as *Our Whole Lives*, recognize

that students in the classroom may already be HIV positive. For example, the discussion on preventive methods (using condoms or other barriers) equips HIV-positive youth with the information they need to protect themselves and their partners throughout their lives. Recognizing that youth may already be HIV positive also provides a forum for discussion about living with HIV. *FLA.S.H.* describes HIV disease in this context, “Even though scientists have not found a cure for HIV, there are medicines available that people with HIV can take in order to stay healthy” (Reis, 1989, p. 25-6).

Views of Sexual Minority Youth

Comprehensive education programs recognize the needs of sexual minority youth. Typically, these curricula first define sexual orientation (heterosexual, homosexual, bisexual) before defining sexual activities. *Our Whole Lives* describes sexual orientation as “the deep-seated direction of one’s romantic and erotic attraction toward the same sex (homosexual), other sex (heterosexual), or both sexes (bisexual)” (Wilson, 1999, p. 92). Describing sexual orientation in this way validates sexual minority youth and prepares them to learn about how they can make good choices and protect their health.

What the Research Says

Abstinence-only and comprehensive sexuality education programs have been studied for many years, and despite the need for continued research some things are clear. In a nutshell, comprehensive programs have been shown to work; abstinence-only programs have been shown not to work.

Abstinence-Only Program Outcomes

The largest and most comprehensive study to date, conducted by Mathematica Policy Research for the federal government, found that students in abstinence-only programs were no more likely to be abstinent than students in the control group. Those who had sex started at the same age and had the same number of partners as students who did not take part in the abstinence-only programs (Mathematica Policy Research, 2007).

Dr. Douglas Kirby’s recently released review of abstinence-only programs, *Emerging Answers 2007*, provides additional analysis:

Several abstinence programs, including abstinence-until-marriage programs, have been *rigorously* evaluated with large experimental designs and found to have no

overall impact on delay in initiation of sex, age of initiation of sex, return to abstinence, number of sexual partners, or condom or contraceptive use. (p.124)

Virginity pledging is a common feature of fear- and shame-based abstinence-only programs that has received a great deal of attention. It is used to promote and document premarital abstinence among students taking part in these programs. Students who pledge promise to remain abstinent until they are legally married to someone of the opposite sex. Research has shown that virginity pledgers are one-third less likely to use contraceptives when they engage in sexual activity compared to their peers who have not pledged (Bearman & Brückner, 2001).

More recent research from Bearman & Brückner (2005) also found that teens who took virginity pledges had the same STD rates as non-pledgers and were nearly as likely to have sex before marriage (88 percent) as the general U.S. population (90 percent). The same study demonstrated that students who pledge are less likely to seek medical attention for a suspected STD infection. This reluctance helps fuel the spread of HIV and other STDs, putting more youth at risk.

Comprehensive Program Outcomes

Comprehensive sexuality education, in contrast, has consistently been shown to delay first intercourse, reduce the frequency of intercourse, reduce the number of sexual partners, and increase condom use among youth (Kirby, 2007; U.S. Department of Health and Human Services, 2001). In an earlier *Emerging Answers* report, Kirby (2001) evaluated several comprehensive sexuality education programs and found that three of the programs—*Safer Choices*, *Becoming a Responsible Teen*, and *Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention*—decreased unprotected sex significantly by delaying sex or increasing condom or other contraceptive use. He also referenced two independent studies evaluating another curriculum, *Reducing the Risk*, that found that this comprehensive curriculum also delayed the onset of intercourse, as well as increased the use of condoms or contraceptives among some groups of youth (Kirby, 2001). Other studies have shown that when comprehensive sexuality education is included as part of a broader youth development program more youth remain abstinent for longer periods of time (Cicatelli Associates Incorporated, 2000; Kirby, 2002).

Finally, an evaluation of sexuality education programs in Illinois looked at three of the programs discussed in this report: *Sex Respect* (abstinence-only), *Our Whole Lives* (comprehensive), and *F.L.A.S.H.* (comprehensive) (Campaign for Responsible Sex Education, 2007). The evaluation rated the programs on a variety of standards and components including, but not limited to: medical accuracy, how they encouraged discussion among parents and caregivers at home, and how they encouraged increased knowledge and skills of young people around sexuality education while also being mindful of their sexual and reproductive health. *F.L.A.S.H.* and *Our Whole Lives* each received the highest possible score—15 out of 15. *Sex Respect* received a 2, the lowest score of the 18 curricula reviewed.

Testimonies of Youth and Parents Living with HIV

During 2006 and 2007, AIDS Alliance conducted one-on-one phone and in-person interviews with a dozen parents and youth living with HIV to collect their views on HIV prevention and sexuality education programs in the U.S. today. Not all of those interviewed wanted to be included in this report because of concerns about disclosing their HIV status, but four parents and five youth (one of whom is also a parent) did. Their stories illustrate how abstinence-only-until-marriage programs have affected their lives and the lives of others living with HIV. The following are a few examples of the stories chronicled.



Chelsea Gulden

Chelsea Gulden is a 25-year-old mother living in North Carolina who contracted HIV in college. Chelsea had sensed that her boyfriend might be cheating on her, but the truth didn't sink in until she was tested for HIV and learned that she was both HIV positive and five weeks pregnant. At a young age, Chelsea had to deal with two life-changing events—being HIV positive and being pregnant—but she was able to get the necessary care right away to prevent transmitting HIV to her baby. As a result, her son is HIV negative.

Since testing positive, Chelsea has channeled her time and effort into work with young people at an AIDS clinic in North Carolina. She also takes part in a local speakers bureau and speaks at schools and organizations in her community. Chelsea hopes that by telling her story through her work at the clinic and in the community she

can prevent others from becoming HIV positive. As a counselor, Chelsea has been frustrated by a local policy that forbids her from sharing information about high-risk sexual behavior or condoms with her younger clients. The policy in her county very strictly limits her. If a young person approaches her with questions about sex, she is allowed to respond only with abstinence messages, and she is required to tell the parents if she thinks that the questions indicate that the youth is probably engaging in sexual activity. “This policy just isn't right, and it helps to spread the disease, rather than prevent it,” says Chelsea.

As a young mother living with HIV, Chelsea says, “Abstinence-only programs not only add to problems with STDs and HIV but also add to stigma. If a young person is already infected, they are not being given any hope for a healthy future.” When asked about her son and sexuality education in the schools, Chelsea shares, “Parents should be aware of what their children are learning in school. I don't want my son being taught that people living with HIV are immoral, or that they are going to die.”



Heather Johnson

Heather Johnson is a 19-year-old who acquired HIV perinatally. When Heather was growing up, her family was so concerned about HIV stigma that they moved frequently—from New York City to Alabama and then to Georgia—where she now lives. Heather's father passed when she was very young, and her mother died when she was 13, just a year after Heather was told about her HIV status. It was around this time that Heather experienced sex education in her school. She remembers being told that one in three of her classmates would acquire HIV in their lifetime. Heather thought to herself, "Wow, they are really trying to scare us into thinking this disease will kill you!"

Heather thought that there was a lot of ignorance about HIV among her schoolmates and within her community, so she was not comfortable disclosing her status. "I tried to ignore my grieving process," she says, and in-

stead found herself in a spiral of confusion—running away, depressed, in social services' custody. Heather took many years to appreciate that her life did have promise and that her HIV status was not a death sentence. Heather has since turned her life around and is working with other young people to help them avoid the depression she faced. She actively speaks out about her status and the need for her peers to protect themselves.



Max Siegel

Max Siegel contracted HIV in high school in Arizona, shortly after completing his school district's abstinence-only program. While Max had some idea of how to practice safer sex, he believes that the abstinence-only program in his school failed to educate him on the best ways to prevent HIV infection, including how to negotiate condom use with a partner. Max, now 23, also worries that youth receiving abstinence-only messages may be less willing to seek

an HIV test if they are engaging in risky sexual activity. “Abstinence education keeps my peers from discovering their status. We’re made to feel shamed and embarrassed because we are having sex.”

Max also notes the importance of teaching people who are HIV positive how to protect themselves and others. “Abstinence-only programs don’t teach those of us living with HIV the ways we can avoid transmitting the virus.”

Chaneil Scott

Chaneil Scott is a 15-year-old from Pennsylvania. Chaneil acquired HIV perinatally but was not told that she was HIV positive until she was seven. “I just had to take a lot of medicine all the time, and then one day I asked my mom why I had to take medicine and no one else did, and she whispered in my ear that I had HIV and it was a secret.” Chaneil kept her secret for a long time. She was afraid of what people would say if she told them she had HIV. A year or so ago, Chaneil attended a summer camp for kids with serious illnesses near her home. Back at school, she noticed a picture taken at the same camp in a friend’s locker, and she asked her about it. Her friend said that she had sickle-cell anemia and then asked why Chaneil was at the camp. Chaneil explains, “I told her that I have H-I-V, and that was it. After I left school that day, I began to think, ‘Maybe she

won’t talk to me again tomorrow because I have HIV.’ I had never told anyone my status before. The next day when I went to school, she talked to me, and I was happy that I still had my friend.”

Chaneil is fortunate. Her experience with sexuality education has included more than abstinence, but even a good program is challenged to dispel the stigma that exists for people living with HIV. “Some students say things like, ‘I wouldn’t want them for a friend,’ if they know someone has HIV. The teachers try to change their minds, but they still think the same.” Chaneil plans to speak out more in her community and school about her HIV status. As a young woman living with HIV, she knows that she needs more than abstinence-only messages to have a healthy life and to make responsible decisions in her future relationships. She also knows that her friends and classmates need more information about HIV prevention and decision making. She hopes that by telling her story, they will better understand HIV disease and people affected by it. “I want to help people get better educated about HIV. If I could just tell anyone my status and they could start asking me questions about it, instead of judging me, I would help explain it to them so that they understand.”

Angelo James

Angelo James is a 26-year-old man who acquired HIV several years ago through sexual contact while living in Kentucky. The news of his diagnosis was surprising since Angelo thought he was protecting himself with condoms and fidelity. Because Angelo had heard negative messages about HIV throughout his life, he had a very hard time overcoming the initial shock of his diagnosis. This turmoil was made worse by his family's negative reaction to the news. Just a few months after learning he was gay, Angelo's mother's reaction to his HIV status was "I told you so."

Angelo believes that abstinence-only programs will worsen the situation for youth who test positive. He explains, "It wasn't until I went through a program specifically designed for HIV-positive youth—long after I received a positive diagnosis—that I began to hope again." Angelo's turning point was getting to know and understand others living with HIV, which helped him dispel negative feelings about being positive himself. He hopes that others will come to understand the distinction between fearing HIV and fearing people living with HIV. "While HIV isn't something you want, it's important that we teach that people who are infected can live with HIV."

Angelo thinks education programs should not only address the importance of protecting one's health but also portray HIV-positive people as human and capable of life. Angelo has worked hard to overcome the stigma surrounding HIV and perceptions about people living with the virus, and he now works to educate others about the realities of living with his illness.



Danielle Warren-Dias

Danielle Warren-Dias is from Connecticut and has been living with HIV since 1992. Shortly after learning her status, Danielle came across a job opportunity to work with perinatally infected youth in an AIDS clinic in Hartford. She has been working there ever since. When asked about her conversations with youth in the program, Danielle says, "I don't wait for kids in the program to ask about sex. I know that docs don't feel comfortable asking kids these ques-

tions, so I talk to the kids for them.” Danielle explains that while many of these perinatally infected youth were not expected to live past their infancy, much less into adulthood, they are now reaching adolescence. And, with that, comes sexual activity. “All of these conversations with the youth really came about after we had a 12-year-old girl come in for a ‘mass in her stomach’ and the tests came back that she was pregnant. Over the years, we were burying these kids. Now, we need to talk to them about their sexual risk reduction.”

Danielle feels that youth, especially youth of color, must be taught about their choices when it comes to engaging in sexual activity. “Sometimes, I may be overkill, but these kids need to know what’s out there besides abstinence.” As a social worker and a mother, she even volunteered to hand out condoms at her children’s high school prom. The school’s policies on sexuality education prevented Danielle from doing so at the prom itself, so her team stood outside, across the street, and handed out condoms to students who ventured to the booth. “I wish I would’ve had this information growing up. I would have had the choice to make, but I also would have had the information to make it. If safer sex had been taught back then, it would be so ingrained in our heads, and maybe we wouldn’t be where we are today.”

Nelson Ramirez

Nelson Ramirez is a 42-year-old father who has been living with HIV since 1990. As a long-term survivor, Nelson has seen the perceptions about people living with HIV change over time. In the early years, he remembers others saying that everyone living with HIV should be killed or sent to an island. So, Nelson wasn’t surprised when he encountered discrimination when fighting for custody of his son in 1997. Although both Nelson and the baby’s mother were HIV positive, the baby was given treatment at birth, which successfully prevented perinatal transmission. Nelson wanted full custody of his son, which was a big challenge because many professionals at the time said that a single father “struggling with his own illness” could not care for a child with special needs. After months of perseverance, Nelson began his journey as a single father, and today both he and his son couldn’t be happier.

Nelson’s son is now nine years old, and Nelson is already thinking about the future and ways to protect his son. “Education is the key for youth to have all the choices to protect themselves. Youth should be able to understand the consequences of all their actions,” he says. While Nelson understands that abstinence is ideal, he thinks that adults need to listen more to youth and be more realistic

about the realities they face.

When asked about abstinence education for his son, Nelson shared his concerns for his family. He has heard what public health officials have to say about abstinence-only approaches, and he is worried. “Misinformation taught in abstinence-only programs adds unnecessary stress to the lives of children living with HIV in their families,” Nelson says. “They may be apprehensive about disclosing their emotions with friends or teachers, and denying youth coping with HIV any potential support is negligent and irresponsible.”



Gina Brown

Gina Brown is a woman living with HIV who believes that she did not receive proper sexuality education when she was young. Born and raised in Louisiana, she remembers no mention of sex from her teachers in school and only recalls her moth-

er saying, “Just don’t get pregnant.” Now the mother of a 13-year-old who is entering adolescence and confronting many physical and emotional changes of her own, Gina says, “It is my duty to arm my daughter with all the information I can, including abstinence, personal hygiene, condoms—you name it. Young people go through so many changes in adolescence that we have to build them up, not teach them to fear their bodies like many abstinence-only approaches do.”

When asked how her family would be affected by abstinence-only programs that teach misinformation about HIV, Gina explained the dangers from the perspective of a family living and coping with HIV disease. “If my daughter were taught in school that HIV can be transmitted through sweat and tears, she would likely not trust all the things I have taught her about HIV. She might begin to think I’ve lied to her, she would stop coming to talk to me, and it could entirely tear our relationship apart.”

Recommendations

In 2004, AIDS Alliance, in partnership with youth, caregivers, and education experts, led a consensus process to develop recommendations for school-based HIV prevention education. They have been adapted and included here because they are relevant to the national sexuality and HIV prevention education debate. AIDS Alliance advises policy makers to use the recommendations in concert with the findings of this report—including the voices of HIV-positive youth and parents—to guide national policy on sexuality education.

Recommendations for School-Based Sexuality and HIV Prevention Education

- Schools should provide comprehensive sexuality and HIV prevention education in grades K-12. These programs should be culturally competent and developmentally and age appropriate.
- Whenever possible, comprehensive sexuality and HIV prevention education should take place within the context of a health education curriculum.
- Comprehensive sexuality and HIV prevention education should be factual and medically accurate. Programs should provide young

people with the knowledge and skills to make healthy decisions about protecting themselves and others lifelong.

- Comprehensive sexuality and HIV prevention programs should be evidence-based, grounded in theories and approaches that have been demonstrated to be effective.
- Comprehensive sexuality and HIV prevention programs should stress abstinence from sex and drugs as the most effective ways to avoid HIV and STD infections, as well as unplanned pregnancies. They must also discuss other strategies for reducing risk if and when students become sexually active.
- Age-appropriate information about the role of condoms in preventing HIV, other STDs, and pregnancy should be part of comprehensive sexuality and HIV prevention programs. Accurate information about condoms should be a part of sexuality and HIV prevention programs in every jurisdiction.
- School staff, families, students, public health officials, and relevant communities should work together to design and implement comprehensive sexuality and HIV prevention programs.

- Schools must provide a safe and supportive environment for all students. Stigma and stereotyping of students thought to be at risk for HIV infection are counterproductive to successful prevention efforts.
- School-based HIV prevention efforts should provide information about and linkages to confidential or anonymous HIV counseling and testing services.
- Teachers and staff responsible for sexuality and HIV prevention education should be fully trained for such instructions, and administrators should provide visible support to these teachers and their efforts.
- The federal Department of Education should take a leadership role to encourage the development and prioritization of comprehensive, age-appropriate sexuality and HIV prevention education in all levels of K-12 instruction, supporting the integration of such programs in both classrooms and throughout all levels of administration.

Conclusion

AIDS Alliance hopes that lawmakers, advocates, and other stakeholders can use the voices and stories presented here and the recommendations that follow to develop support for comprehensive, age-appropriate sexuality education programs for youth. The health and well-being of millions of America's youth depend on culturally competent and scientifically sound HIV prevention programs, and HIV-positive youth and parents are speaking to that truth.

School-aged youth need honest, accurate information about sex and HIV if they are to protect themselves and others. By denying them this comprehensive information, abstinence-only programs put young people at risk for unintended pregnancy, HIV infection, and other STDs. For families affected by HIV, abstinence-only programs can endanger relationships and interfere with conversations among youth and parents. The programs' inaccurate and stigmatizing approaches to HIV disease further marginalize these youth and families and perpetuate myths and misconceptions about HIV disease. Finally, these programs consistently dehumanize and even demonize people living with HIV and sexual minority youth. Precious federal resources should not go to ineffective and harmful programs. These funds would be put to better use supporting

comprehensive programs that delay the age of first intercourse, increase contraception and condom use once youth become sexually active, and reduce the number of sexual partners while providing accurate information about HIV disease and transmission, promoting positive images of people living with HIV, and respecting sexual minority youth.

Teens living with HIV—and young people who became HIV positive in their teen years—know first hand that AIDS is not over and that ignorance is not bliss. Parents who are living with HIV know that their hopes and dreams for their children are not enough to keep them safe from the virus. For these HIV-positive youth and parents, the debate about sexuality and HIV prevention education is not an abstraction. Nor is it something that can be left to others with less at stake to argue about. These young people and families have something to say that they want everyone to hear, before it is too late for other teens and other families. AIDS Alliance hopes that America is listening.

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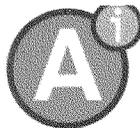
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AIDS Alliance advances the partnership between consumers and providers – we are the voice of women, children, youth and families living with and affected by HIV/AIDS.

published by
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**THE AIDS INSTITUTE**

April 21, 2008

The Honorable Henry Waxman
Chairman
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

RE: The AIDS Institute Comments on Impact of Abstinence-Only-Until-Marriage Programs on HIV Infection

Dear Chairman Waxman:

The AIDS Institute, a national public policy research, advocacy, and education organization, is pleased to submit this statement for the record in regards to the Committee on Oversight and Government Reform's hearing focusing on the public health and ethical concerns with domestic abstinence-only-until-marriage programs.

The AIDS Institute is very pleased with the Committee's decision to hold this critically important hearing. We are deeply concerned with the public health and ethical implications of federally funded abstinence-only-until-marriage programs on HIV infections in the United States. A growing body of research has shown that such programs are ineffective at increasing rates of sexual abstinence, delaying the age of sexual debut, changing sexual risk behaviors, or decreasing rates of pregnancy, HIV, and other sexually transmitted diseases. In addition to being simply ineffective, The AIDS Institute believes that abstinence-only-until-marriage programs are scientifically and ethically unsound, and may have harmful public health consequences.

As rates of HIV and other STD's continue to increase among youth, especially minority youth, the need for proven, evidence-based prevention education programs is greater now more than ever. Since abstinence-only-until-marriage programs teach that heterosexual marriage is the only context in which sexual behavior is acceptable, they are ineffective in preventing HIV among men who have sex with men (MSM) who account for 53% of all new HIV/AIDS cases. Since gay men can not marry, there must be appropriate prevention education that reflects their needs and the reality of their lives.

As a Nation, we can not afford to deny young people medically accurate and potentially life-saving information about condoms and other forms of contraception - too many lives are at stake. While federal funding for evidence based HIV prevention programs has decreased in recent years, abstinence-only-until-marriage programs have seen record increases. In a time of scarce resources, we can not afford a continued investment in these failed, unscientific, ideologically driven programs.

The AIDS Institute is joined by many highly respected public health and medical organizations in

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strongly supporting abstinence as a critically important element of a comprehensive sex education program – which includes education about abstinence, values, communication and decision-making skills, and HIV/STD and pregnancy prevention, including a discussion of condoms at an appropriate age level. We fully support programs that promote abstinence – we are merely opposed to programs that solely focus on the promotion of abstinence-only-until-marriage.

We hope that the testimony and facts presented at this hearing will provide a compelling case for why such programs should no longer be funded.

The AIDS Institute commends you, Chairman Waxman, and other members and staff of the Committee on Oversight and Government Reform, for holding this critically important hearing.

Sincerely,



Dr. A. Gene Copello
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4/22/08

To the congressional committee:

This week, you will take part in the first ever congressional oversight hearing dealing with the problems of abstinence-only-until-marriage programs. I am writing to state my strong support for comprehensive sex education programs, and to represent the perspectives of young people, students, and journalists.

My name is Alyse Knorr, and I am a junior English and journalism student at Elon University in North Carolina. I am an Honors student and an active member of Elon's student media: I have worked for *The Pendulum*, Elon's student newspaper, for three years now, and have also completed several research projects through Elon's School of Communications. I am also a part-time features reporter for the *Greensboro News & Record*, the daily newspaper for Greensboro, N.C.

Last year, I completed a nine-month independent research project about teen pregnancy in my region, North Carolina's Alamance and Guilford Counties. I used qualitative research methods including interviews and field observation to delve into the lives of teen mothers between the ages of 15 and 17, and in so doing, to gain a better understanding of the serious problem of teen pregnancy. My research culminated in two serialized centerpiece articles in *The Pendulum* and two articles in the *Greensboro News & Record*.

As a published author on the subject of teen pregnancy in Alamance and Guilford Counties, I can attest to the failure of abstinence-only sex education programs. Our society, with its double standard of a sexually-permeated media and strong stigma against premarital sex, leaves many teens feeling lost and confused. The young women I interviewed during the research for my articles revealed to me, over and over again, that what teens need is not to be instilled with the values Congress chooses for them, or forced into making certain decisions about their own bodies, but to be given all of the resources and education they need so that they can make healthy choices no matter what they decide to do with their body.

It's a simple fact that some teens will have sex no matter how many times a teacher tells them not to. It's also a simple fact that they will not use a condom when they have sex if they do not know how to use one. This lack of education about birth control is what causes teen pregnancy rates to be so high: not a higher rate of teen sex, but a higher rate of *unprotected* teen sex.

As a 21-year-old college student, I represent an age group that has only recently transitioned from teenager to adult. I also represent the next generation of tax payers whose money may be wasted by passing abstinence-only education legislation that does not work. The majority of people in my age demographic, a group that has experienced high school sex education only a few years ago, feels strongly against abstinence-only education.

Members of my age group know that abstinence-only sex education does not affect our sexual decisions, but that comprehensive sex education does. At the end of the day, teens will always make their own choices about their bodies and their relationships, but in order to make the smartest ones (using condoms and other methods of birth control), they must be armed with knowledge.

As a journalist, I can speak to the professional goal of objectivity, an ethical principle that all media personnel strive for. While journalists strive to be objective in their reporting and representation of society, legislators must strive for objectivity in making decisions that affect society directly. Keeping this in mind, any legislator must put aside his/her personal

beliefs, which may be based in faith, family values, or life experience, and instead make decisions based off of tested scientific research, and off of what will be most technically effective in solving problems.

Look into the scientific research on this topic, and you will find that it supports the success of comprehensive sex education programs. Your duty to society is to be objective and fair in passing legislation – please do this by considering the facts, and only the facts, and putting aside personal beliefs.

The two proposed solutions to this problem, and the two opposing sides they have created, may have helped the issue become more confusing than it actually is. But teen pregnancy in the United States is the problem, not teen sex. Address the *problem*, which is pregnancy, by teaching teens the corresponding solution: methods of safe sex. Do not rely on abstinence-only programs to prevent all teens from ever having sex, but instead, stop teen pregnancy by understanding that we must give teens all of the resources and education they need to make their own choices about their bodies, not make all of those choices for them.

Sincerely,

Alyse Knorr
Elon University Class of 2009



Michael D. Maves, MD, MBA, Executive Vice President, CEO

April 30, 2008

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Waxman:

The American Medical Association (AMA) and its physician and medical student members appreciate the opportunity to provide for the hearing record the AMA's policy on abstinence-only education programs and comprehensive sexuality education. We request that this letter be included in the record for the hearing by the Committee on Oversight and Government Reform held on April 23, 2008, assessing the evidence on domestic abstinence-only programs.

The AMA recognizes that the primary responsibility for family life education is in the home, but also supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction. AMA policy does not support the sole use of abstinence-only education within school systems. The AMA urges schools to implement comprehensive, developmentally appropriate sexuality education programs that:

- are based on rigorous, peer reviewed science;
- show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and at risk for pregnancy;
- include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives that include condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases;

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The Honorable Henry A. Waxman
April 30, 2008
Page 2

- utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth;
- include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and
- are part of an overall health education program.

In addition, the AMA endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes, and supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teaches about contraceptive choices and safer sex. The AMA does not support federal funding of community-based programs that do not show evidence-based benefits. The AMA's support of comprehensive family life education extends to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually transmitted diseases while also discussing the roles of condoms and birth control.

Responsible sexual behavior is one of the leading health indicators for the federal government's Healthy People 2010 initiative, which includes several specific objectives related to adolescent health. As the largest professional physician membership organization in the United States, the AMA is in a unique position to encourage physician participation in the national health objectives through publications and online resources on adolescent health. The AMA encourages physicians to assist parents in providing human sexuality education to children and adolescents, and encourages physicians to support comprehensive health education programs in kindergarten through grade 12.

Thank you for considering our views on this important issue affecting the health of our nation's youth.

Sincerely,



Michael D. Maves, MD, MBA

H-170.968 Sexuality Education, Abstinence, and Distribution of Condoms in Schools
Our AMA:

- (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
- (2) Urges schools to implement comprehensive, developmentally appropriate sexuality education programs that:
 - (a) are based on rigorous, peer reviewed science;
 - (b) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant;
 - (c) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases;
 - (d) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth;
 - (e) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and
 - (f) are part of an overall health education program;
- (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
- (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
- (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
- (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
- (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy.

(CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04)

**Written Testimony by Kevin Robert Frost, Chief Executive Officer
amfAR, The Foundation for AIDS Research
Submitted to the United States House of Representatives
Committee on Oversight and Government Reform**

“Domestic Abstinence-Only Programs: Assessing the Evidence”

April 23, 2008

Chairman Waxman, distinguished Members of the House Committee of Government Oversight and Reform, and Committee Staff, first let me thank you for holding this hearing on such an important matter. On behalf of amfAR, The Foundation for AIDS Research, I am providing this testimony regarding the efficacy of abstinence-only programs because HIV/AIDS is dramatically rising among our nation’s youth. There is an urgent need to stop this epidemic from devastating the lives of America’s young people and evidence-based education is essential.

amfAR is one of the world’s leading nonprofit organizations dedicated to the support of AIDS research, HIV prevention, treatment, education, and the advocacy of sound AIDS-related public policy. amfAR believes that HIV/AIDS and related public health policy should be based on scientific evidence. As an organization dedicated to advancing evidence-based policy, we are deeply concerned about the continued federal support of abstinence-only programs. Instead of providing young people with the critical, comprehensive health education necessary to make informed choices about sexual behavior and the prevention of sexually transmitted infections (STIs) including HIV/AIDS, these programs provide misinformation to advance the ideological position that individuals should not engage in sexual activity unless or until they are in a heterosexual marriage. It is a disservice to provide our nation’s youth with anything less than medically accurate, scientifically-based information about health. Continued investment in abstinence only programs is poor public health policy and irresponsible fiscal policy on the part of the federal government.

The United States government has been supporting abstinence-only programs to prevent teen pregnancy since 1981. Since that time, the aim of these programs has expanded to include prevention of HIV/AIDS and other sexually transmitted infections (STIs). In the U.S., federal funding for abstinence only programs increased from \$97.5 million in 2000 to \$241.5 million in 2007. Congress has funneled more than \$1 billion (through both federal and matching state funds) to abstinence-only-until-marriage programs since 1996. The scientific evidence, however, neither supports the U.S. government's current policy of making abstinence-only programs the cornerstone of its HIV prevention strategy among youth, nor does it support the unprecedented increases in funding these programs have received during the current Administration.

Abstinence-only programs are provided in approximately one-third of U.S. schools, reaching about eight million students annually. These programs restrict information about condoms and contraception thereby decreasing young people's abilities to protect themselves against HIV and other STI(s). When information on condoms or contraception is included, it is often incorrect and misleading. A report evaluating the content of abstinence-only curricula found that over 80% of these programs contained erroneous scientific information about reproductive health and misrepresented the effectiveness of condoms in preventing STIs and pregnancy.¹ Furthermore, research has shown that these programs are ineffective in promoting abstinence, reducing sexual activity or the number of sexual partners among youth. Abstinence-only programs have also been shown to be ineffective at reducing unprotected sex or impacting the risk of HIV transmission among youth. A federally-supported 10-year evaluation of abstinence-only programs found that these programs had negative effects on knowledge: youth enrolled in abstinence-only programs were less likely to report that condoms were effective in preventing STIs and more likely to report that condoms were never effective at preventing HIV.²

The lack of effectiveness of abstinence-only programs in preventing HIV transmission is particularly troubling given that, in the United States, youth are increasingly affected by the

¹ United States House of Representatives. Committee on Government Reform, Minority Staff Special Investigations Divisions. The Content of Federally Funded Abstinence-Only Education Programs. December 2004. Available at: <http://oversight.house.gov/documents/20041201102153-50247.pdf>.

² Mathematica Policy Research, Inc. Impacts of Title V, Section 510 Abstinence Education Programs. Final Report. April 2007. Available at: <http://www.mathematica-mpr.com/publications/PDFs/impactabstinence.pdf>

ongoing HIV/AIDS epidemic. Between 2002 and 2006, there was a 25% increase in the number of young people living with AIDS in the United States, and HIV/AIDS is now a leading cause of death among young adults domestically.³ Certain sub-groups of young people are at particularly elevated risk for HIV in the United States. Young people of color, particularly African Americans, accounted for 61% of all new HIV infections among 13 to 24 year-olds in 2005. Young men who have sex with men (MSM), especially those of color, are also at increased risk of infection. Since 1994, the number of new HIV cases has risen sharply among young MSM.⁴ African American MSM, aged 13 to 24 years, have experienced an 80% increase in HIV rates between 2001 and 2005.⁵ Young women of color are also at elevated risk. In 2004, the AIDS case rates for African American women (48.2 per 100,000) was 23 times higher than the rate for Caucasian women (2.1 per 100,000), and the case rate for Latina women (11.1 per 100,000) was 5 times the rate for Caucasian women.⁶

The increase in HIV rates among certain vulnerable youth -- particularly young women and young gay men and men who have sex with men (MSM) -- is also troubling because the content of abstinence-only programs does not address the needs of these populations. Federally funded abstinence-only programs are required to teach that the only appropriate and healthy sexual behavior occurs within marriage, which is defined only as a union between one man and one woman.⁷ Inherently, this message excludes those who are prohibited from legal marriage in the United States and portrays the sexual feelings of lesbians, young gay men and MSM as outside the standards and norms of behavior supported by society. This does nothing to provide these youth with the skills and knowledge they need to reduce their health risks, but rather perpetuates a stigma that may have harmful effects on their lives and choices.

³ Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report, 2006. Volume 18. Atlanta: U.S. Department of Health and Human Services. CDC, March 2008. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/pdf/2006SurveillanceReport.pdf>; CDC. Ranking of 10 Leading Underlying Causes of Death among Persons 25-44 Years of Age in State X, 1999. Retrieved on September 21, 2007. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/epi-guideline/tables.htm>.

⁴ Jaffe HW, Valdiserri RO, De Cock KM. The Reemerging HIV/AIDS Epidemic in Men Who Have Sex with Men. *JAMA* 2007; 298(20): 2412-2414.

⁵ CDC. HIV/AIDS Update: New Surveillance Slide Set on Men Who Have Sex with Men (MSM). March 2008. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/msm/index.htm>.

⁶ CDC. HIV/AIDS Surveillance Report. Volume 16. 2004. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report/pdf/2004SurveillanceReport.pdf>

⁷ Sexuality Information and Education Council of the U.S. (SIECUS). Reality Behind Abstinence Only Programs. Available at: <http://www.nomoremoney.org>. Retrieved on April 8, 2008.

Abstinence-only programs may also have harmful effects on the health of young women. These programs often lack accurate and complete sexual health information about condom use, contraception, and disease transmission. While these medical inaccuracies are detrimental to all youth, they can be particularly harmful for young women who are more susceptible to HIV (and other STI) transmission because of multiple biological, social and economic factors. Abstinence-only programs not only fail to take into account the special risk factors of young women, but they also perpetuate gender stereotypes that may make young women feel guilty and ashamed of their sexuality. Research has demonstrated that the stigma surrounding female sexuality can prevent women from protecting themselves during sexual activity and even from seeking medical treatment for sexually transmitted infections.⁸ As with gay youth and MSM, the impact of abstinence-only programs on young women serves to do more harm than good.

Research has shown that abstinence-only programs are ineffective at providing young people with the tools and information needed to reduce their risk of HIV and other STIs. The scientific evidence to date suggests that investing in comprehensive sexuality education that includes support for abstinence but that also provides risk reduction information would be a more effective HIV prevention strategy for young people.

American youth are growing up during a time when AIDS in America is considered a treatable disease. Unlike young people in the early days of the U.S. epidemic, they have not experienced the deaths of hundreds of their peers from AIDS. Because the sense of urgency surrounding HIV/AIDS has turned into generalized public and political complacency, young people may be more likely to have misconceptions about HIV/AIDS, including the modes of transmission and the ways of preventing HIV infection.⁹ In order to correct these misconceptions, our public health policies must be based on scientific evidence rather than ideology. To do otherwise ignores the rights and realities of young people and denies them the knowledge needed to safeguard their health.

⁸ Kay J, Jackson A. Sex, Lies and Stereotypes: How Abstinence Only Programs Harm Woman and Girls. Legal Momentum 2008. Available at: <http://www.legalmomentum.org>.

⁹ Hancock T, Mikhail BI, Santos A, Nguyen A, Nguyen H, Bright D. A Comparison of HIV/AIDS Knowledge among High School Freshmen and Senior Students. *Journal of Community Health Nursing* 1999; 16(3): 151-163.

amfAR urges you to consider this testimony as you deliberate on the future of federal funding for abstinence-only programs in the United States. Should you have any questions, please feel free to contact me or Elisha Dunn-Georgiou, Legislative Analyst, at amfAR (1150 17th St., NW, Washington, D.C. 20036; (202) 331-8600; elisha.dunn-georgiou@amfar.org).

Founded in 1985, amfAR is dedicated to ending the global AIDS epidemic through innovative research, programs, and policies worldwide. amfAR-funded pioneering research has increased our understanding of HIV and has helped lay the groundwork for major advances in the study, treatment, and prevention of HIV/AIDS globally. Since 1985, amfAR has invested nearly \$275 million in its mission and has awarded grants to more than 2,000 research teams worldwide.

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AMERICAN
PSYCHOLOGICAL
ASSOCIATION

**Written Statement from the
American Psychological Association
for the
House Committee on Oversight and Government Reform
On
Domestic Abstinence-Only Programs: Assessing the Evidence
April 23, 2008**

On behalf of the 148,000 members and affiliates of the American Psychological Association (APA), we thank you for holding this important hearing to assess the evidence regarding domestic abstinence-only programs.

APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprising researchers, educators, clinicians, consultants, and graduate students, APA works to advance psychology as a science, a profession, and as a means of promoting health, education and human welfare. Psychologists play a vital role in assessing the effectiveness of and making recommendations regarding programs, such as those that impact sex education. As such, we appreciate the opportunity to share our comments regarding these critically important programs with members of the Committee.

"Sexual education" refers to instructional curricula that teach students about human sexuality. Specific practices broadly fall into two categories: abstinence-only/ abstinence until marriage and comprehensive. In the 2008 fiscal year, the Administration for Children and Families at the Department of Health and Human Services (HHS) will make available to states and other grantees \$163 million in federal aid for the implementation of abstinence-only sexual education programs.

Programs receiving these funds must follow what is known as the "A-H" definition of abstinence education, set forth by section 510 of the Social Security Act. These criteria include that abstinence-only curricula have as their "exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity" and that teach, "abstinence from sexual activity outside marriage as the expected standard for all school-age children." Other criteria under the "A-H" definition are couched less in terms of concrete gains or behavioral expectations, including that programs teach "that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects."

Comprehensive sexual education programs share many core features with abstinence-only approaches, including elements of the "A-H" definition. Indeed, comprehensive approaches present abstinence from sexual activity as carrying health benefits and as the best and only assured way of eliminating the risk of pregnancy or of contracting HIV/AIDS or other sexually transmitted infections (STIs). Both approaches frequently include lessons on ways to reject sexual advances and on how the presence of alcohol and drugs is associated with increased sexual activity. However, comprehensive sex education curricula also include lessons on contraception and condom use as means of reducing the risk of unintended pregnancy and disease contraction associated with sexual activity.

A recent outcome analysis by Mathematica, Inc. of several federally supported abstinence-only programs found that while the students enrolled in the programs had greater knowledge of the risks associated with teen sexual activity than the control group, there were no between-group differences in age of first intercourse or frequency of sexual activity or number of sexual partners.

Scientific literature also stands at odds with specific criteria for federal funding of abstinence-only education. Criterion (E) in the “A-H” definition states that eligible programs must teach “that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.” In fact, little research evidence exists showing that consensual sex between adolescents leads to negative mental health outcomes. Equally little data exist to evidence the positive impact of marriage upon sexual function or individual resilience.

Research Literature

In 2005, the APA Council of Representatives approved a *Resolution in Favor of Empirically Supported Sex Education and HIV Prevention Programs for Adolescents*. The resolution outlines an extensive body of research available about sexual education and related programs and provides recommendations for future policy and research activities. The findings of the resolution are summarized in this statement.

Research demonstrates that young people report concerns about HIV/AIDS, but many do not perceive themselves to be personally at risk and lack accurate information about circumstances that put them at risk for HIV infection. This is particularly alarming given that the proportion of newly identified HIV cases among persons under the age of 25 has increased since 1994 and that statistical models suggest that half or more of all HIV infections occur before age 25. In fact, most of those diagnosed with AIDS at ages 21 to 24 were most likely infected during adolescence as a result of the latency between acquiring HIV and an AIDS diagnosis.

Abstinence-only and Abstinence until Marriage Programs

Little evidence exists regarding the efficacy of abstinence-only and abstinence until marriage programs, with only a few published scientific studies that are quite limited as a result of a lack of randomization and homogeneity, making behavioral change difficult to measure and the results not generalizable.

Many published studies associated with abstinence-only education programs have failed to find a reduction in sexual behavior. In fact, virginity pledges, abstinence-only programs, and abstinence until marriage programs have been shown to have the unintended consequence of increasing the probability that adolescents will have unprotected intercourse at the time of first intercourse. Additionally, research shows that virginity pledgers who contracted STIs have been less likely to know they had an STI.

Furthermore, using these programs as a way to prevent HIV transmission was found not to be effective in long-term, randomized controlled studies, especially for sexually experienced adolescents. Moreover, abstinence until marriage programs have not shown to make a substantial effort to address the unique needs of lesbian, gay, bisexual and transgendered (LGBT) adolescents and thereby discriminate against LGBT adolescents

who are disproportionately affected by HIV and who are precluded by law from marrying.

Comprehensive Sexuality Education Programs

Most comprehensive sexuality education programs include the message that abstinence or mutual monogamy with a partner known not to be HIV-infected are the safest ways to prevent sexual transmission of HIV and thus support the goals of abstinence and delaying initiation of sexual behavior.

HIV prevention programs for youth that focus on delaying initiation of sexual behavior are valuable and justified on the basis of developmental theory. Comprehensive sexuality education programs that provide information, encourage abstinence, promote condom use for those who are sexually active, encourage fewer sexual partners, educate about the importance of early identification and treatment of STIs, and teach sexual communication skills have proven effective with sexually experienced adolescents. In fact, research demonstrates that comprehensive sexuality education programs that discuss the appropriate use of condoms do not accelerate sexual debut and do decrease pregnancy rates.

Empirical research shows that these programs decrease the likelihood of unprotected sexual intercourse at the time of first intercourse and reduce sexual risk behaviors that contribute to HIV. In addition, targeted comprehensive sexuality education programs for adolescents have been shown to decrease high risk sexual behaviors among gay, lesbian and bisexual youth.

Furthermore, targeted comprehensive sexuality education programs for substance dependent adolescents have not only decreased high risk sexual behaviors, but also increased the number of adolescents who abstained from sex. Comprehensive sexuality education programs for high risk adolescents in family and community-based institutional settings provide access to hard-to-reach adolescents and have been demonstrated to be effective, particularly in increasing condom use and condom acquisition. In addition, comprehensive sexuality education programs are effective in reducing risky behaviors and HIV transmission and increasing condom use among those having sex for the first time. They have also proven effective in preventing high risk sexual behaviors for adolescents living with HIV.

A considerable body of evidence shows that programs focusing on both abstinence and condom use for those who choose to have sex have resulted in reductions in HIV-risk behavior and delays in the onset of intercourse.

Federal guidelines recommend that programs to prevent HIV/STIs among youth be based on empirical evidence derived from methodologically sound studies characterized by:

- a) adequate sampling strategies to ensure minimum selection bias and maximum generalizability;

- b) valid and reliable measurement techniques;
- c) the use of appropriate comparison groups; and
- d) pre and post-intervention assessment that includes long-term follow-up to ensure maintenance of intervention effects.

The APA strongly supports the foregoing Federal guidelines and further recommends that:

- 1) Programs to prevent HIV/STIs among youth include clear definitions of the behaviors targeted for change, address a range of sexual behaviors, be available to all adolescents (including youth of color, youth with mental health problems, gay and lesbian adolescents, adolescents exploring same-sex relationships, drug users, adolescent offenders, school dropouts, runaways, homeless, culturally diverse and migrant adolescents), and focus on maximizing a range of positive and lasting health outcomes;
- 2) Widespread implementation of particular programs occur only in those instances when the efficacy and effectiveness of the programs have been well-established through sound scientific methods;
- 3) New programs, including abstinence-only and abstinence until marriage programs, be tested in comparison to programs with proven effectiveness;
- 4) Public funding for the implementation of comprehensive sexuality education programs be given priority over public funding for the implementation of abstinence-only and abstinence until marriage programs until such programs are proven to be effective;
- 5) Congress and HHS promote and encourage programs that serve the needs of those whose sexual experiences, by law, occur exclusively outside of the context of traditional marriage, including men who have sex with men and gay, lesbian, bisexual and transgendered youth; and,
- 6) Congress and HHS advocate for more rigorous evaluation of abstinence-only programs.

In closing, the American Psychological Association would like to thank you for the opportunity to share our comments on the evidence of domestic abstinence-only programs. We appreciate the Committee's ongoing commitment to the positive development of children and adolescents and look forward to serving as a resource and partner as you work on this and other important issues affecting children and youth.



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April 21, 2008

The Honorable Henry Waxman
 Chairman
 Committee on Oversight and Government Reform
 U.S. House of Representatives
 2157 Rayburn House Office Building
 Washington, D.C. 20515

RE: Abstinence-Only-Until-Marriage Education and HIV Infection

Dear Chairman Waxman:

AIDS Project Los Angeles commends both you and the Committee on Oversight and Government Reform for conducting a hearing on domestic abstinence-only-until-marriage sex education programs.

APLA has been vocal and public in its opposition to funding for abstinence-only programs. The U.S. has now spent over \$1.5 billion on abstinence-only-until-marriage programs, while HIV prevention funding overall has been reduced and now approximates what we as a nation were spending on HIV prevention efforts in the mid-1990's.

All available study – including reports from Congress, the General Accountability Office, and the Institute of Medicine – indicates that that abstinence-only-until-marriage education programs are ineffective at best. They fail to achieve their basic goals of increasing rates of sexual abstinence, delaying sexual debut, changing sexual risk behaviors, or decreasing rates of pregnancy, HIV, and other sexually transmitted diseases. At the same time they have been shown to be circulating inaccurate medical information, and withhold critical information about safer sex practices from young people who must be taught how to protect themselves.

The Centers for Disease Control and Prevention (CDC) is expected to announce new increases in the estimated annual number of HIV infections in the U.S. Recently, the CDC also reported increases in HIV infections among men who have sex with men (MSM), including dramatic increases among young gay men in minority communities.

Abstinence-only-until-marriage programs teach that heterosexual marriage is the only context in which sexual behavior is acceptable. These programs are consequently inappropriate for and ineffective in preventing HIV among men who have sex with men (MSM) who cannot marry and who now account for 53% of all new HIV/AIDS cases.

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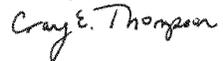
U. S. prevention funding must support evidence-based HIV prevention and sexual education that reflects the needs and realities of the MSM population. U. S. prevention programs must also be expanded to include more culturally-appropriate HIV/AIDS prevention programs to better serve minority communities and gay men of color.

APLA supports abstinence education only as one element of comprehensive sexual education which includes culturally appropriate education about abstinence, values, communication and decision-making skills, and HIV/STD and pregnancy prevention, including condom use.

We hope that the testimony and facts presented at this hearing will provide a compelling case for why abstinence-only-until-marriage programs should no longer be funded.

AIDS Project Los Angeles is one of the nation's largest AIDS service organizations. Founded in 1982, we provide direct services each year to more than 9,500 men, women and children living with HIV and AIDS in Los Angeles County. Our services include prevention education, a food bank, a dental clinic, housing assistance, mental health counseling, women's services and case management.

Sincerely,

A handwritten signature in cursive script that reads "Craig E. Thompson".

Craig E. Thompson
Executive Director



**Statement of the Adolescent Pregnancy Prevention Coalition of North Carolina (APPCNC)
on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage
Programs and the Need for Comprehensive Sexuality Education**

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

The Adolescent Pregnancy Prevention Coalition of North Carolina (APPCNC) is a statewide organization dedicated to the prevention of adolescent pregnancy through advocacy, collaboration, and education. We serve the resource and education needs of educators, health care professionals, religious leaders, child and health advocates, and policy organizations in all 100 North Carolina counties.

In the year 2006, a total of 19,597 girls ages 10-19 became pregnant in North Carolina; nearly 29% of these pregnancies were repeat pregnancies.¹ Additionally:

- Each day in North Carolina, 53 girls ages 19 and younger become pregnant²
- The number of 10-14-year-old girls who became pregnant in 2006 could fill eight school buses³
- Sixty-nine percent of North Carolina high school seniors report having sexual intercourse at least once⁴

As an organization concerned about the health and education of our state's and our nation's young people, APPCNC wishes to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs. There is a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth, and fully informs them about abstinence and contraception, among a variety of other topics. We are committed to using sound scientific evidence in promoting the health and welfare of North Carolina's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years even though no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally funded study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-

¹ NC Department of Health and Human Services, Division of Public Health, State Center for Health Statistics

² Adolescent Pregnancy Prevention Coalition of North Carolina

³ Adolescent Pregnancy Prevention Coalition of North Carolina

⁴ 2007 North Carolina Youth Risk Behavior Survey

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marriage programs have achieved their goal to increase rates of sexual abstinence--the entire supposed purpose of the programs. This report followed the findings from 13 states that have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful.

A report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the already significant body of knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs.

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, which discussed what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.

These programs are not supported by any of the leading national or international public health and medical organizations. Every major medical and public health organization supports a comprehensive approach to sexuality education. These include the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, the American Public Health Association, the Institute of Medicine, the National Institutes of Health, and the Society for Adolescent Medicine, among others. Several, including the American Public Health Association, the Institute of Medicine, and the Society for Adolescent Medicine, have gone so far as to call for the repeal of current abstinence-only-until-marriage programs and funding.

In addition, on November 21, 2007, ten public-health researchers sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid urging Congress to reduce or eliminate federal support for abstinence-only-until-marriage programs, in part because the programs have "multiple scientific and ethical errors." We strongly support the researchers' conclusion that abstinence-only-until-marriage programs withhold "potentially life-saving information" about birth control and ignore the health needs of lesbian, gay, bisexual, and transgender (LGBT) youth. The letter focused on the large body of evidence showing that abstinence-only-until-marriage programs are ineffective in getting young people to delay sexual initiation, noting that, "Recent reports in professional publications by the authors of this letter have highlighted multiple deficiencies in federal abstinence-only programs."

Our youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.



Statement on the Need for Comprehensive Sexuality Education
Submitted for the Record to the Committee on Oversight and Government Reform
April 23, 2008

Arkansas is a poor state. One must question whether the state school districts think abstinence-until-marriage programs are really the ideal type of education for young people or merely the only program for which there is desperately needed funding. Currently the state receives over \$2.5 million for abstinence education. Obviously, the playing field is not level when school districts make choices about educating youth about sex. Although three credible national studies have shown the abstinence-until-marriage programs are ineffective, how will school districts replace federal funds to hire or to train educators for anything but abstinence-until-marriage?

The Arkansas legislature appropriated \$375,000 in general revenue for comprehensive sexuality education for 2007 and for 2008, which uses the CDC's Programs That Work curricula. These are evaluated curricula shown to be effective in getting young people to delay sexual initiation and to use protection if and when they become sexually active. Evaluated, effective, recommended by the CDC, the National Campaign to Prevent Teen Pregnancy, yet hardly available in Arkansas.

For the last four years a Planned Parenthood health educator has used the Programs That Work curricula in 4 high schools in Little Rock. What is most important about comprehensive sexuality education? She replies that it reaches all the kids—those who are abstinent, those who are already sexually active, gay, lesbian and heterosexual youth—without shame or guilt. Abstinence-until-marriage is one-size-fits-all, never acknowledging the diversity one finds in a classroom. She questions her kids, asking if they think talking about contraception and safer sex along side abstinence is a double message. Invariably, the answer is no.

Parents, educators, legislators want young people to be safe. It is easy to default to abstinence-until-marriage because it seems safe and it is a familiar message. In reality, it puts kids in harm's way, denying them the information they need to make good choices and to act responsibly. Comprehensive sexuality education is not sexual intercourse education, a fact often distorted by the media and people without any real knowledge of what is taught. Making informed choices about whether or not to engage in sexual activity, how to deal with coercion, how to deal with a media chock-a-block with sexual images, how to define love and intimacy—all are aspects of real sexuality education.

To draw an Arkansas analogy, hunting for game is so popular in the state that some school districts will make the first day of hunting season a holiday. However, before a

young person can go into the woods alone with a gun, he has to have hunting education. This education is not left to parents. Safety is important enough that kids are taught how to use a gun, what to wear, what is legal to shoot. With this education 16 year olds are considered capable of going into the woods alone with a lethal weapon. Yet information about contraception and safer sex is considered too dangerous. Need I say more?

Respectfully submitted,

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**Statement of the American Social Health Association
on the
Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage
Programs
Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

Since 1914 the American Social Health Association (ASHA) has been dedicated to improving the health of individuals, families, and communities, with a focus on sexually transmitted infections. We have consistently incorporated abstinence, as the surest way to prevent infection, into our STI prevention messages. We strongly support both encouraging teens to delay sexual activity and informing them about how to protect themselves against STIs and unintended pregnancy when they become sexually active.

The United States has the highest STI rates in the industrialized world, with nearly 19 million new STI cases each year. In one year, our nation spends over \$8.4 billion to treat the symptoms and consequences of STIs. The health consequences include: chronic pain, infertility, cervical cancer and increased vulnerability to HIV. Persons with a pre-existing STD have a 3 to 5 fold increased risk of acquiring HIV. By age 24, at least one in three sexually active people will have contracted an STI. Young people bear a disproportionate burden of nearly half of all new STIs.

Scientific evidence confirms that abstinence-only programs are not effective in delaying sexual initiation, preventing unwanted pregnancy, or reducing sexually transmitted infections. Federal and state governments have invested more than \$1.3 billion in these programs since 1997 and evidence shows that they are ineffective. Programs that fail to provide comprehensive messages leave youth vulnerable to unintended pregnancy, and STIs including HIV/AIDS. Sadly, abstinence-only programs put health educators in the untenable and unethical position of withholding vital information.

These programs do not reflect the reality of life in the United States, where sex before marriage is the norm. According to the National Center for Health Statistics *more than 90 percent of Americans have sex before marriage*. Likewise, sexual activity among teenagers is commonplace – the Centers for Disease Control and Prevention's 2005

Youth Risk Behavior Surveillance data indicate that *63 percent of high school seniors report having engaged in sex by the spring semester of their senior year.*

ASHA believes strongly that parents, health care providers, educators, and other responsible adults have critical roles to play in educating young people about responsible sexual behavior, including use of condoms and other contraception. We urge Congress to eliminate abstinence-only-until-marriage programs and to support programs that provide young people with comprehensive, medically accurate information that includes information on condoms and other forms of contraception.

Respectfully submitted,

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**Statement of the the Caucus for Evidence-Based Prevention on the
Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs
and the Need for Comprehensive Sexuality Education**

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

The Caucus for Evidence-Based Prevention would like to thank the members of the House Oversight and Government Reform Committee for allowing us to submit a statement for the first-ever oversight hearing on domestic abstinence-only-until marriage programs. The Caucus for Evidence-Based Prevention applauds the committee for taking this necessary step to address our public health and ethical concerns as well as question and analyze the funding of programs that have no basis in sound science. The Caucus membership includes a wide spectrum of US-based NGOs and their international partners dedicated to the promotion of evidence-based policies. Our goal is to monitor and analyze evidence about HIV programs and alert the community when ideology, opinion, or prejudice interferes with evidence-based approaches to reducing the further spread of HIV.

This is why we find the continued promotion of abstinence-only-until-marriage programming so troubling. Since 2000, study after study has led to a large body of scientific evidence indicating that abstinence-only-until-marriage programs do not work. For example, in a study published in 2004, scientists revealed that a nationally representative sample of teenagers who pledged to remain virgins until they were married had the same rate of STDS as those who did not take the pledge. They also were more likely to practice risky behavior.¹ More recently, a study conducted by Mathematica Policy Research, Inc. on behalf of the Department of Health and Human Services found that abstinence-only-until-marriage programs are ineffective at changing young people's sexual behavior.² Yet further evidence from another study published in this month's *Journal of Adolescent Health* revealed that abstinence-only-until-marriage programs did not significantly reduce the number of teen pregnancies among adolescents nor did it reduce the likelihood of engaging in vaginal intercourse.³ Conversely, a recent review of curriculum-based sex and HIV education programs found that **comprehensive programs** can delay or decrease sexual behavior and improve the use of condoms and contraception.⁴

Despite this overwhelming evidence, federal and state funding for abstinence-only-until-marriage programs continues to grow. Why does the government continue to waste taxpayer dollars on ineffective, unscientific programming when there is clear evidence about what is effective? Congress has a momentous opportunity to answer this question at this hearing by shedding light on the public health failure of a program that has squandered more than \$1.5 billion in federal tax payer dollars. Continuing to fund abstinence-only-until marriage programs in lieu of more comprehensive programming is a risky proposition to say the least; as the evidence indicates, the consequences of a lack of knowledge about sexuality can be disastrous for a young people, putting them at higher risk for unintended pregnancy, sexually transmitted infections and HIV/AIDS.

<http://www.hiv-prevention.org>

Therefore, we strongly recommend that the Government Oversight and Reform Committee heed the wisdom of world-renowned scientific experts and consistent findings from rigorously-conducted research to support programs and policies that will actually help young people and conclude that abstinence-only-until-marriage funding must end.

As you begin your deliberations, we urge Congress to place evidence over ideology. Anything less would not be supported by medical science and sound public health practice. Anything less would put children at risk for pregnancy, sexually transmitted disease, and HIV/AIDS. We ask Congress to end federal funding for abstinence-only-until-marriage programs and to invest these funds in evidence-based programs that can make a difference in young people's lives. We also urge the Congress to avoid exporting these ineffective programs to other countries.

Sincerely,



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AIDS Vaccine Advocacy Coalition
Co-Chair Caucus for Evidence-Based Prevention



Katie Porter, Legislative Policy Analyst
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Co-Chair Caucus for Evidence-Based Prevention

***The views expressed in this Caucus for Evidence-Based Prevention statement do not necessarily reflect the views of all of our membership.**

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**Written Testimony of Center for Reproductive Rights and Human Rights Watch to
the Committee on Oversight and Government Reform on the Human Rights
Concerns of Abstinence-Only-Until-Marriage Programs**

As organizations committed to human rights in the United States and worldwide, the Center for Reproductive Rights and Human Rights Watch urge the Committee to end federal funding for abstinence-only-until-marriage programs and to provide funding for comprehensive sexuality education programs. The Center for Reproductive Rights is a New York-based organization that uses the law to advance reproductive freedom as a fundamental human right. Human Rights Watch is an international human rights research and advocacy organization committed to researching and advocating on behalf of populations that are being denied their right to health.

Since 1996, the federal government has spent over \$1.5 billion to fund abstinence-only programs. Federal guidelines prohibit abstinence-only programs from teaching about contraceptive use, therefore only permitting the discussion of contraceptive methods in the context of failure rates.¹ Many of these programs exaggerate contraceptive failure rates and provide false or misleading information about the effectiveness of contraception in preventing STI infection, including HIV.² Research shows abstinence-only programs do not deter premarital sex or diminish the rate of STI infection,³ and some programs

¹ 42 U.S.C. § 710(b)(2) (2007) (requiring that any program receiving federal funding promote abstinence outside of marriage as its “exclusive purpose”); Heather D. Boonstra, *The Case for a New Approach to Sex Education Mounts: Will Policymakers Heed the Message?*, 10 GUTTMACHER POL’Y REV. 2 (Spring 2007), available at <http://www.guttmacher.org/pubs/gpr/10/2/gpr100202.html> (last viewed Nov. 2, 2007) (showing how the “exclusive purpose” definition of abstinence education bars programs from “providing any information that could be construed as promoting or advocating contraceptive use.”).

² H.R. Rep., Committee on Government Reform, *The Content of Federally Funded Abstinence-Only Education Programs* 8 (Dec. 2004) [hereinafter “Waxman Report”], available at <http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf> (last viewed Dec. 14, 2007).

³ Mathematica Policy Research, Inc., *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report 59* (April 2007), available at <http://www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf> (last viewed Oct. 19, 2007) (finding that the surveyed abstinence programs had “no overall impact on teen sexual activity [and] no differences in rates of unprotected sex” among those who completed the programs); Am. Psychological Ass’n, *Resolution in Favor of Empirically Supported Sex Education and HIV Prevention Programs for Adolescents* (Feb. 18-20, 2005); Society for Adolescent Medicine, *Abstinence-only education policies and programs: A position*

deter condom use among sexually active teens.⁴ By failing to teach adolescents about the risks of unprotected sex, including STI infection, adolescents who become infected lack information about testing and treatment.⁵ Research also indicates that adolescents who complete abstinence-only programs are 50 percent more likely to have an unintended pregnancy than those who receive comprehensive sexuality education.⁶

Despite the proven ineffectiveness of abstinence-only-until-marriage programs, government funding for them has increased dramatically in recent years, with the Bush Administration proposing \$204 million in funding for fiscal year 2009.⁷ In contrast, there is no designated funding specifically for comprehensive sexuality education, which has proven to be effective in promoting positive behaviors, including delaying initiation of sex and increasing condom and contraceptive use.⁸

Accurate and objective sexual education is critical to advancing public health and promoting human rights. This fact is widely accepted within the international community and is supported by the provisions of fundamental human rights instruments. Indeed, the current federal policy of funding abstinence-only programs while failing to fund comprehensive sexuality education raises serious human rights concerns. Federal abstinence-only programs threaten a number of basic human rights, including the rights to health, information, and nondiscrimination. These rights are recognized by the international community and are inscribed in major international human rights treaties to which the U.S. is a party.

In addition, the United States has ratified two major human rights treaties that implicate abstinence-only programs – the International Covenant on Civil and Political Rights (ICCPR) and the International Convention on the Elimination of All Forms of Racial Discrimination (CERD). Upon ratification of these treaties, the U.S. assumed an international legal obligation to comply with their terms. The U.S. also has signed, but

paper of the Society for Adolescent Medicine, 38 J. ADOLESCENT HEALTH 83-87, 84 (2006); Boonstra, *The Case for a New Approach to Sex Education Mounts*, at 5.

⁴ Waxman Report, at 4 (showing that students who took a “virginity pledge” as part of an abstinence-only curricula did not have lower rates of STIs than non-pledgers but were less likely to use contraception when they had sex).

⁵ Boonstra, *The Case for a New Approach to Sex Education Mounts*, at 5 (stating that “[t]o the extent that they ignore contraception and the benefits of safer-sex practices generally, abstinence-only programs do nothing to help prepare young people for when they will become sexually active.”); Waxman Report, at 4; John Santelli et al., *Abstinence and abstinence-only education: A review of U.S. Policies and programs*, 38 J. ADOLESCENT HEALTH 72-81, 76 (2006) (summarizing data showing that although virginity pledge-breakers had fewer sexual partners, they were less likely to report seeing a doctor for an STI concern and were less likely to get tested for STIs).

⁶ Pamela Kohler et al., *Abstinence-Only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy*, 42 J. ADOLESCENT HEALTH 344-51 (2008).

⁷ President Releases Fiscal Year 2009 Budget Request; Cuts Critical Healthcare Program; Requests Huge Increase for Abstinence-Only Programs, POL’Y UPDATE (SIECUS, New York, N.Y.), Jan. 2008, *available at* <http://www.siecus.org/policy/PUupdates/pdate0377.html> (last viewed Apr. 25, 2008); The President’s FY09 Budget, *available at* <http://www.whitehouse.gov/omb/budget/fy2009/budget.html> (last viewed Apr. 25, 2008).

⁸ See Press Release, Alan Guttmacher Inst., *Abstinence-Only Programs Do Not Work, New Study Shows* (Apr. 18, 2007); The President’s FY09 Budget.

not ratified, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Signing a treaty creates an obligation to refrain from actions that would defeat the treaties' object and purpose.⁹

The Right to Health and Information

The human right to the highest attainable standard of health requires that individuals have access to accurate information, including information related to sexual and reproductive health. UN treaty bodies that monitor compliance with human rights treaties have repeatedly discussed the importance of sexual education and information as a means of ensuring the right to health because it contributes to reduction of the rates of maternal mortality, abortion, adolescent pregnancies, and HIV/AIDS.¹⁰

The right of all people to "seek, receive and impart information and ideas of all kinds," including information about their health, is guaranteed by the ICCPR, which was ratified by the U.S. in 1992.¹¹ The Human Rights Committee, the UN treaty body which oversees compliance with the ICCPR, also has linked the obligation to provide accurate and objective sexuality education to the treaty's right to life provision.¹² Other treaty bodies have recognized that the provision of information and life skills necessary to develop a healthy lifestyle is an important component of the human right to education.¹³

Although the United States has not ratified the ICESCR, nor any other human rights treaty which contains an explicit right to health, the U.S. has expressed support for the right to health as a policy goal.¹⁴ Further, as a signatory to the ICESCR and the CRC, the U.S. is bound to refrain from acts that would defeat the objects and purposes of those

⁹ Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331, arts. 10, 18 (*entered into force* Jan. 27, 1980) [hereinafter Vienna Convention].

¹⁰ See, e.g., *Concluding Observations of the Committee on the Elimination of Discrimination against Women*: Belize, 01/07/99, U.N. Doc. A/54/38, ¶¶ 56-57; Burundi, 02/02/2001, U.N. Doc. A/56/38, ¶ 62; Chile, 09/07/99, U.N. Doc. A/54/38, ¶¶ 226-27; Dominican Republic, 14/05/98, U.N. Doc. A/53/38, ¶ 349; *Concluding Observations of the Committee on the Rights of the Child*: Cambodia, 28/06/2000, U.N. Doc. CRC/C/15/Add.128, ¶ 52; Colombia, 16/10/2000, U.N. Doc. CRC/C/15/Add.137, ¶ 48; Dominican Republic, 21/02/2001, U.N. Doc. CRC/C/15/Add.150, ¶ 37; Ethiopia, 21/02/2001, U.N. Doc. CRC/C/15/Add.144, ¶ 61; *Concluding Observations of the Committee on Economic, Social, and Cultural Rights*: Bolivia, 21/05/2001, U.N. Doc. E/C.12/1/Add.60, ¶ 43; Honduras, 21/05/2001, U.N. Doc. E/C.12/1/Add.57, ¶ 27; Libyan Arab Jamahiriya, 25/11/2005, U.N. Doc. E/C.12/LYB/CO/2; Senegal, 31/08/2001, U.N. Doc. E/C.12/1/Add.62, ¶ 47; Ukraine, 31/08/2001, U.N. Doc. E/C.12/1/Add.65, ¶ 31.

¹¹ ICCPR, Art. 19; see also CRC, art. 13(2).

¹² *Concluding Observations of the Human Rights Committee*: Poland, 02/12/04, U.N. Doc. CCPR/CO/82/POL, ¶ 9.

¹³ Committee on the Rights of the Child, *General Comment 1: The Aims of Education* (26th Sess., 2001) in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 282, ¶ 9, U.N. Doc. HRI/GEN/1/Rev.6 (2003).

¹⁴ Universal Declaration of Human Rights, art. 35, *adopted* Dec. 10, 1948, G.A. Res. 217A(III), at 71, U.N. Doc. A/810 (1948); American Declaration of Rights and Duties of Man, art. XI, O.A.S. Off. Rec. OEA/Ser.L/V/II.82 doc. 6, rev. 1, at 17 (1948).

treaties.¹⁵ Therefore the U.S. government cannot censor, limit, or otherwise misrepresent health-related information in ways that would impede the realization of the fundamental right to health recognized by these treaties.

Affirming the importance of child and adolescent health, the CRC, which is the most widely ratified of all international human rights treaties, requires that governments “ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health.”¹⁶ This obligation encompasses both the need to provide accurate and appropriate information and to refrain from censoring, withholding or misrepresenting health information. The Committee on the Rights of the Child has stated that adolescents “have the right to access to adequate information essential for their health and development” and that countries have an obligation to ensure

that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviours. This should include information on . . . safe and respectful social and sexual behaviours¹⁷

Such information includes “sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs).”¹⁸

The Committee has also addressed the need for education and information as part of the response to the HIV/AIDS epidemic and has emphasized access to adequate HIV/AIDS and sexual health information as essential to securing children’s rights to health and information.¹⁹ Further, the Committee has stated that effective HIV/AIDS prevention requires that countries

refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and . . . must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.

¹⁵ Vienna Convention, art. 18.

¹⁶ Convention on the Rights of the Child, art. 24(2)(e), *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990).

¹⁷ Committee on the Rights of the Child, *General Comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child* (33rd Sess., 2003), ¶ 26, U.N. Doc. CRC/GC/2003/4 (2003).

¹⁸ *Id.* ¶ 28.

¹⁹ Committee on the Rights of the Child, *General Comment 3: HIV/AIDS and the Rights of the Child* (32nd Sess. 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 296, ¶ 16, U.N. Doc. HRI/GEN/1/Rev.6 (2003).

The need for comprehensive sexual education has also been addressed by numerous international sources as both a human rights and a public health and policy imperative.

- The International Conference on Population and Development (ICPD) Programme of Action recognizes the need for education about population issues, including sexual and reproductive health, and that such curricula should be gender sensitive and cover reproductive choices and responsibilities, and sexually transmitted diseases, including HIV/AIDS;²⁰
- Guidelines from the WHO Regional Office for Europe specifically call on Member States to ensure that education on sexuality and reproduction is included in all secondary school curricula and is comprehensive.²¹

Impact on Communities of Color

The continuing racial disparities in reproductive health in the United States raise serious human rights issues. In March of 2008, the UN committee charged with reviewing U.S. compliance with the Convention on the Elimination of All Forms of Racial Discrimination expressed concern that “wide racial disparities continue to exist in the field of sexual and reproductive health” and recommended that the U.S. address these disparities by “providing adequate sexual education aimed at the prevention of unintended pregnancies and sexually-transmitted infections.”²²

Low-income young women of color are disproportionately affected by abstinence-only programs. Racial disparities in reproductive health have been well-documented and include an HIV/AIDS infection rate for African-American women that is 23 times that of white women²³ and an unintended pregnancy rate of black women that is twice the national average.²⁴ Rather than addressing these disparities through comprehensive sexuality education, current government funding of abstinence-only programs have resulted in a situation where poor communities and communities of color are more likely to rely on such programs than higher income and white communities.

A study conducted from 1995 to 2000, years which marked an exponential growth in abstinence-only instruction, revealed that by 2000 the number of young black and Hispanic women receiving abstinence-only instruction in lieu of other forms of sexuality

²⁰ See *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1, ¶¶ 7.44(a), 7.44(b), 7.47, 11.9 (1995).

²¹ WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE (WHO Europe), WHO REGIONAL STRATEGY ON SEXUAL AND REPRODUCTIVE HEALTH, EUR/01/5022130 at 9, 14 (2001).

²² *Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America*, 03/05/2008, U.N. Doc. CERD/C/USA/CO/6, ¶ 33.

²³ Ctrs. for Disease Control, *HIV/AIDS among African Americans 2* (June 2007), available at <http://www.cdc.gov/hiv/topics/aa/resources/factsheets/aa.htm> (last viewed Dec. 14, 2007).

²⁴ Heather D. Boonstra et al., *Abortion in Women's Lives* 28 (Alan Guttmacher Inst., May 2008); see also Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH 90-96, 94 (2006).

education had significantly increased and was higher than young white women.²⁵ In addition, young women living below 200 percent of the poverty level were more likely to receive abstinence-only instruction (or no sexuality education at all) compared to their higher-income peers.²⁶ Fewer than half of sexually experienced young black women had received instruction about contraception prior to their first sexual encounter, compared to two-thirds of their white peers.²⁷ Thus, young women of color—the population facing the highest risk of STI infection and unintended pregnancy—is also the least likely to receive the information necessary to protect themselves against those outcomes.

Discrimination

Abstinence-only curricula also pose serious concerns about discrimination and the perpetuation of harmful stereotypes based on gender and sexual orientation. Discrimination on the basis of gender and sexual orientation violate fundamental rights to equality and non-discrimination in the ICCPR, CEDAW and CRC.

Both the ICCPR and CEDAW require the elimination of discrimination against women in all fields, including education and schools.²⁸ CEDAW discusses the need to eliminate gender stereotypes in education, including the revision of textbooks and school programs.²⁹ The CEDAW Committee has stressed the need to eliminate gender stereotypes in curricula³⁰ and for development of sexual education programs that address the specific needs of women and girls.³¹ Rather than addressing the specific needs of women and girls, abstinence-only curricula often rely on stereotypes that undermine female sexual decision-making. Abstinence-only programs have been criticized for portraying “women as socially and sexually submissive and strip[ping] them of ownership of their own ambitions and desires.”³² They also reinforce stereotypes that undermine girl’s achievement and promote the idea that girls are overly emotional, weak and in need protection and that men are sexually aggressive and lack deep emotions.³³

²⁵ Laura Duberstein Lindberg et al., *Changes in Formal Sex Education: 1995-2002*, 38 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH No. 4, 182-88, 185-86 (Dec. 2006).

²⁶ *Id.*

²⁷ *Id.* at 186.

²⁸ See Human Rights Committee, *General Comment 28: Equality of Rights Between Men and Women (Art. 3)* (68th Sess., 2000), ¶ 28, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000). Convention on the Elimination of All Forms of Discrimination Against Women, art. 10, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

²⁹ CEDAW, art. 10(c).

³⁰ Committee on the Elimination of Discrimination Against Women, *Concluding Observations, Croatia*, 01/28/2005, U.N. Doc. A/60/38, ¶ 201.

³¹ Committee on the Elimination of Discrimination Against Women, *General Comment 15: Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)* (9th Sess., 1990), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 240, U.N. Doc. HRI/GEN/1/Rev.6 (2003).

³² Julie F. Kay, *Sex, Lies & Stereotypes: How Abstinence-Only Programs Harm Women and Girls* 21 (Legal Momentum, New York, NY, 2008), available at

http://www.legalmomentum.org/site/PageServer?pagename=sfr_26 (last viewed Apr. 28, 2008).

³³ Waxman Report, at 16-18.

Further, both the Human Rights Committee³⁴ and the CRC Committee have made it clear that the obligation to protect against discrimination includes the obligation to protect against discrimination based on sexual orientation. The CRC Committee has stressed the importance of preventing discrimination against LGBT youth, noting that “[a]dolescents who are subject to discrimination are more vulnerable to abuse, other types of violence and exploitation, and their health and development are put at greater risk. They are therefore entitled to special attention and protection from all segments of society.”³⁵

Abstinence-only-until-marriage programs by their terms discriminate against lesbian, gay, bisexual, and transgender youth, both by teaching that heterosexual marriage is the only appropriate context for sex and that sex outside of marriage is both psychologically and physically harmful. In effect, these programs tell LGBT youth that there is no safe way for them to have a sexual relationship either as youth or adults. This reinforces the stigma and hostility that LGBT youth experience both at school and in society at large.

A comprehensive understanding of sexual and reproductive health is imperative to an individual’s ability to protect his or her health and to make informed decisions about sexuality and reproduction. Such information is vital to reducing adolescent and unwanted pregnancies and preventing transmission of STIs, including HIV/AIDS. Current exclusive government funding of abstinence-only programs raises serious public health and human rights concerns. We urge Congress to end funding for abstinence-only programs and instead invest in comprehensive sexuality education that provides accurate and objective information about contraceptives, condom-use and STI prevention.

³⁴ See *Toonen vs. Australia*, Human Rights Committee, U.N. Doc. CCPR/C/50/D/488/1992 (Apr. 4, 1994).

³⁵ Committee on the Rights of the Child, *General Comment 4*, ¶ 6.



**Committee on Oversight and Government Reform
Written Statement from Chicago Foundation for Women
April 22, 2008**

Chicago Foundation for Women appreciates the committee's exploration of the public health and ethical concerns of abstinence-only-until-marriage programs and we thank you for the opportunity to provide you with our perspective on this critical issue. Chicago Foundation for Women strongly urges Congress to end its public support for abstinence-only-until-marriage programs. Use of taxpayer dollars to support these programs is a missed opportunity for our federal government to promote effective solutions to adolescent health issues.

One of the largest women's funds in the world, Chicago Foundation for Women believes that all women and girls should have the opportunity to achieve their potential and live in safe, just and healthy communities. For 22 years, the Foundation has influenced social justice through advocacy, grant making, leadership development, and public and grantee education. Our work is rooted in three principles of women's human rights: economic security, freedom from violence, and access to health information and services. We believe that young women are stronger, healthier, and reach their full potential when all youth have access to comprehensive health services and information, including their reproductive and sexual health. Adolescent sexual health education should be comprehensive, medically accurate and appropriate for their age.

Unfortunately, the vision Chicago Foundation for Women has for adolescent female health is unrealized in Illinois, which has the 20th highest teen pregnancy rate in the nation. As we know, pregnant teens are less likely to obtain prenatal care and more likely to have low-weight babies. Recent research shows that 1 in 4 American girls has a sexually transmitted infection, and the rate soars to 1 in 2 for African American girls.

Even though we know that comprehensive sexual health education programs are known to reduce unintended teen pregnancy, Illinois provides no public support for a comprehensive sexual health education program. Yet Gov. Blagojevich accepts \$1.8 million in federal Title V Abstinence-Only-Until-Marriage funds each year. As you have been made aware, these programs are ineffective, inaccurate, and insufficient. Research and medical experts overwhelm us with proof of each of these deficiencies, and we know you have been fully briefed about them.

What is not as commonly understood is that "abstinence-only" programs present real threats to women and girls. A report recently released by Legal Momentum, "Sex, Lies & Stereotypes: How Abstinence-Only Programs Harm Women and Girls," provides an excellent analysis of federally supported programs that promote outdated gender and racial stereotypes and myths about sexual assault. Several of these programs place unfair shame and stigma on girls who were sexually assaulted and implore them to improve their skills at saying no. Because these programs discuss only abstinence, little or no attention is paid to educating boys about the importance of making sure that they have the consent of their partners for any sexual activity. And, because these programs intentionally omit information about contraception, STI testing or treatment, they "impede girls ability to avoid unwanted pregnancy and STIs to which they are more biologically susceptible," the report noted.

Chicago Foundation for Women advocates for the elimination of federal support for abstinence-only-until-marriage programs. Thank you for allowing us to share our perspective on such an important public health issue.

COALITION FOR *Responsible* SEX ED
Advocating for Minnesota's Youth

Statement of the Coalition for Responsible Sex Ed on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

The Coalition for Responsible Sex Ed is a coalition of 51 educational, religious, health, social service and advocacy organizations, as well as concerned individuals that promotes lifelong healthy sexuality by advocating for policies on comprehensive sexuality education. Our Minnesota Coalition has a 9 year history of advocating on both a state and federal level for policies and investments in the health and wellbeing of Minnesota's youth.

Our Minnesota Coalition is writing today to request that you end abstinence-only-until-marriage funding and we ask that you support investments in comprehensive sexuality education.

Please provide the necessary oversight to bring an end to funding for abstinence-only-until-marriage programs. States and community organizations need the federal government to make a real investment in youth. We need investment in comprehensive, medically accurate, age-appropriate programs that include abstinence, contraception and disease prevention based on the best scientific evidence available. Implementing effective programs helps states meet the needs of their youth as they grow and develop decision making skills.

The state of Minnesota has experienced the first increase in teen pregnancy and birth rates in 16 years. While this 6% increase in teen pregnancy and 7% increase in teen birth rates (2006 data) may only represent a single year increase and not a trend, this should serve as a wake up call to all advocates concerned for the health of young people. Teen pregnancy prevention is a complex and requires coordinated and comprehensive prevention efforts. Comprehensive sex education is one necessary component of this prevention.

The absence of funding for effective programs has put many states, Minnesota included, in the difficult position of turning away needed federal dollars. Because current federal funding for abstinence-only-until-marriage programs does not allow states the ability to implement effective programs, we support Minnesota's decision not to request Title V funds in 2007. Please change this funding strategy to invest in programs that have been shown to have a positive impact on the behavior of youth.

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**Colorado
Organization on
Adolescent
Pregnancy,
Parenting and
Prevention**

April 22, 2008

The Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention (COAPPP) is concerned about the amount of money that has been poorly invested into abstinence-only-until-marriage programs in Colorado and throughout our country. With mounting evidence indicating that the only curricula shown to both delay sexual activity and increase safer practices among already sexually active youth are comprehensive science-based sexuality curricula programs, we ask this: *Why does our elected Congress continue to fund programs that evidence shows do not work to delay the onset of sexual activity and do not offer medically-accurate information about the benefits of safer sex practices among sexually active young people?*

The National Campaign to Prevent Teen and Unplanned Pregnancy reports that the number one reason girls drop out of high school is teen pregnancy. Everyday COAPPP sees the impact of teen pregnancy among adolescents, especially young girls who are trying to balance the needs of their young children with their own education and self-sufficiency. While access to comprehensive sex education is not the only way to reduce the incidence of teen pregnancy, it is a critical piece that research demonstrates, over and over again, does work to delay sexual initiation and increase safer sex practices among already sexually active youth. Safer sex practices are not only critical in decreasing teen pregnancy, but they also reduce health risks related to unsafe sex practices including HIV and other sexually transmitted diseases (STDs).

The call of like-minded organizations to end funding for abstinence-only education comes not from a desire to silence a personal value for an abstinence-until-marriage message but from a public health reality where 60 percent of all seniors in high school have reported being sexually active. The education we are calling for is comprehensive science-based sexuality education which has shown to *delay sexual initiation* and *increase safer sex practices among already sexually active youth*. We ask Congress to stop legislating support through funding for programs that, from medical and scientific measurements, have not only failed to show effectiveness in decreasing the onset of initial sexual activity, but have also been detrimental to safer sex messages that research shows can reduce the transmission of HIV/STDs and the risk of unplanned pregnancy.

America's youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect the opinion of the large majority of parents, families, and communities in Colorado and across the country.

Thank you for considering our comments.

Lori Casillas
Executive Director

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April 22, 2008

Committee on Oversight and Government Reform
United States Congress
Washington, DC

Dear Honorable Committee Members:

Planned Parenthood of Delaware is the only statewide non-profit organization that provides reproductive healthcare education and services to approximately 10,000 Delawareans on a yearly basis. Our medical center staff members witness the consequences of unintended pregnancy and unprotected sexual relations on a daily basis. Sexually transmitted infections are on the rise across the nation, and in Delaware teens. Delaware has also historically had a high teen pregnancy rate, until recent efforts over the last decade have curtailed this. These efforts included comprehensive sexuality education and outreach to individuals who may not have the information they need to protect themselves from unintended consequences from unprotected sexual activity. The State of Delaware has funded Wellness Centers in our high schools, as well as dedicated nurses at these centers to answer questions about reproductive health, as well as treat common illnesses. The Delaware Division of Public Health recently declined abstinence-only funding due to the fact that all of the community organizations that participated in receiving this funding in the past, did not re-apply for funding.

Planned Parenthood of Delaware supports the scientifically based findings that abstinence only education by itself, is not an effective tool in the fight against unintended consequences to our teens and young adults in their reproductive health care. It is only a piece of the comprehensive reproductive health information our children need to make responsible decisions regarding their health care with their family members and trusted adults.

Sincerely,

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**The Impact of Abstinence and Comprehensive Sex and STD/HIV Education
Programs on Adolescent Sexual Behavior**

Douglas B. Kirby, Ph.D.

ETR Associates

Working paper. *Sexuality Research & Social Policy*, 5(2). In Press.

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Abstract

In an effort to reduce unintended pregnancy and sexually transmitted disease (STD) in adolescents, both abstinence and comprehensive sex and STD/HIV education programs have been proffered. Based on specified criteria, the author searched for and reviewed 56 studies that assessed the impact of such curricula (8 that evaluated 9 abstinence programs and 48 that evaluated comprehensive programs) on adolescents' sexual behavior. Study results indicated that most abstinence programs did not delay initiation of sex and only 3 of 9 had any significant positive effects on any sexual behavior. In contrast, about two thirds of comprehensive programs showed strong evidence that they positively affected young people's sexual behavior, including both delaying initiation of sex and increasing condom and contraceptive use among important groups of youth. Based on this review, abstinence programs have little evidence to warrant their widespread replication; conversely, strong evidence suggests that some comprehensive programs should be disseminated widely.

Key words: teen pregnancy; sexually transmitted disease; curriculum-based programs; teens

Ongoing throughout the United States is an intense and sometimes passionate debate about the relative impacts of abstinence sex education programs (also called *abstinence-only* programs) versus those of comprehensive sex education programs (also called *abstinence-plus* programs) on adolescents' sexual behavior. For this review, *abstinence programs* are defined as curricula that encourage only abstinence and *comprehensive programs* as curricula that emphasize abstinence as the safest behavior but also promote the use of condoms or other forms of contraception for those who do have sex (Kirby, 2001).¹

Proponents of abstinence programs argue that only abstinence allows youth to avoid the risks of unwanted pregnancy and sexually transmitted diseases (STDs); using condoms or other forms of contraception merely reduces these risks. Thus, they refer to abstinence sex education curricula as risk-avoidance or risk-elimination programs and to comprehensive curricula as risk-reduction programs.

Proponents of comprehensive sex education programs argue that, because such programs emphasize abstinence and also encourage the use of condoms and contraception for those youth who do initiate sex, comprehensive programs can both delay adolescents' initiation of sex and increase their condom or other contraceptive use. Thus, these proponents conclude, comprehensive programs can have a greater impact on rates of unwanted pregnancy and STDs among youth than abstinence programs.

In response, proponents of abstinence programs claim that comprehensive sex education programs send a mixed message about behavior to youth, thereby confusing adolescents and preventing comprehensive programs from having a positive, significant affect either on abstinence or on condom or other contraceptive use. These proponents also claim that if abstinence programs prevent enough youth from having sex, those programs will have a greater impact on teen pregnancy and STD rates than comprehensive programs—even if comprehensive program modestly delay adolescents' initiation of sex or modestly increase their condom or other contraceptive use.

The proponents of comprehensive curricula respond by claiming that a message about both abstinence and condom and contraceptive use is not confusing to teens and, in fact, is more acceptable to them. They also claim that comprehensive curricula have a greater impact on adolescents' behavior than abstinence programs.

This ongoing debate is important for at least three reasons:

1. The United States has high teen pregnancy rates and the teen parents, the infants involved, and taxpayers pay dearly for these unintended pregnancies (Hoffman, 2006). In addition, this country has high STD rates among young adults and the people involved experience a variety of negative consequences (Kirby, 2007).
2. Most middle or senior high schools in this country implement either abstinence or comprehensive sex and STD/HIV education programs in order to reduce unintended pregnancy and STDs among youth (Landry, Kaeser, & Richards, 1999).
3. Considerable federal and state funds are directed solely to promoting and implementing abstinence programs. These funds have had a huge impact on the field of teen pregnancy and STD prevention.

During the last roughly 15 years, researchers have conducted many studies of the impact of abstinence programs on adolescents' sexual knowledge, intentions, and behavior (e.g., Bearman

¹ For the purposes of this review, comprehensive sex education programs do not include curricula that cover a very broad range of topics about sexuality more generally.

& Bruckner, 2001; Doniger, Riley, Utter & Adams, 2001; Howard & McCabe, 1990; Jorgensen, Potts, & Camp, 1993; Kirby, Korpi, Barth, & Cagampang, 1997; Weed, 2001; Weed, Ericksen, & Birch, 2005; Weed, Ericksen, Lewis, Grant, & Wibberly, 2008; Weed, Olsen, DeGaston, & Prigmore, 1992; Weed, Prigmore, & Tanas, 2002). Some proponents of abstinence selectively cite these studies to prove that abstinence programs are effective (Rector, 2002). In fact, most of the aforementioned studies are poorly designed and do not meet reasonable standards for scientific evidence, thus necessitating a more objective review of the evidence regarding these programs.

This review is particularly timely because, in years past, the dearth of rigorous evaluation of abstinence programs has made fair comparison between comprehensive programs and abstinence programs impossible. However, a very rigorous study of four abstinence programs was recently released (Trenholm et al., 2007) and the literature now includes enough studies to provide a partial, although not final answer to the debate regarding abstinence and comprehensive sex education curricula.

Criteria for Selection of Evaluation Studies

To be included in this review of the impact of abstinence and comprehensive sex education programs, each study had to meet the following criteria:

1. The evaluated program had to
 - (a) be a curriculum- and group-based abstinence, sex, or STD/HIV education program (as opposed to an intervention involving only spontaneous discussion, only one-on-one interaction, or only broad school, community, or media awareness activities).
 - (b) focus primarily on sexual behavior (as opposed to covering a variety of risk behaviors such as drug use, alcohol use, and violence in addition to sexual behavior).
 - (c) focus on adolescents of middle-school or high-school age.
 - (d) be implemented in the United States.
2. The research methods had to
 - (a) include a reasonably strong experimental or quasi-experimental design with well-matched intervention and comparison groups and both pretest and posttest data collection.
 - (b) have a sample size of at least 100.
 - (c) measure program impact on one or more of the following sexual behaviors: initiation of sex, frequency of sex, or number of sexual partners; use of condoms or contraception more generally; composite measures of sexual risk (e.g., frequency of unprotected sex); pregnancy rates; birth rates; and STD rates.
 - (d) measure impact on those behaviors that can change quickly (i.e., frequency of sex, number of sexual partners, use of condoms, use of contraception, or sexual risk taking) for at least 3 months or measure impact on those behaviors or outcomes that change less quickly (i.e., initiation of sex, pregnancy rates, or STD rates) for at least 6 months.
3. The study had to be completed or published in 1990 or thereafter.²

Studies meeting these criteria were identified in several ways, including by searching 10 databases (Biologic Abstracts, Bireme, CHID, Dissertation Abstracts, ERIC, Popline, PsychInfo, Psychological Abstracts, PubMed, and Sociological Abstracts); reviewing past issues of 12

² In an effort to be as inclusive as possible, the criteria did not require that studies had been published in peer-reviewed journals.

journals; contacting researchers at professional meetings and those in the process of completing studies; reviewing reports, training materials, and process evaluation reports; and using previous literature searches and reviews from various authors.

Results of Studies Evaluating Abstinence or Comprehensive Sex and STD/HIV Education Programs

Although the purpose of this review is to compare the impact on youth of abstinence programs versus comprehensive programs, sex education curricula represent a continuum and cannot always be separated neatly into these two types of programs. Thus, it is difficult to classify some of these programs.

Furthermore, both groups of programs are very diverse. For example, some abstinence programs emphasize abstinence until marriage, whereas others do not. Some allow objective discussion of the effectiveness of condoms and contraceptives without encouraging their use, whereas others (at least in the past) have very strongly opposed condoms and contraceptives and exaggerated their lack of effectiveness. Still others do not even mention condoms or contraception. Although most abstinence programs are secular, a few are overtly religious. Some are character education programs that emphasize more basic values that apply not only to sexual behavior but also to other behavior, such as drug use or violence.

As for diversity in comprehensive programs, some target younger high school students and very strongly emphasize abstinence (while also supporting condom or contraceptive use), whereas others target older teens already having sex and therefore give primary emphasis to condom or other contraceptive use while also identifying abstinence as the safest approach. Some of these programs include only education; others are linked to contraceptive services.

Impact of Abstinence Programs

Thus far, only eight studies of nine abstinence programs (Borawski, Trapl, Lovegreen, Colabianchi, & Block, 2005; Clark, Trenholm, Devaney, Wheeler, & Quay, 2007; Denny & Young, 2006; Kirby, Korpi, Barth, & Cagampang, 1997; Rue & Weed, 2005; Trenholm et al., 2007; Weed et al., 1992; Weed et al., 2008) meet the selection criteria for this review. One of these studies (Trenholm et al.) measured the impact of four different abstinence programs, but two of those programs focused on broader youth development and so do not meet the criteria for this review. The Trenholm et al. study and the study of the Heritage Keepers Life Skills Education curriculum (Clark et al.) are particularly important for several reasons. First, these two studies, which were carefully selected to represent potentially effective abstinence-until-marriage programs, evaluated the impact of abstinence programs that meet the restrictive federal A–H guidelines for abstinence education (Title V, § 510). Second, they employed rigorous experimental designs and statistical analyses and tracked youth for 4 to 6 years. Last, for both studies, results demonstrated that the curricula had no effects on initiation of sex, age of initiation of sex, abstinence in the previous 12 months, number of sexual partners, or condom use during sex (see Table 1).³ The lack of behavioral results was quite compelling.

A third very rigorous study (Kirby et al., 1997), which also used an experimental design, measured the impact of Postponing Sexual Involvement, a five-session curriculum focused on

³ For the study that evaluated four curricula (Trenholm et al., 2007), the findings for the two programs that included youth development components (and therefore do not quite meet the criteria for this review) were the same as the results for the two programs that did meet the criteria for this review.

delaying the initiation of sex. Like the studies above, it found no significant positive effects on any behavior.

<insert Table 1 about here>

The studies of the five remaining abstinence programs, shown in Table 2, were methodologically much weaker than the studies outlined in Table 1. These studies employed quasi-experimental designs with comparison groups that were not always well matched, they sometimes had high attrition rates, they measured program impact for a shorter period of time, and their statistical analyses were not always as strong as those in the aforementioned studies. Of these five weaker studies, two found that the evaluated programs delayed sexual initiation; the other three studies showed no significant program effect on adolescents' sexual behavior. Two studies in this group measured program impact on frequency of sex among youth who had previously had sex; both found that the program reduced teens' frequency of sex. Finally, the one study measuring program impact on number of sexual partners found that the curriculum resulted in a reduced number of sexual partners among participating youth.

<insert Table 2 about here>

Of the five studies with either experimental or quasi-experimental designs that measured condom use, none found a significant effect of abstinence programs on adolescents' condom use. Similarly, the four studies that measured program impact on contraceptive use found no effect one way or the other.

Impact of Comprehensive Programs

The author found 48 studies⁴ of a variety of curriculum-based comprehensive sex and STD/HIV education programs in the United States that met the criteria for this review. Although this large sample of programs may not accurately represent the full range of comprehensive sex education programs being implemented throughout the United States, it certainly represents a variety of the kinds of programs that could be put in place if policymakers chose to do so.

As shown in Table 3, 15 out of 32 (47%) of the programs in the aforementioned 48 studies delayed the initiation of sex and none hastened initiation; 6 out of 21 (29%) reduced frequency of sex and none increased frequency. Furthermore, 11 out of 24 (46%) reduced the number of sexual partners; 1 program out of 24 (4%) increased the number of sexual partners.⁵ In addition, 15 out of 32 (47%) of the evaluated programs increased condom use; 4 out of 9 (44%) increased

⁴ Aarons et al., 2000; Blake et al., 2000; Borawski, Trapl, Lovegreen, et al., 2005; Borawski et al., 2005; Boyer et al., 2005; Boyer, Shafer, & Tschann, 1997; Coyle et al., 2001; Coyle et al., 2006; Coyle, Kirby, Marin, Gomez, & Gregorich, 2000; DiClemente et al., 2004; Eisen, Zellman, & McAlister, 1990; Ekstrand et al., 1996; Fisher, Fisher, Bryan, & Misovich, 2002; Gillmore et al., 1997; Gottsegen & Philliber, 2001; Harrington, Giles, Hoyle, Feeney, & Yungbluth, 2001; Howard & McCabe, 1990; Hubbard, Geise, & Rainey, 1998; Jemmott, Jemmott, Braverman, & Fong, 2005; Jemmott, Jemmott, & Fong, 1992, 1998; Jemmott, Jemmott, Fong, & McCaffree, 1999; Kirby, Barth, Leland, & Petro, 1991; Kirby, Korpi, Adivi, & Weissman, 1997; Koniak-Griffin et al., 2003; LaChausse, 2006; Levy et al., 1995; Lieberman, Gray, Wier, Fiorentino, & Maloney, 2000; Little & Rankin, 2001; Magura, Kang, & Shapiro, 1994; Main et al., 1994; Middlestadt et al., 1998; Morrison et al., 2007; Nicholson & Postrado, 1991; Rotheram-Borus, Gwadz, Fernandez, & Srinivasan, 1998; Rotheram-Borus, Koopman, Haigners, & Davies, 1991; Siegel, Aten, & Enaharo, 2001; Siegel, DiClemente, Durbin, Krasnovsky, & Saliba, 1995; Slonim-Nevo, Auslander, Ozawa, & Jung, 1996; Smith, Weinman, & Parrilli, 1997; St. Lawrence, Crosby, Belcher, Yazdani, & Brasfield, 1999; St. Lawrence, Crosby, Brasfield, & O'Bannon, 2002; St. Lawrence et al., 1995; Stanton et al., 1996; Stanton et al., 2005; Villarruel, Jemmott, & Jemmott, 2006; Walter & Vaughn, 1993; Zimmerman et al., 2008; Zimmerman et al., n.d.

⁵ This finding, the only negative result for sexual activity, would be expected by chance.

contraceptive use but 1 program out of 9 (11%) decreased it. Finally, 15 out of 24 (62%) reduced sexual risk taking through a combination of changes in multiple behaviors.

<insert Table 3 about here>

These positive results become slightly more positive when the studies are restricted to those large studies with rigorous experimental designs: That is, the positive results occur more frequently in the studies with experimental designs than in those with quasi-experimental designs. Thus, the evidence for these positive results is quite strong.

Furthermore, a study that compared effective comprehensive programs with ineffective ones (Kirby, 2007) revealed that effective programs typically incorporate the same 17 characteristics; when comprehensive programs incorporate these 17 characteristics, they almost always have a positive effect on adolescent sexual behavior.

Finally, the results of several replication studies (Hubbard, Giese, & Rainey, 1998; Jemmott, Jemmott, Braverman, & Fong, 2005; St. Lawrence, Crosby, Brasfield, & O'Bannon, 2002; St. Lawrence et al., 1995; Zimmerman et al., 2008; Zimmerman et al., n.d.) are quite encouraging, providing greater evidence that curricula can be effective when they are implemented with fidelity by others in different communities. It is less clear whether effective programs will remain effective if (a) they are shortened considerably, (b) they omit activities that focus on increasing condom use, or (c) they are designed for and evaluated in community settings but are subsequently implemented in classroom settings.

Conclusions

These results suggest several important conclusions about abstinence and comprehensive sex and STD/HIV education programs in the United States.

Rigorous evaluations using large experimental designs have assessed multiple abstinence programs, including at least three abstinence-until-marriage programs and have found that these curricula have no overall impact on adolescents' delay in initiation of sex, age of initiation of sex, return to abstinence, number of sexual partners, or condom or contraceptive use. A few other abstinence programs have been evaluated less rigorously with smaller quasi-experimental designs; those results suggested that three of the programs may have had some positive effects on adolescents' sexual behavior. Two programs appear to have delayed the initiation of sex among middle-school youth. One of these also appears to have decreased the frequency of sex, whereas a third may have reduced the frequency of sex and the number of sexual partners. Thus, 3 of 9 studies found that abstinence curricula had some positive effects on teens' sexual behavior. Moreover, the abstinence programs evaluated in the literature thus far did not appear to have significant negative effects on behavior. In particular, they did not appear to decrease condom or other contraceptive use.

Overall, these results are not very encouraging. They provide strong evidence that some abstinence programs are ineffective and weak evidence that three programs might have some positive effects on the sexual behavior of particular subgroups of youth. Taken as a whole, this evidence certainly does not justify the widespread replication of abstinence sex education programs. Furthermore, no abstinence programs evaluated with rigorous experimental designs show evidence that they delayed adolescents' initiation of sex.

In contrast, the results for comprehensive programs are very encouraging, both in increasing abstinence and improving other sexual behaviors among youth. Nearly half of the 48 comprehensive programs delayed adolescents' initiation of sex, one fourth reduced the frequency

of sex, and nearly half reduced the number of sexual partners. In addition, nearly half of the comprehensive programs increased condom or contraceptive use and three-fifths reduced various measures of sexual risk behavior. Thus, overall, more than two thirds of the 48 comprehensive programs had a positive effect on one or more sexual behaviors and two-fifths had a positive impact on two or more sexual behaviors among youth. Moreover, these positive effects remained strong even when the reviewed studies were restricted to those with rigorous experimental designs.

These studies of comprehensive sex education programs clearly demonstrate that it is possible both to delay first sex and to increase use of condoms or other forms of contraception among adolescents with the same programs. In other words, programs that emphasize both abstinence and the use of protection for those who do have sex are not confusing to young people; rather, they are realistic and effective.

When comparing recent studies of the effectiveness of abstinence and comprehensive sex education programs, the following conclusions are dramatically evident:

1. Some evidence (but no strong evidence) currently supports the supposition that any particular abstinence program is effective at delaying first sex for adolescents.
2. Abstinence programs are not more effective at delaying initiation of sex than comprehensive sex education programs.
3. Abstinence programs are not sufficiently effective to eliminate teens' sexual risk or to eliminate the need for comprehensive sex education programs.
4. Much strong evidence supports the supposition that comprehensive sex education programs can both delay initiation of sex and increase condom or other contraceptive use among youth.

Acknowledgments

The Hewlett Foundation provided financial support for this review. This article is based, in part, on the National Campaign to Prevent Teen and Unplanned Pregnancy publication *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, which is available at <http://www.thenationalcampaign.org/EA2007/> as a PDF file or print document.

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Table 1. Characteristics and Results of Experimental Studies of Abstinence Education Programs

Study	Design	Intervention	Results ^a
Clark, Trenholm, Devaney, & Wheeler, & Quay (2007) Curriculum: Heritage Keepers Life Skills Education	Individual youth randomly assigned to the intervention (Life Skills plus Abstinence Education) or control (Abstinence Education) group. Matched pre- and posttest surveys at baseline and follow-up surveys 2 to 4 years later. Matched N = 604	Middle and high schools: 45 minutes weekly throughout the school year (up to 28 hours per year), voluntary. Message: Be abstinent until marriage. Character development to support abstinence, self-responsibility, avoidance of risky behaviors, and maximizing potential and opportunities.	Initiation of sex 0 Had sex last 12 months 0 Age of initiation of sex 0 Number of partners 0 Condom use 0 Contraceptive use 0 Unprotected sex 0 Pregnancy rates 0 Birth rates 0 STD rates 0
Kirby, Korpi, Barth, & Cagampang (1997) Curriculum: Postponing Sexual Involvement (PSI)	Random assignment of entire schools, classrooms, or individuals. Classrooms randomly assigned to adult-taught PSI, peer-taught PSI, or a control group; schools and individuals randomly assigned to adult-taught PSI or control group. Matched pre- and posttest surveys at baseline, 3 months, and 17 months. Matched N = 7,340	Middle schools: Five 1-hour sessions. Message: You can say no to sex. Class discussions, group activities, videos or slides, and role playing.	Adult taught 0 Teen taught 0 Initiation of sex 0 Frequency of sex 0 Number of partners 0 Use of condoms 0 Use of birth control pills 0

Study	Design	Intervention	Results ^a
Trenholm, Devaney, Forston, Quay, Wheeler, & Clark (2007) Curriculum: My Teens in Control	Random assignment of individual youth. Matched pre- and posttest surveys at baseline and three follow-up surveys with the last survey 4 to 6 years later. Matched N = 715	Elementary schools: One lesson per week for 2 academic years, including Postponing Sexual Involvement (year 1) and Sex Can Wait (year 2). Message: You can say no to sex. Interactive activities to involve youth in discussing and practicing concepts, building skills.	Initiation of sex 0 Had sex last 12 months 0 Age of initiation of sex 0 Number of partners 0 Condom use 0 Use of birth control 0 Unprotected sex 0 Pregnancy rates 0 Birth rates 0 STD rates 0
Trenholm, Devaney, Forston, Quay, Wheeler, & Clark (2007) Curriculum: My Choice, My Future	Random assignment of individual youth. Matched pre- and posttest surveys at baseline and three follow-up surveys with the last survey 4 to 6 years later. Matched N = 448	Middle schools: Many lessons. Year 1: Thirty sessions (Reasonable Reasons to Wait: The Keys to Character). Year 2: Eight sessions (Art of Loving Well: A Character Education Curriculum for Today's Teenagers). Year 3: Fourteen sessions (WAIT Training).	Initiation of sex 0 Had sex last 12 months 0 Age of initiation of sex 0 Number of partners 0 Condom use 0 Use of birth control 0 Unprotected sex 0 Pregnancy rates 0 Birth rates 0 STD rates 0

^a+ denotes a significant positive effect on behavior; 0 denotes a nonsignificant effect; - denotes a significant negative effect.

Table 2. Characteristics and Results of Quasi-Experimental Studies of Abstinence Education Programs

Study	Design	Intervention	Results ^a
Borawski, Trapl, Lovegreen, Colabianchi, & Block (2005) Curriculum: For Keeps	Classrooms in 7 schools assigned to intervention or comparison groups. Matched pre- and posttest surveys at baseline and 4 to 6 months later. Matched <i>N</i> = 2,069	Middle schools: Five 40-minute lessons. Message: Be abstinent until marriage.	Initiation of sex 0 Recent sex (sexually experienced at baseline) 0 Frequency of sex + Multiple episodes of sex + Two or more sex partners + Consistent condom use 0
Denny & Young (2006) Curriculum: Sex Can Wait	Fifteen school districts assigned to intervention and comparison groups. Matched pre- and posttest surveys at baseline, immediately after the intervention, and 18 months later. Matched <i>N</i> = 680	Upper elementary schools (ES): 23 lessons Middle schools (MS): 24 lessons High schools (HS): 25 lessons Message: Sex can wait. Lecture, activities, handouts, and parent-child homework.	ES MS HS Initiation of sex 0 + 0 Sex in last month + + 0

Rue & Weed (2005) Curriculum: WAIT Training	Four schools in intervention group, 1 in comparison group. Matched pre- and posttest surveys at baseline, immediate post, and 12 months. Matched N = 308	Middle schools: 15 lessons Message: Have the best sex... by waiting for marriage. Individual goal setting, skills to build a successful marriage, and renewed commitment to abstinence.	Initiation of sex 0
Weed, Ericksen, Lewis, Grant, & Wiberly (2008) Curriculum: Reasonable Reasons to Wait: Keys to Character	Three middle schools in intervention group and 2 in comparison group. Matched pre- and posttest surveys at baseline and 1 year. Matched N = 550	Middle schools: 20 sessions Message: Abstain from sex until marriage. Emphasized the development of personal character and taught the benefits for individuals, families, and society of abstaining from sex until marriage.	Initiation of sex +
Weed, Olsen, DeGaston, & Prigmore (1992) Curriculum: Sex Respect; Teen-Aid; Values and Choices	Three high schools and 5 junior high schools in intervention group, 2 high schools and 3 junior high schools in comparison group. Matched pre- and posttest surveys at baseline, 3 to 4 weeks later, and 1 year. Matched N = 3,634	Five high schools and 8 junior high schools Each school implemented one of three curricula (Teen-Aid, Sex Respect, or Values and Choices) to students in classrooms for a 3-week period. Abstinence values, decision-making, skills.	Initiation of sex 0

^a+ denotes a significant positive effect on behavior; 0 denotes a nonsignificant effect; - denotes a significant negative effect.

Table 3. Abstinence Education Programs Versus Comprehensive Sex and STD/HIV Education Programs: Number of Studies Reporting Program Effects on Different Sexual Behaviors

Outcomes measured	Abstinence programs (N = 9)	Comprehensive programs (N = 48)
Initiation of sex	(n = 9)	(n = 32)
Hastened initiation	0	0
No significant results	7	17
Delayed initiation	2	15
Frequency of sex	(n = 6)	(n = 21)
Increased frequency	0	0
No significant results	4	15
Reduced frequency	2	6
Number of partners	(n = 5)	(n = 24)
Increased number	0	1
No significant results	4	12
Reduced number	1	11
Condom use	(n = 5)	(n = 32)
Reduced use	0	0
No significant results	5	17
Increased use	0	15
Contraceptive use	(n = 4)	(n = 9)
Reduced use	0	1
No significant results	4	4
Increased use	0	4
Sexual risk taking	(n = 3)	(n = 24)
Increased risk	0	0
No significant results	3	9
Reduced risk	0	15



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**Statement of Family Planning Advocates of New York State (FPA) on the Public Health
and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for
Comprehensive Sexuality Education
Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

Family Planning Advocates of New York State (FPA) is a non-profit statewide membership organization dedicated to protecting and expanding access to a full range of reproductive health services. FPA represents and is primarily funded by New York's Planned Parenthood affiliates, with additional support from member family planning clinics and dozens of sister organizations, as well as thousands of individual members across the state.

As an organization committed to advancing public policies that fulfill the rights of individuals to comprehensive sexual and reproductive health services and education, we wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs. New Yorkers see a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. We are committed to using sound scientific evidence in promoting the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

At one time, New York received more than \$13 million in federal abstinence-only funding each year. However, none of the programs implemented with these funds were ever scientifically evaluated to have any proven effectiveness in decreasing sexual activity or increasing contraception use among New York's youth. In fact, FPA has continually brought our concerns about these programs to the New York State Department of Health and the general public.

Scientific evidence does not support abstinence-only-until-marriage programs. The federal government has promoted these programs for more than 25 years even though no study in a professional peer-reviewed journal has found them to be broadly effective.

According to a report released by the Reproductive Rights Project of the New York Civil Liberties Union in September 2007, taxpayer-funded abstinence-only-until-marriage programs in New York State have used materials that rely on scare tactics, contain inaccurate and medically unsound information, include religious messages and leave youth unprepared to make healthy decisions about sexuality. The report, *Financing Ignorance: A Report on Abstinence-Only-Until-Marriage Funding in New York*, chronicles an in-depth investigation of 39 abstinence-only-until-marriage programs statewide that received federal funding through 2006.

The NYCLU's analysis revealed that:

- Abstinence-only-until-marriage curricula used across the state contained serious medical inaccuracies and employ fear-based teaching methods.
 - Curricula used by 22 programs inflated rates of STIs and HIV/AIDS and exaggerated the failure rates of condoms in preventing STIs, HIV/AIDS and pregnancy.
 - These same curricula relied on scare-tactics, presenting a list of dire consequences of pre-marital sexual activity; one curriculum includes in this list: "heartbreak, infertility, loneliness, cervical cancer, [and] poverty."
 - Curricula used by seven programs contained falsehoods regarding abortion, telling students, for example, that an abortion could significantly endanger a young woman's ability to have children in the future. Five programs partnered with crisis pregnancy centers, organizations that frequently promote inaccurate and biased views about abortion.
- The same curricula demonstrated serious bias:
 - Gender stereotypes regarding the different "natures" of girls and boys with respect to sexuality and relationships were presented as immutable, scientific facts. For example, one program taught that "financial support" is one of the five "major needs of women," and "domestic support" is one of the five "major needs of men."
 - Lesbian/gay/bisexual/transgender youth were either completely ignored or demonized as "unnatural."
- At least 19 of the funded programs focused a significant amount of programming on after school recreational activities with no direct relation to sex education.
 - Instructors were not required to have special training or expertise as educators.
 - Programs were not evaluated, or even required to evaluate themselves.
 - Religious groups received more than half (53 percent) of this government funding without adequate safeguards against proselytizing, and religious content was included in some of the programming.

This information only further raises our concerns that the federal government has promoted these programs in our state without any oversight. We have a right to expect is that the programs are teaching accurate, scientific information. Yet according to the NYCLU report, that level of expectation is not being met by many programs here in New York State.

Fortunately, in September, 2007, New York State made the decision to refuse federal Title V funding for abstinence-only programs. Commissioner of Health Dr. Richard Daines said in a

statement, "The Bush administration's Abstinence Only Program is an example of a failed national health-care policy directive, based on ideology rather than on sound scientific-based evidence that must be the cornerstone of good public health-care policy." New York State began redirecting its matching funds to expand comprehensive sexuality education in schools and other community settings that provide teens with medically accurate information and life skills to equip them with the necessary tools that they need to make the crucial healthy life choices needed for a healthy adulthood.

New Yorkers fully support these efforts. A 2006 poll by Lake Associates found that 77 percent of voters in New York State support teaching age-appropriate, medically accurate sex education in public schools. A full 88 percent agree that all students in New York should have information about contraception and the prevention of sexually transmitted diseases.

Given that 63 percent of high school seniors report having had sex in New York State (CDC, Youth Risk Behavior Survey, 2007), it is vitally import that we promote abstinence but do not ignore the thousands of students who are having sex and need to protect themselves. Additionally, there were nearly 40,000 teen pregnancies in New York State in 2005 (New York State Department of Health Vital Statistics). Some of our communities see twenty percent of teenage girls pregnant before they graduate high school. More must be done.

New York's Planned Parenthood affiliates and family planning providers remain committed to providing the best educational programs to young people in New York State. The goal of these programs is always to have improved health behavior outcomes. Only with a change in behavior can we expect to lower the high rates of sexually transmitted infections among young people. It is unconscionable to do anything less.

We expect to do more here in New York State. FPA is part of a coalition of 150 organizations working to pass the Healthy Teens Act which would create a competitive grant program for school districts, BOCES, school-based health centers and community-based organizations to provide age-appropriate, medically accurate sex education. These coalition partners understand that it will take more than one sex education class to tackle these important health problems – it will take a community effort that includes parents, teachers, community organizations and leaders to make a positive impact in the lives of our young people.

America's youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted infections, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We urge Congress to stand up against these outrageous findings and end abstinence-only-until-marriage programs. Congress must act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.



Statement of the Florida Healthy Teens Campaign on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sex Education

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

Healthy Teens Campaign is a broad-based coalition made up of 31 education, faith-based, and public health organizations that seek to improve the health and safety of Florida teens through comprehensive sex education. Comprehensive sex education teaches abstinence as well as life-saving information about other prevention methods such as condoms and contraceptives.

As organizations concerned about the health and education of Florida's young people, the undersigned organizations of the Florida Healthy Teens Campaign wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs. There is a true need for evidence-based, comprehensive sex education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. We are committed to using sound scientific evidence and promoting the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years even though no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally funded study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-marriage programs have achieved their goal to increase rates of sexual abstinence--the entire supposed purpose of the programs. This report followed the findings from 13 states that have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful.

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, which discussed what programs work

in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.

A report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the already significant body of knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs.

These programs are not supported by any of the leading national or international public health and medical organizations. Every major medical and public health organization, and all 31 members of the Florida Healthy Teens Campaign, support a comprehensive approach to sex education. These include the ACLU of Florida - Reproductive Freedom Project, American Association of University Women, Greater Naples Branch Arnold Palmer Hospital for Children, Division of Adolescent Medicine, Connect to Protect Project, University of Miami, Connect to Protect Tampa Bay, University of South Florida, Florida Association of Planned Parenthood Affiliates (FAPPA), Hadassah Florida Central Region, Healthy Start Coalition of Pinellas, Healthy Start Coalition of Orange County, Healthy Start Coalition of Sarasota County, Healthy Start of St. Lucie County, Hispanic Latino Network, League of Women Voters, Palm Beach County, Lee County Health Department, National Council of Jewish Women State Public Affairs, Physicians for Reproductive Health and Choice, Seminole County Health Department, Sexuality Information and Education Council of the United States, St. Lucie County Health Department, Turtle Nest Village, and the YWCA of Tampa Bay

In addition, on November 21, 2007, ten public-health researchers sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid urging Congress to reduce or eliminate federal support for abstinence-only-until-marriage programs, in part because the programs have "multiple scientific and ethical errors." We strongly support the researchers' conclusion that abstinence-only-until-marriage programs withhold "potentially life-saving information" about birth control and ignore the health needs of lesbian, gay, bisexual, and transgender (LGBT) youth. The letter focused on the large body of evidence showing that abstinence-only-until-marriage programs are ineffective in getting young people to delay sexual initiation, noting that, "Recent reports in professional publications by the authors of this letter have highlighted multiple deficiencies in federal abstinence-only programs."

In November 2007, the University of Florida released a study showing that there are no statewide standards for sex education and Florida students receive too little information, too late. Unfortunately, this is not new information to Florida's health educators and teachers. They know that as a result of abstinence-only programs, Florida's teens either get no information or inaccurate information in the classroom. This means that Florida teens get their sex education from popular culture or their peers.

Because of a lack of factual information, Florida health educators hear myths that young people truly believe and repeat everyday.

- Myths like teen boys who believe that drinking mountain dew makes them unable to cause a pregnancy.
- Myths like teens who believe that if a boy smokes marijuana he will be unable to cause a pregnancy.
- Myths like boys who reported that drinking a capful of bleach was the best way to prevent getting HIV/AIDS.

Based on this lack of medically-accurate information, it is not surprising that Florida has the 6th highest teen pregnancy rate in the countryⁱ and the second highest rate of both AIDS and HIV.ⁱⁱ AIDS-related illnesses are the 9th leading cause of death for teens and teens report 31% of all newly acquired cases of sexually transmitted infections.ⁱⁱⁱ According to 2005 data from the CDC, 9% of students in Florida had sex for the first time before age 13 (compared to 6% nationwide).

Abstinence-only programs cost not only the lives and futures of our youth, but also taxpayer dollars. Between 1991 and 2004 there have been more than 354,100 teen births in Florida, costing taxpayers a total of \$8.1 billion over this period.^{iv} In 2004 alone, the cost of 23,804 births to teen mothers, age 0-19, on Federal, State and Local Governments, and the taxpayers who support them – \$489,158,000.^v Of the total costs, 52% were federal costs, and 48% were state costs. In Fiscal Year 2006, Florida received \$10,700,147 in federal funds for abstinence-only-until-marriage programs and \$2,521,581 in federal Title V funding specifically. In Fiscal Years 2006 and 2007, Florida provided \$1.5 million in general revenue to make the required 4:3 match for Title V funding.

Floridians reject abstinence-only programs and instead support comprehensive sex education by a wide margin. An overwhelming 78% of registered voters support a proposal that would require sex education to be taught in Florida public schools. Geographically the support for comprehensive sex education is consistent statewide. More than 84% of voters in Miami, Tampa, Orlando and the Panhandle regions say that it is important to teach comprehensive sex education in public schools. And across party lines, there is overwhelming support among Republicans, Democrats and Independents (Democrats 85% support --Independents 82% -- Republicans 68%).^{vi}

Recently, four Florida school districts, Brevard County, St. Lucie County, Palm Beach County, and Hillsborough County, have soundly rejected abstinence-only curricula in favor of comprehensive sex education which provides information about abstinence and methods of pregnancy and disease prevention. And editorial boards across the state are voicing what Floridians believe – abstinence-only programs are not working and are putting the health and safety of our youth at risk.

The South Florida Sun-Sentinel attributed Broward Counties decline in repeat teen birth rates to comprehensive sex education – including information about abstinence and contraception. “Federally funded abstinence-only programs have proven that a no-sex message is not enough.” According to the Sun-Sentinel, “many health experts blame the increased federal funding on abstinence-only programs that do not teach how to use

condoms and other contraception.” “Bottom line: Programs that educate teens about family planning deserve credit, and must continue.”^{vii}

According to Florida Today, abstinence-only programs “fail to persuade too many kids not to have sex, as studies have shown” and “also teach them contraceptives aren’t worth the bother, because of high failure rates.” “That’s dangerous misinformation, and why at least 14 states already have opted to turn down federal funds tagged to abstinence-only mandates that compromise teens’ health.” “Florida teens need the facts about contraceptive options. It’s literally a matter of life and death.”^{viii}

The Tampa Tribune editorial recognized that “abstinence programs are no longer dissuading more teens from having sex” and suggested that “schools should adopt a more measured approach” and that young people need information about abstinence and “how to protect themselves.” According to the Tampa Tribune, “Most parents want a balanced curriculum in sex-education classes.”^{ix}

Florida’s youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.

ⁱ Guttmacher Institute

ⁱⁱ Centers for Disease Control and Prevention

ⁱⁱⁱ Danice K. Eaton, et. al., “Youth Risk Behavior Surveillance—United States, 2005,” *Surveillance Summaries, Morbidity and Mortality Weekly Report*, vol. 55, no. SS- 5 (9 June 2006): 1- 108, accessed 26 January 2007, <<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>>.

^{iv} National Campaign to Prevent Teen Pregnancy,

http://www.teenpregnancy.org/costs/pdf/fact_sheet/FL_Final.pdf

^v National Campaign to Prevent Teen Pregnancy <http://www.teenpregnancy.org/costs/calculator.asp>

^{vi} Hamilton-Beattie & Staff and Public Opinion Strategies conducted a survey of 700 registered voters in Florida during January 2007.

^{vii} South Florida Sun-Sentinel, 2/12/08

^{viii} Florida Today, 1/5/08

^{ix} Tampa Tribune, 1/2/08



Statement of the Florida Association of Planned Parenthood Affiliates on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sex Education

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

The Florida Association of Planned Parenthood Affiliates is the state public policy office representing six Planned Parenthood affiliates and 22 health care centers across the state that provide health care to over 111,000 women, men, and families and provide educational programs that reach more than a half million Floridians every year. We also represent over 186,000 activists and supporters who live in every county across the state.

As the most trusted provider of reproductive health care in the country, Planned Parenthood does more to prevent unintended pregnancy than any other organization. In fact, 97% of our health services focus on preventing unintended pregnancy and the spread of disease. As an organization, we know best that medically-accurate, comprehensive sex education is the key to preventing unintended pregnancy and reducing the spread of disease.

As an organization that provides reproductive health care and education programs across Florida, we wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs. There is a true need for evidence-based, comprehensive sex education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. We are committed to using sound scientific evidence and promoting the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years even though no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally funded study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-marriage programs have achieved their goal to increase rates of sexual abstinence--the entire supposed purpose of the programs. This report followed the findings from 13 states that have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful.

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, which discussed what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.

A report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the already significant body of knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs.

In addition, on November 21, 2007, ten public-health researchers sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid urging Congress to reduce or eliminate federal support for abstinence-only-until-marriage programs, in part because the programs have "multiple scientific and ethical errors." We strongly support the researchers' conclusion that abstinence-only-until-marriage programs withhold "potentially life-saving information" about birth control and ignore the health needs of lesbian, gay, bisexual, and transgender (LGBT) youth. The letter focused on the large body of evidence showing that abstinence-only-until-marriage programs are ineffective in getting young people to delay sexual initiation, noting that, "Recent reports in professional publications by the authors of this letter have highlighted multiple deficiencies in federal abstinence-only programs."

In November 2007, the University of Florida released a study showing that there are no statewide standards for sex education and Florida students receive too little information, too late. Unfortunately, this is not new information to Florida's health educators and teachers. They know that as a result of abstinence-only programs, Florida's teens either get no information or inaccurate information in the classroom. This means that Florida teens get their sex education from popular culture or their peers.

Because of a lack of factual information, Planned Parenthood health educators across Florida hear myths that young people truly believe and repeat everyday.

- Myths like teen boys who believe that drinking mountain dew makes them unable to cause a pregnancy.
- Myths like teens who believe that if a boy smokes marijuana he will be unable to cause a pregnancy.
- Myths like boys who reported that drinking a capful of bleach was the best way to prevent getting HIV/AIDS.

Based on this lack of medically-accurate information, it is not surprising that Florida has the 6th highest teen pregnancy rate in the countryⁱ and the second highest rate of both AIDS and HIV.ⁱⁱ AIDS-related illnesses are the 9th leading cause of death for teens and teens report 31% of all newly acquired cases of sexually transmitted infections.ⁱⁱⁱ

According to 2005 data from the CDC, 9% of students in Florida had sex for the first time before age 13 (compared to 6% nationwide).

Abstinence-only programs cost not only the lives and futures of our youth, but also taxpayer dollars. Between 1991 and 2004 there have been more than 354,100 teen births in Florida, costing taxpayers a total of \$8.1 billion over this period.^{iv} In 2004 alone, the cost of 23,804 births to teen mothers, age 0-19, on Federal, State and Local Governments, and the taxpayers who support them – \$489,158,000.^v Of the total costs, 52% were federal costs, and 48% were state costs. In Fiscal Year 2006, Florida received \$10,700,147 in federal funds for abstinence-only-until-marriage programs and \$2,521,581 in federal Title V funding specifically. In Fiscal Years 2006 and 2007, Florida provided \$1.5 million in general revenue to make the required 4:3 match for Title V funding.

Floridians reject abstinence-only programs and instead support comprehensive sex education by a wide margin. An overwhelming 78% of registered voters support a proposal that would require sex education to be taught in Florida public schools. Geographically the support for comprehensive sex education is consistent statewide. More than 84% of voters in Miami, Tampa, Orlando and the Panhandle regions say that it is important to teach comprehensive sex education in public schools. And across party lines, there is overwhelming support among Republicans, Democrats and Independents (Democrats 85% support --Independents 82% -- Republicans 68%).^{vi}

Recently, four Florida school districts, Brevard County, St. Lucie County, Palm Beach County, and Hillsborough County, have soundly rejected abstinence-only curricula in favor of comprehensive sex education which provides information about abstinence and methods of pregnancy and disease prevention. And editorial boards across the state are voicing what Floridians believe – abstinence-only programs are not working and are putting the health and safety of our youth at risk.

The South Florida Sun-Sentinel attributed Broward Counties decline in repeat teen birth rates to comprehensive sex education – including information about abstinence and contraception. “Federally funded abstinence-only programs have proven that a no-sex message is not enough.” According to the Sun-Sentinel, “many health experts blame the increased federal funding on abstinence-only programs that do not teach how to use condoms and other contraception.” “Bottom line: Programs that educate teens about family planning deserve credit, and must continue.”^{vii}

According to Florida Today, abstinence-only programs “fail to persuade too many kids not to have sex, as studies have shown” and “also teach them contraceptives aren't worth the bother, because of high failure rates.” “That's dangerous misinformation, and why at least 14 states already have opted to turn down federal funds tagged to abstinence-only mandates that compromise teens' health.” “Florida teens need the facts about contraceptive options. It's literally a matter of life and death.”^{viii}

The Tampa Tribune editorial recognized that “abstinence programs are no longer dissuading more teens from having sex” and suggested that “schools should adopt a more

measured approach” and that young people need information about abstinence and “how to protect themselves.” According to the Tampa Tribune, “Most parents want a balanced curriculum in sex-education classes.”^{ix}

Florida’s youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.

ⁱ Guttmacher Institute

ⁱⁱ Centers for Disease Control and Prevention

ⁱⁱⁱ Danice K. Eaton, et. al., “Youth Risk Behavior Surveillance—United States, 2005,” *Surveillance Summaries, Morbidity and Mortality Weekly Report*, vol. 55, no. SS-5 (9 June 2006): 1- 108, accessed 26 January 2007, <<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>> .

^{iv} National Campaign to Prevent Teen Pregnancy.

http://www.teenpregnancy.org/costs/pdf/fact_sheet/FL_Final.pdf

^v National Campaign to Prevent Teen Pregnancy <http://www.teenpregnancy.org/costs/calculator.asp>

^{vi} Hamilton-Beattie & Staff and Public Opinion Strategies conducted a survey of 700 registered voters in Florida during January 2007.

^{vii} South Florida Sun-Sentinel, 2/12/08

^{viii} Florida Today, 1/5/08

^{ix} Tampa Tribune, 1/2/08



**Statement of FutureNet on Abstinence-Only-Until-Marriage Programs
and the Need for Comprehensive Sexuality Education**

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

FutureNet, the Iowa Network for Adolescent Pregnancy Prevention, Parenting, and Sexual Health, rejects the practice and funding of abstinence-only education in the state of Iowa.

As the leading state organization in Iowa for evidence-based teen pregnancy prevention strategies, FutureNet believes it is imperative that all adolescents receive comprehensive, age-appropriate, and medically accurate sexual health information. Further, as much as possible, the delivery of this content should be planned, provided, and evaluated using science-based strategies. Research continues to show that abstinence-only education fails to delay sexual initiation, reduce numbers of sexual partners, or prevent pregnancy in adolescents. FutureNet challenged the State of Iowa to take a stand against the irresponsible, ineffectual use of tax dollars by refusing any further federal abstinence-only funding.

In late February, 2008, Governor Chet Culver decided to reject federal funding for the state's abstinence-only education program provided under Title V of the Social Security Act. Iowa became the 17th state to reject federal funding and this will become effective starting Fiscal Year 2009. Governor Culver's decision came shortly after Dr. Doug Kirby of ETR Associates presented at FutureNet's State Policy Briefing at which he discussed both abstinence-only and comprehensive sex education programs. Kirby's research, published in *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Disease*, concluded that the only programs with strong evidence to delay sexual initiation were comprehensive sex education programs. Sex education programs that emphasize both abstinence and the use of condoms and contraception are realistic and most effective in achieving positive sexual health outcomes in adolescents.



FutureNet is not opposed to abstinence. Abstinence from any risky sexual behavior is the only completely effective way to prevent unintended pregnancy and the spread of sexually transmitted infections, including HIV. We are opposed to policies that deny young people age-appropriate, medically accurate information about contraception and condoms—information that can save their lives.

Abstinence-only programs do not change teen sexual behavior. In 2007, the 10-year congressionally mandated study, conducted by Mathematica Policy Research Inc., found that youth in the abstinence-only programs did not abstain from sex and had as many sexual partners as those who did not have abstinence-only education. In short, the abstinence-only programs did not change teen sexual behavior.

Evaluations repeatedly show that abstinence-only education doesn't work. The National Campaign to Prevent Teen and Unplanned Pregnancy commissioned a study in 2007 to examine both comprehensive and abstinence-only education programs. The study, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Disease*, authored by Douglas Kirby, Ph.D., a leading researcher in adolescent health, found that the only programs that delayed sexual initiation were comprehensive sex education programs. Moreover, the report clearly states, "*there does not exist any strong evidence that any abstinence program delays that initiation of sex, hastens the return to abstinence, or reduces the number of sexual partners.*"

Statement of Get Real! Indiana Coalition to Promote Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education

**Committee on Oversight and Government Reform
Submitted for the Record
April 25, 2008**

Get Real, Indiana! is a coalition of organizations calling for medically accurate, age-appropriate, affirming sexuality curricula for Indiana students. We represent numerous Indiana-based research organizations, wellness centers, health organizations and college campus-based groups which believe that comprehensive sexual education in public schools is an important tool to help Hoosier citizens lead overall healthy lives.

As a coalition concerned about the health and education of Indiana's young people, the undersigned organizations of Get Real want our voices heard, and wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge them to provide the necessary oversight to bring an end to federal funding for these ineffective programs.

Here in Indiana, our teen pregnancy rate is higher than the national average (31 Hoosier teens become pregnant every day), and there was even a recent syphilis warning heard around the state due to the high increase in outbreaks.

There are currently 43 statewide organizations working to ensure that the above stated problems are addressed appropriately. We believe that:

- Parents have the right to choose a suitable sexuality curriculum for their children.
- Education is the key to a healthy and vibrant community.
- Truly honest sex education seeks to help all young people garner information and skills about taking care of their sexual health and make responsible decisions.
- Comprehensive sex education is absolutely necessary for our youth to be able to avoid ignorance, unintended pregnancies and sexually transmitted diseases.

We feel the current pregnancy rates and STI problems provide the evidence that there is a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. We are committed to using sound scientific evidence and promoting the health and

welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Get Real! Indiana is dedicating to ensuring that in the future, Hoosier citizens will have the medically accurate, non-discriminatory, age-appropriate information they need to make healthy decisions about their own sexuality. We ask that you also consider the same.

Girls Incorporated®

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Statement of

**Joyce M. Roché
President and CEO
Girls Incorporated**

Submitted to the

**Committee on Oversight and Government
Reform
U.S. House of Representatives**

April 23, 2008



Inspiring all girls
to be strong,
smart, and boldSM

Mr. Chairman and members of the Committee, thank you for the opportunity to submit this testimony regarding funding of abstinence-only programs. My name is Joyce Roché, and I am the President and CEO of Girls Incorporated, the national non-profit youth organization that inspires all girls to be strong, smart, and bold. On behalf of Girls Inc., our more than 80 local affiliates, and the girls that we serve, I want to share with you our stance against continued federal funding of abstinence-only programs.

Girls Incorporated believes that for young people, abstinence should be the first choice. Through our Girls Inc. Preventing Adolescent Pregnancy program, we combine a strong abstinence message with concrete skills needed to say no to sex, including refusal skills, avoiding risky situations, and finding a positive peer group. Additionally, we affirm, and teach, that the only certain way to avoid sexually transmitted diseases is to avoid sexual activity. Finally, we recognize that the family is the primary source of information about sex and we help girls and young women communicate with their families about sexuality.

Girls Inc. also believes, however, that to make responsible decisions about sexuality, pregnancy, and parenthood, girls need and have the right to sensitive, comprehensive sexuality education. Young people face many challenges in navigating their adolescent years. However, they also show tremendous resilience, responsibility, and judgment when availed of resources and skills they can use to build a positive future for themselves. We have learned that giving youth information and responsibility increases the chance they will use it wisely.

Girls Incorporated works proactively to deliver comprehensive sex education, an approach that gets proven, positive results. A three-year evaluation of Girls Inc. Preventing Adolescent Pregnancy[®], published in 1991, found that older teens who completed the program were half as likely to have sex and one-third as likely to get pregnant in the year following the program as those who participated less or not at all; younger teens who completed the program were half as likely to have sexual intercourse as those who participated less or not at all.¹

By contrast, significant scientific evaluations of abstinence-only education conclude that abstinence-only education is not effective, and, in fact, can be harmful.

A 2007 study of federally funded abstinence-only education programs, authorized by Congress and conducted for the U.S. Department of Health and Human Services by Mathematica Policy Research, Inc. found that the abstinence-only programs studied had no effect on sexual abstinence of youth.² The study was targeted to evaluate program impacts upon youth behavior, including sexual abstinence, risks of pregnancy and sexually transmitted diseases (STDs), and other outcomes. The study surveyed 2,057 U.S. students who participated in four abstinence-only programs in late elementary and middle school, as well as students in the same grades who did not participate in such programs. Key findings in the study are that:

- Youth in the abstinence-only programs were no more likely than youth not in the programs to have abstained from sex in the four to six years after they began participating in the study.
- Youth in the abstinence-only programs had similar numbers of sexual partners as those not in the programs (more than one-third of both groups had two or more sexual partners).
- Youth in the abstinence-only programs initiated sex at the same mean age (15) as those not in the programs.
- Youth in both groups had almost identical rates of unprotected sex (17% of both groups reported having had sex and only sometimes using a condom; and 4% of the students in both groups reported having had sex and never using a condom) but youth in the abstinence-only programs were less likely to believe that condoms prevent STDs, according to the report.

¹ Nicholson, H. J. & Postrado, L.T. (1992). A comprehensive age-phased approach: Girls Incorporated. In Miller, B., Card, J., Paikoff, R., Peterson, J. (Eds.), *Preventing Adolescent Pregnancy* (pp. 110-138). Newbury Park, CA: Sage Publications and Girls Incorporated. (1991). *Truth, trust and technology: New research on preventing adolescent pregnancy*. New York: Author.

² Barbara Devaney et al., Mathematica Policy Research, Inc., *The Impacts of Four Title V, section 510 Abstinence Education Programs. Final Report 2007*.

In a study conducted by Texas A&M in 2004 of five self-selected “abstinence education” contractors, the analysis revealed that the percentage of students reporting having ever engaged in sexual intercourse **increased** for nearly all ages between 13 and 17.³

The consequences of teenage pregnancy and childbirth are devastating to both mothers and babies and harmful to fathers. The Robin Hood Foundation reports that 40 percent of girls who begin families before age 20 will not complete high school or a GED by age 30.⁴ Many teenage mothers end up raising their children alone and in poverty. Children born to teen mothers are at risk of premature birth, low birthweight, lower academic achievement, more behavior and emotional problems, and greater likelihood of becoming teenage parents themselves. Teen fathers are more likely to engage in delinquent behaviors and to use alcohol routinely, deal drugs, or quit school.

Most recently, the Centers for Disease Control and Prevention released a study in March 2008 that estimates that 1 in 4 young women between the ages of 14 and 19 in the United States – or 3.2 million teenage girls – is infected with at least one of the most common sexually transmitted diseases. The study also found disturbing racial differences, as 48% of young African-American women are infected with an STD.⁵ The findings in this study warrant a response that is rapid, effective, and based on science.

Girls Inc. joins our nation’s leading medical associations, child welfare organizations, and most Americans in advocating comprehensive sex education as the soundest approach to helping young people avoid pregnancy and sexually transmitted diseases and infections. During a time when families are losing their homes, children are going without meals, and the healthcare crisis is reaching epidemic proportions, we respectfully submit that continued federal funding for abstinence-only education damages the public trust in Congress and does a disservice to the families and girls we serve.

Thank you for the opportunity to contribute to this important debate.

Girls Incorporated® is a national nonprofit organization that inspires all girls to be strong, smart, and bold™. With local roots dating to 1864 and national status since 1945, Girls Inc. has responded to the changing needs of girls and their communities through research-based programs and advocacy that empower girls to reach their full potential and to understand, value, and assert their rights. Programs focus on science, math, and technology, health and sexuality, financial literacy, sports, leadership and advocacy, and media literacy for girls ages 6 to 18 throughout the United States and in Canada.

³ Patricia Goodson, et al., *Abstinence Education Evaluation Phase 5: Technical Report* (College Station, TX: Department of Health & Kinesiology–Texas A&M University, 2004), 170-172.

⁴ Rebecca Maynard, *Kids Having Kids: A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing*, 1996. <http://www.robinhood.org/approach/KHK.pdf>

⁵ <http://www.cdc.gov/std/conference/2008/media/release-11march2008.htm>



April 28, 2008

Rep. Henry A. Waxman, Chairman
 Committee on Oversight and Government Reform
 U.S. House of Representatives
 2157 Rayburn House Office Building
 Washington, D.C. 20515

Dear Chairman Waxman,

Thank you for the opportunity to submit a statement for the record in connection with the Committee's hearing titled, "Domestic Abstinence-Only Programs: Assessing the Evidence," held on Wednesday, April 23, 2008. Through its work as an independent, not-for-profit organization focusing on sexual and reproductive health research, policy analysis and public education in the United States and internationally, the Guttmacher Institute has developed and analyzed a great deal of information on sex and American's teenagers and on the effectiveness of the federal abstinence-only-until-marriage programs.

Since 1996, when a major overhaul of the nation's welfare policy led to a massive escalation of funding in this area, the federal government has spent well over one billion dollars to promote premarital abstinence among young Americans, through highly restrictive programs that ignore or often actively denigrate the effectiveness of contraceptives and safer-sex behaviors. Currently, 17 states have declined to apply for the annual abstinence education grants set aside for them under Title V of the Social Security Act. More than 12 million adolescents, 42% of young people aged 12–18 nationwide, are living in the states that have passed up Title V abstinence-only funding. At the same time, more than \$113 million in abstinence-only funds continue to flow directly from the federal government to community and faith-based organizations, primarily under the Community-based Abstinence Education (CBAE) program.

Evidence forcefully demonstrates that the current U.S. emphasis on stopping teens from having sex is out of touch with young people's lives and needs. The attached article—"The Case for a New Approach to Sex Education Mounts; Will Policymakers Heed the Message?" published in the Spring 2007 *Guttmacher Policy Review*—summarizes in one place the relevant research and shows just how dysfunctional the U.S. government's approach to sex education is. The article makes the following six points:

- While most people would agree that teens, especially younger teens, should be encouraged to delay sexual activity, the fact remains that most young women and men will become sexually active during their teenage years, or very soon thereafter. Therefore, the challenge is in helping teens, especially young teens, delay sexual

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initiation, while also preparing them with the information and skills needed to protect themselves and their partners when they do become sexually active.

- Contraceptive use plays a critical role in preventing teen pregnancy. Teen birth and pregnancy rates declined impressively between 1991 and 2005. Research indicates that the vast majority of the decline (86%) was the result of dramatic improvements in contraceptive use.
- Contrary to the tenets of abstinence-only-until-marriage education, premarital sex is nearly universal. By the time they reach age 44, 99% of Americans have had sex, and 95% have done so before marriage.
- A recent, congressionally mandated evaluation of federally funded abstinence-only programs by Mathematica Policy Research—conducted over nine years at a cost of almost \$8 million—found that these programs have no beneficial impact on young people’s sexual behavior. Teens who participated in the programs were no more likely to abstain than those who did not.
- Comprehensive sex education can assist young people in the transitions inherent in adolescence by helping them both “delay” and “prepare.” There is strong evidence that comprehensive sex education can effectively result in delays in sexual initiation among young people, even as it increases condom and overall contraceptive use among sexually active youth.
- Most Americans believe that sex education should promote abstinence *and* provide information about the effectiveness and benefits of contraception. According to the results of a 2005–2006 nationally representative survey of U.S. adults, published in the *Archives of Pediatrics and Adolescent Medicine*, 82% of those polled support a comprehensive approach, and 68% favored instruction on how to use a condom; only 36% supported abstinence-only education.

The time has come for Congress to make a more significant break from the past. We call on Congress to end federal funding for abstinence-only-until-marriage programs and, instead, to put these funds toward evidence-based programs that will give teenagers the information and guidance they need—both to withstand pressure from their peers and the media to have sex too soon, and to have healthy, responsible, mutually protective relationships when they do become sexually active.

Sincerely,



Cory L. Richards
Executive Vice President
Vice President for Public Policy

The Case for a New Approach to Sex Education Mounts; Will Policymakers Heed the Message?

By Heather D. Boonstra

Abstinence-only-until-marriage education is a key component of social conservatives' global moral and religious agenda, and the cornerstone of the Bush administration's approach to reducing U.S. teen pregnancy and sexually transmitted infection (STI) rates. Since 1996, when a major overhaul of the nation's welfare policy prompted a massive escalation of funding in this area, the federal government, with mandatory matching grants from the states, has spent well over one billion dollars to promote premarital abstinence among young Americans, through highly restrictive programs that ignore or often actively denigrate the effectiveness of contraceptives and safer-sex behaviors.

Fearful of being portrayed as anti-abstinence, policymakers have continued to support these rigid, ideologically driven programs even though there is clear evidence—including compelling recent evidence from a long-awaited, congressionally mandated report on federally funded abstinence-only-until-marriage programs—that they are not effective in stopping or even delaying teen sex. In fact, the federal government has been supporting and evaluating single-purpose abstinence promotion programs since the early 1980s, and there is now evidence suggesting that they may be harmful to young people in the long term. Meanwhile, there is still no comparable federal program to support comprehensive approaches that promote delayed sexual activity as well as protective behaviors for when young people do initiate sex, even though such programs have been shown to be effective at accomplishing both.

Adding to the body of evidence on sex education approaches and teen sexual behavior, three new studies from Guttmacher Institute researchers forcefully demonstrate that the current U.S. emphasis on stopping teens from having sex is out of touch with young people's lives and needs. The question that now presents itself is whether the new Congress may at long last be ready to change course and, if so, how far and how fast.

Restrictive Policy

The Bush administration has recommended that a total of \$204 million be spent on abstinence-only-until-marriage education in FY 2008, up from \$176 million in the current fiscal year. Of that, \$50 million goes automatically to the states for abstinence education programs that must conform to a highly restrictive eight-point definition enshrined in Title V of the Social Security Act. Some of the more controversial components of this definition include teaching that "a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity" and that "sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects." Because one of the planks of the eight-point definition requires funded programs to have as their "exclusive purpose" the promotion of abstinence outside of marriage, these programs are barred from providing any information that could be construed as promoting or advocating contraceptive use. In practice, programs have a choice between not discussing contraceptive methods at all or doing so in a negative manner by emphasizing their failure rates. Moreover, as of last year, state programs must now target "ado-

lescents and/or adults within the 12- through 29-year-old age range" in their programming, signaling that the federal government will no longer allow states to use their federal funds to support programs targeting only preadolescents.

Some states have found the rules that govern the abstinence program so restrictive that they have decided to turn down the funding altogether. In March, Ohio Gov. Ted Strickland (D) announced that his administration will not reapply for Title V abstinence education funds when the current \$1.6 million grant expires. Ohio joins a growing list of states—among them, California, Maine, New Jersey and Wisconsin—that have said they cannot accept the federal government's restrictions.

The lion's share of abstinence program dollars bypass state governments altogether and go directly to local organizations, including faith-based groups. Recipients of grants under the Community-Based Abstinence Education (CBAE) program must comply with the stringent rules that govern the states—only CBAE is even more rigid. Its guidelines expand on the definition of what constitutes a fundable abstinence program to 13 "themes" and expound at length on the recommended curricula content (related article, Winter 2006, page 19). CBAE is a favorite among social conservatives, and funding for the program—currently at \$113 million—has risen 465% since its inception just five years ago. Indeed, all of the increases for abstinence-only education in recent years have gone to the CBAE program.

New Research

In the last few months alone, Guttmacher Institute researchers have published three studies that, when viewed together, demonstrate just how dysfunctional the U.S. government's approach to sex education is. The first, published in the December 2006 issue of *Perspectives on Sexual and Reproductive Health*, analyzes trends in the provision of school-based instruction about contraception and abstinence between 1995, the year before enactment of the welfare reform law, and 2002. It shows that during this period in which abstinence-only funding grew exponentially, the proportion of U.S. teens who had received any formal instruction about birth

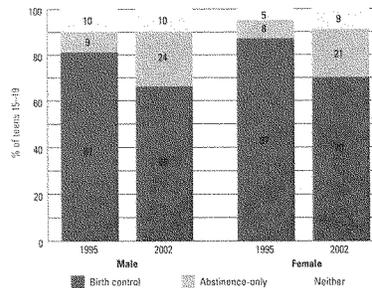
control methods declined sharply, while the proportion who received only information about abstinence more than doubled (see chart).

Equally important, many did not get birth control information when they needed it most. In 2002, only slightly more than half of sexually experienced males and six in 10 females had received any instruction about birth control methods before they first had sex. Minority and low-income youth were especially disadvantaged: For example, only one-third of black males had received instruction about birth control prior to first sex, compared with two-thirds of their white peers. And teens living below 200% of poverty (an annual income of \$34,340 for a family of three) were less likely than their higher-income peers to have received birth control education before first sex (see chart, page 4).

This trend is all the more disturbing considering the critical role of contraceptive use in preventing teen pregnancy. The second study, by researchers from Guttmacher and Columbia University, analyzes the relative contributions of abstinence and contraceptive use to the 24% decline in the U.S. teen pregnancy rate seen during the same 1995–2002 period. This study, published in the January 2007 issue of the *American Journal of*

MORE GETTING LESS

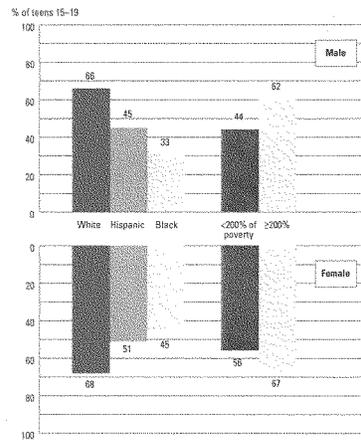
Over just seven years, the proportion of teens receiving information on birth control dropped precipitously; in its place, education only about abstinence.



Source: *Perspectives on Sexual and Reproductive Health*, 2006.

NOT SOON ENOUGH

Black, Hispanic and low-income teens are particularly unlikely to have received education on birth control before they first have sex.



Source: *Perspectives on Sexual and Reproductive Health, 2006.*

Public Health, finds that the decline occurred primarily because teens were using contraceptives better. Examining data from two rounds of a large-scale national survey, the researchers conclude that the vast majority of the decline (98%) was the result of dramatic improvements in contraceptive use, including increases in the use of individual methods, increases in the use of multiple methods and substantial declines in nonuse. Just 14% of the decline could be attributed to a decrease in sexually activity.

Not surprisingly, abstinence played a greater role among younger teens aged 15-17, but even among this age-group (in which sexual activity declined a healthy 17% between 1995 and 2002), only 23% of the decline in teen pregnancy could be attributed to decreased sexual activity. Among 18-19-year-olds, there was no change in sexual activity during this period; accordingly, the preg-

nancy rate decline among this group was entirely attributable to improved contraceptive use.

The third study demonstrates how unrealistic the goal of abstinence until marriage is now and has been for decades. According to the study, published in the January/February 2007 issue of *Public Health Reports*, premarital sex is normal behavior for the vast majority of Americans: By the time they reach age 44, 99% of Americans have had sex, 95% have done so before marriage and 74% have done so before age 20. Even among those who abstain from sex until age 20 or older, 81% eventually have premarital sex. (The typical age of marriage is currently 25 for women and 27 for men.) Further, contrary to public perception that premarital sex is much more common now than in the past, the study shows that even among women who were born in the 1940s, nearly nine in 10 had sex before marriage (see chart).

What Should Be Done?

Most people would agree that teens, especially younger teens, should be encouraged to delay sexual activity. Sex among very young adolescents is frequently involuntary, at least to some degree: It may involve a partner who is substantially older, which may make it hard for such teens to resist their partner's approaches or to insist on using condoms or other contraceptive methods. Teens who have sex at a young age tend to have relatively unstable relationships and quickly acquire other sexual partners, which increases their risk of exposure to STIs. And young teenagers who get pregnant are rarely, if ever, in a position to support and raise a child.

The fact remains, however, that although only 13% of teens have ever had sex by age 15, sexual activity is common by the late teen years. By their 19th birthday, seven in 10 teens of both sexes have had intercourse. Therefore, the challenge is in helping teens, especially young teens, delay sexual initiation, while also preparing them with the information and skills needed to protect themselves and their partners when they do become sexually active.

The good news is that comprehensive sex educa-

tion can assist young people in the transitions inherent in adolescence by helping them delay and prepare. According to Douglas Kirby, a senior research scientist at ETR Associates who has analyzed hundreds of program evaluations, there is strong evidence that comprehensive sex education can effectively delay sex among young people, even as it increases condom and overall contraceptive use among sexually active youth. This is in sharp contrast to what can be said about the effectiveness of abstinence-only education. A recent, congressionally mandated evaluation of federally funded abstinence-only programs by Mathematica Policy Research—conducted over nine years at a cost of almost \$8 million—found that these programs have no beneficial impact on young people's sexual behavior. As Kirby puts it, we can no longer say the jury is out on abstinence-only-until-marriage programs (see box).

To the extent that they ignore contraception and the benefits of safer-sex practices generally, abstinence-only programs do nothing to help prepare young people for when they will become sexually active. And some abstinence-only programs may be doing long-term damage by deterring contraceptive use among sexually active teens, increasing their risk of pregnancy and STIs. According to research by Hannah Brückner and Peter Bearman published in the *Journal of Adolescent Health* in 2005, the major-

ity of teens enrolled in grades 7–12 in 1995 who pledged to remain virgins until marriage had sex before marriage or by the time of a follow-up survey in 2001–2002. Furthermore, compared with those who never took a pledge, “pledge breakers” were less likely to use condoms and to seek testing and treatment for STIs, and just as likely to test positive for STIs.

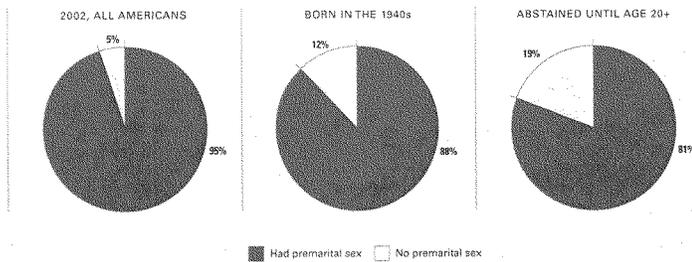
Turning Point?

Counter to the priorities of the Bush administration and social conservatives, most Americans believe that sex education should promote abstinence and provide information about the effectiveness and benefits of contraception. According to the results of a 2005–2006 nationally representative survey of U.S. adults, published in the *Archives of Pediatrics and Adolescent Medicine*, there is far greater support for comprehensive sex education than for the abstinence-only approach, regardless of respondents’ political leanings and frequency of attendance at religious services. Overall, 82% of those polled supported a comprehensive approach, and 68% favored instruction on how to use a condom; only 36% supported abstinence-only education. These results are consistent with those from a range of previous surveys among adults, parents, teachers and young people.

Over the last several years, various measures

STANDARD OF SEXUAL ACTIVITY

Contrary to the tenets of abstinence-only-until-marriage education, premarital sex is nearly universal, and has been for decades.



Note: Percentages are of Americans who had premarital sex by age 44. Source: Public Health Reports, 2007.

have been proposed in Congress to address the disconnect between young people's need for realistic sex education and the hard-line abstinence-only approach embodied in current federal law. The more modest of these proposals have sought to curb the most grievous excesses of the current policy. One such proposal, for example, would require medical accuracy in abstinence-only educational materials, after a Government Accountability Office report raised serious concerns on that score. Another would remove the

most unscientific and ideologically driven planks in the eight-point definition of abstinence education, such as the one requiring grantees to teach that sex outside of marriage is likely to be physically and psychologically harmful. As far back as 2002, Sen. Max Baucus (D-MT) proposed a "state flexibility" approach, which would give states the option of using their allotments to promote abstinence according to the eight-point definition or to teach abstinence within a more comprehensive sex education program.

A Sex Education Expert Discusses the State of the Evidence on Programs

For more than 25 years, Douglas Kirby of ETR Associates has studied adolescent sexual behavior and programs designed to change that behavior. In 2001, under the auspices of the National Campaign to Prevent Teen Pregnancy, he authored Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, which analyzed the impact evaluations of more than 100 teenage pregnancy prevention programs across the country that met rigorous research standards. He is currently updating this report and will publish Emerging Answers 2007 later this year.

HB: A major conclusion of your 2001 report, *Emerging Answers*, was that comprehensive programs that urge teens to postpone having sex but also help teens to engage in protective behaviors are effective at doing both. At the same time, the report concluded that there was no reliable evidence to support the effectiveness of abstinence-only education. Is this still true today?

DK: The evidence that comprehensive programs work has only become stronger over time. In a recent review of some 80 studies that measure the impact of comprehensive programs, two in three programs had a significant positive impact on behavior.

Many either delayed or reduced sexual activity, or increased condom or contraceptive use. At least 10 interventions had long-term behavioral effects lasting two or more years; some lasted three or more years—as long as the effects were measured.

What is particularly encouraging about the evidence from these studies of comprehensive sex and HIV education programs is that when some curricula that were found to be effective in one study were implemented by other educators in other states and evaluated by independent research teams, they remained effective if they were implemented with fidelity in the same type of setting and with similar youth.

HB: As you know, opponents of comprehensive sex education argue that encouraging abstinence while promoting the use of condoms and other forms of contraception for those who are sexually active only sends a mixed message that will result in increased sexual behavior. Is there any evidence to support that fear?

DK: No, in fact the evidence is very strong that comprehensive programs do not increase sexual behavior.

HB: And what about abstinence-only

programs? In 2001, you characterized the situation by saying that the "jury is out" on abstinence-only programs, even though the government already had spent almost a billion dollars on this approach and, in fact, had been funding and evaluating abstinence promotion interventions since the early 1980s. Six years later, and with many more programs evaluated and dollars spent, is the jury still out?

DK: At least with regard to the abstinence-only-until marriage programs currently being promoted under federal policy, we can no longer say the jury is out.

Until recently, there had been very few rigorous studies conducted on abstinence-only programs and even fewer studies of programs that meet the strict federal Title V requirements. The evaluation by Mathematica Policy Research changes all of that, and its importance cannot be denied. This was a rigorous, nine-year study that focused on four abstinence-only-until-marriage programs, all of which met the eight-point definition stipulated in Title V and were considered by state officials and abstinence education experts to be especially promising. The study used an experimental design and followed more than 2,000 teens—a very large sample—who

Ultimately, however, most opponents of abstinence-only-until-marriage education argue that the time has come for Congress to make a more significant break from the past. In light of the changed political climate and the more robust body of research in support of a comprehensive approach, they are calling on Congress to throw its support behind the Responsible Education About Life (REAL) Act, sponsored by Reps. Barbara Lee (D-CA) and Christopher Shays (R-CT) in the House and Frank R. Lautenberg (D-NJ) in

the Senate. The REAL Act would support state programs that operate under a nine-point definition of "family life education" that stands in sharp contrast to the eight-point definition of abstinence-only education. According to Lee, "We should absolutely be teaching young people about abstinence, but we shouldn't be holding back information that can save lives and prevent unwanted pregnancies." www.guttmacher.org

were randomly assigned to a program group or a control group. Data were collected from this study sample through a series of four surveys; the most recent and final survey was completed between 2005 and 2008, four to six years after study enrollment. The response rate on this survey was very high, ranging from 80% to 84%. All in all, this was a very well done study.

The evaluation found that none of the programs had a statistically significant beneficial impact on young people's sexual behavior. In fact, I was surprised by just how flat the results were. Teens who participated in the programs were no more likely to abstain than those who did not. Those who reported having had sex did so at the same age and had similar numbers of sexual partners. The only good piece of news was that youth who participated in the programs were no less likely to use condoms or other forms of contraception.

HB: So, what about abstinence education programs more generally?

DK: First, let me be clear that, as a researcher, I am not saying that no abstinence-only program can work. What I am saying is that currently there are no abstinence-only pro-

grams with strong evidence that they actually delay sex. Thus, there is no evidence base upon which to recommend their widespread dissemination and implementation.

Also, let me say that personally, I do not oppose abstinence-only programs for some grade levels—and by abstinence-only, I mean programs that discuss abstinence without addressing contraception. In every school district, there is some grade level where very few, if any, students are having sex. At this grade level, emphasizing only abstinence—without denigrating condoms or other forms of contraception—may be appropriate.

However, I do oppose programs in schools that only address abstinence in grades where some teens are having sex. Once 10% to 20% of students in a given school district are beginning to have sex, I believe they have the right to accurate and balanced information about abstinence, condoms and other forms of contraception. Furthermore, from a public health standpoint, they should be given information, as well as the skills and access to condoms and contraception, so that they are more likely to use protection if they do have sex.

HB: In conclusion, then, given the

state of the research today on the relative effectiveness of abstinence-only and more comprehensive programs, what are your recommendations for public policy?

DK: Based on the evidence to date, I would suggest that comprehensive programs be implemented broadly. There is strong evidence supporting these programs. Accordingly, we should eliminate the funding restrictions that prevent the funding of comprehensive programs that effectively delay sex among young people. After all, it makes no practical sense to fund programs that do not work and to prevent funding of comprehensive programs that actually delay sex, and increase protective behavior.

Finally, more research is needed on programs that have demonstrated that they effectively reduce sexual risk. How can we make them even more effective? How can we disseminate effective programs widely? Must these programs be implemented exactly as designed? To what extent can they be adapted for individual communities and groups of youth? The more quickly we can resolve these issues, the more rapidly we can reduce teen pregnancy and STI rates in this country.



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April 22, 2008

The Honorable Henry A. Waxman
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Waxman:

I am writing on behalf of the members of the HIV Medicine Association (HIVMA) to offer our strong support for the April 23rd hearing to evaluate the evidence for domestic abstinence-only education programs. We commend you for sponsoring the first hearing on this important topic, which we feel is long overdue.

HIVMA represents more than 3,600 medical providers and scientists from across the country devoted to preventing, treating and eventually eradicating HIV disease. We are deeply concerned by our country's continued investment in abstinence-only education programs over the past several years despite a dearth of evidence documenting their effectiveness. We are particularly troubled because during this period overall federal funding for domestic HIV prevention and surveillance has decreased while the number of new HIV infections has remained steady with at least 40,000 occurring annually.

As clinicians and scientists, we advocate investing the limited federal prevention dollars into practices that are empirically proven to prevent the transmission of HIV and other sexually transmitted diseases (STD). To do otherwise is irresponsible, jeopardizes the health of individuals, and compromises the public health of our nation. As stated in our policy statement (enclosed), the only way to stop the spread of HIV and sexually transmitted infections is to use a comprehensive approach to educating young people. To date, no data have demonstrated any long term benefit to abstinence only education programs; to the contrary, they are ineffective and, since they prevent delivery of a complete message, are hazardous.

What is more concerning is the lack of rigor in the direction provided to sites funded to provide 'abstinence only' education. The Department of Health and Human Services does not require abstinence-only programs to provide medically accurate information in their curricula or their educational materials despite requirements in the Public Health Service Act to the contrary. Ignoring and/or misrepresenting the evidence for what works in preventing HIV transmission, and for when sexual activity is initiated among adolescents, places their lives at serious risk.

Until we develop a vaccine, a robust prevention strategy that employs all of the tools proven to be effective at preventing HIV transmission is our best,

Honorable Henry A. Waxman
April 22, 2008
2

and for now, only weapon to prevent this deadly disease. We must take a comprehensive approach to HIV/STD prevention that unties the hands of educators to provide the complete story of risk avoidance and risk minimalization.

Our concerns regarding federal support for unproven prevention programs and policies led us in 2005 to develop the enclosed policy statement with the Infectious Diseases Society of America that calls for federal policies based on the best available science, including comprehensive sexual health education programs that are culturally and developmentally appropriate. We urge you and the Committee members to consider it as you continue your evaluation of abstinence-only education programs and develop recommendations regarding continued federal support for these programs. We also urge you to consider our leaders and membership a resource on this issue and others related to HIV prevention, care and treatment, and research.

Thank you for your continued leadership on HIV prevention issues and other critical HIV-related topics such as care, treatment and research.

Sincerely,



Arlene Bardeguéz, MD, MPH
Chair, HIVMA



Michael Saag, MD, FIDSA
Vice-Chair, HIVMA



HIV Medicine Association (HIVMA) and Infectious Diseases Society of America (IDSA) Joint Policy Statement

Preventing HIV and other Sexually Transmitted Infections: A Call for Science-Based Government Policies

Sexually transmitted infections, including HIV/AIDS, are a major source of morbidity and mortality in the U.S. and around the world.ⁱ Despite knowledge of how HIV is transmitted, the number of new HIV infections was as high last year as in any year since the epidemic began. In the absence of preventative vaccines or cures for HIV and a number of other sexually transmitted infections, it is imperative that federal and local governments support science-based information and programs to assist persons of all ages in protecting themselves from the acquisition of sexually transmitted infections, including HIV/AIDS.

The HIV Medicine Association (HIVMA) and the Infectious Diseases Society of America (IDSA) are strongly committed to public health interventions that decrease the transmission of all infectious diseases (see related policy statement on syringe exchange lawsⁱⁱ). We believe strongly that the federal government must play a leading role in protecting our nation's health by reducing the spread of STIs.

- The federal government must continue to support a robust portfolio of biomedical and behavioral research that aims to identify preventive vaccines, new diagnostics and treatments, and behavioral intervention strategies that reduce the risks of transmission. Adequate support for public health infrastructure to conduct surveillance and to administer STI screening and treatment programs is also essential.
- The federal government has an obligation to ensure that public health information that is developed and disseminated with federal dollars is evidence-based and comprehensive.

Clearly, delaying or abstaining from sexual activity is an effective method for preventing sexually transmitted infections. Similarly, it is irrefutable that a monogamous relationship with an uninfected partner will prevent sexually transmitted infections. Nevertheless, it is also true that the majority of teenagers have had a sexual encounter before they graduate from high schoolⁱⁱⁱ, and millions of young people and adults are sexually active outside the bounds of marriage and mutually monogamous relationships. Prevention messages must be tailored to specific segments of the population to be effective, and should be age and culturally appropriate and value neutral. There is a public health obligation to offer guidance about risk reduction strategies, in addition to messages that encourage abstinence and/or fidelity, to sexually active youth and adults.

Moreover, it is critical that programs emphasizing abstinence do not do so at the expense of offering accurate information about behaviors associated with the acquisition of sexually transmitted infections, and the efficacy of risk reduction strategies like consistent and appropriate use of condoms.^{iv}

There is a large body of scientific literature that demonstrates that condoms are very effective in preventing HIV transmission when used consistently and correctly.^{v vi vii} An international study of HIV discordant couples demonstrated that condoms were 100 percent effective in preventing HIV transmission.^{viii} There is also significant scientific data linking consistent condom use with prevention of gonorrhea, chlamydia, herpes simplex virus, and syphilis.^{ix} A recent randomized controlled clinical trial has linked condom use with accelerated clearance of the human papilloma virus (HPV) and HPV disease.^x

Our current approaches are failing to reduce the number of new infections. We need to critically evaluate current education messages and practices in an effort to have a meaningful impact on this global plague.

Specifically, HIVMA and IDSA strongly support the following federal policy actions:

- Federally funded sexual health education programs for use in the U.S. and in the developing world should be scientifically based, comprehensive, and culturally and developmentally appropriate. Legislation authorizing current programs that are limited to so called “abstinence only” or “abstinence until marriage” strategies should be modified to reflect these standards.^{xi xii xiii} The curricula of programs eligible for federal funding should be reviewed for scientific accuracy.
- The provision in the law authorizing the President’s Emergency Plan for AIDS Relief (PEPFAR) that requires that 33 per cent of prevention funds be targeted to “abstinence only” programs^{xiv} should be repealed. Funds allocated for prevention should be directed to programs that provide comprehensive education about the prevention of HIV/AIDS.
- Funding for research to develop new diagnostics and treatments for the prevention of sexually transmitted infections, including HIV, should be maintained and increased.

^{iv}Joint United Nations Programme on HIV/AIDS, *2004 Report on the Global AIDS Epidemic*, July, 2004.

^vHIV Medicine Association. Policy Statement on Syringe Exchange, Prescribing and Paraphernalia Laws, October 2001.

^{vi}The Henry J. Kaiser Family Foundation, *National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes and Experiences*, 2003.

^{vii}United States House of Representatives, Committee on Government Reform- Minority Staff, Special Investigations Division, *The Content of Federally Funded Abstinence-Only Programs*, December 2004.

^{viii}National Institute of Allergy and Infectious Diseases. Workshop summary: Scientific evidence on condom effectiveness for sexually transmitted disease prevention. National Institutes of Health, 2001.

^{ix}Weller S, Davis K. Condom effectiveness in reducing heterosexual HIV transmission. *Cochrane Database Syst Rev 2004 (1)*: CD003255.

^xHearst N, Chen S. Condoms for AIDS prevention in the developing world: A review of the scientific literature. University of California, 2003.

^{viii} De Vincozi I. *A longitudinal study of human immunodeficiency virus transmission by heterosexual partners.* New England Journal of Medicine 1994; 331:341-46.

^{ix} Manhart, L., Holmes, K. *Randomized Controlled Trials of Individual-Level, Population-Level, and Multilevel Interventions for Preventing Sexually Transmitted Infections: What Has Worked?* The Journal of Infectious Diseases 2005; 191:S7-24.

^x Hogewoning, CJ, et al. *Condom use promotes regression of cervical intraepithelial neoplasia and clearance of human papillomavirus: a randomized clinical trial.* International Journal of Cancer 2003; 107: 811-816.

^{xi} Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, *SPRANS Community-based Abstinence Education Project Grant Program.* Provides federal grants to community-based organizations that teach abstinence until marriage to youth.

^{xii} Section 510 of the 1996 Welfare Reform Act. TANF and Related Programs Continuation Act of 2004, P.L. 108-262. Provides funds to states for the exclusive purpose of promoting abstinence, requiring a state match of \$3 for every \$4 from the federal government

^{xiii} Adolescent Family Life Act, 42 U.S.C. 300Z (1982 & Supp. III 1985). It provided \$13 million for fiscal year 2005 for abstinence-only education programs.

^{xiv} The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, P. L. 108-25.

Written Statement of
Joe Solmonese
President
Human Rights Campaign

To the

Committee on Oversight and Government Reform
United States House of Representatives
Room 2154
Rayburn House Office Building
April 23, 2008

Mr. Chairman and Members of the Committee:

My name is Joe Solmonese, and I am the President of the Human Rights Campaign, America's largest civil rights organization working to achieve gay, lesbian, bisexual and transgender (GLBT) equality. By inspiring and engaging all Americans, HRC strives to end discrimination against GLBT citizens and realize a nation that achieves fundamental fairness and equality for all. On behalf of our over 700,000 members and supporters nationwide, I am honored to submit this statement regarding our opposition to continued federal funding of abstinence-only-until-marriage (hereinafter, "abstinence-only") programs. The Human Rights Campaign supports providing our youth with comprehensive sex education, which includes abstinence as one method of reducing disease and unwanted pregnancies, but alongside education on contraception, which can stop the spread of HIV and other sexually transmitted diseases.

Today, you will hear my colleagues at numerous organizations detail how "abstinence-only" programs are ineffective in delaying sexual activity and all too often contain medically inaccurate or incomplete information regarding contraception and sexually transmitted diseases. Since 1996, Congress has spent more than \$1.5 billion on "abstinence-only" programs, yet there remains no credible evidence that these programs are effective; in fact, quite the opposite is true. A 2004 report prepared for Chairman Waxman demonstrated that eleven of the thirteen most commonly used "abstinence-only" programs contain unproven claims and medically inaccurate information.¹ In 2006, the Government Accountability Office issued a report admonishing the Department of Health and Human Services for a potential violation of the Public Health Services Act due to lack of oversight of the programs' effectiveness or scientific accuracy.² And finally, in April 2007, the Department of Health and Human Services released the results of a study conducted by the independent research firm Mathematica Policy Research, Inc. which found that youth who participated in "abstinence-only" programs are no more likely to abstain from sex, delay sex, or have fewer sexual partners than youth who receive no sex education at all.³ Respected public health experts such as the Institute of Medicine, the American Academy of Pediatrics, and the American Medical

¹ Minority Staff of House Committee on Government Reform, "The Content of Federally Funded Abstinence-Only Education Programs," December 2004.

² Government Accountability Office, Report No. B-308128, October 8, 2006.

³ Trenholm et al, "Impacts of Four Title V, Section 510 Abstinence Education Programs," April 2007, *available at* www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf.

Association all oppose government funding for these programs on the grounds that they are ineffective and fail to give youth the tools they need to make responsible decisions.

While these unproven programs do a disservice to all young people, they are particularly harmful to GLBT youth, and it is upon three particular harms that I will focus my testimony today. First, because same-sex couples cannot marry in all but one state in this country, “abstinence-only” programs, by their very nature, ignore the reality of GLBT students. Second, to add insult to injury, many “abstinence-only” programs go further and affirmatively denigrate GLBT people as disordered and diseased. Third, despite overwhelming evidence that GLBT youth are an at-risk population for sexually transmitted diseases, notably HIV, “abstinence-only” programs offer nothing in the way of prevention messages that could help to protect this already-marginalized population.

Ignoring GLBT Youth

“Abstinence-only” programs teach youth that abstinence from sexual activity until marriage is the expected social norm and the only manner in which to avoid sexually transmitted diseases and unwanted pregnancy. Federal law requires that all “abstinence-only” programs follow a strict eight-point definition of “abstinence education,” including teaching that “a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity” and “sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.”⁴ Because federal law defines marriage as only the union of a man and a woman, these programs’ discussion of marriage must also include that restriction.⁵ As a result, from the outset of any “abstinence-only” program, GLBT students are presented with an unreachable goal.

Furthermore, despite the structural exclusion of GLBT youth, these programs provide little information to these students about their lives and futures, and even actively avoid an issue perceived as difficult or controversial. For example, a program called “FACTS” explains:

Some wonder why instruction in homosexuality and masturbation are not included in FACTS. First, it has been fairly well documented that providing information about reproduction and sexual behavior does not change attitudes or behavior, but does increase knowledge. Teachers and students already have a great deal of information to cover or master and it is a matter of prioritizing what is needed at a given point in time...Second, these issues are currently emotionally laden.⁶

Another program, “Sex Respect,” includes in its information to parents:

...because of the freedom of religion in our country the public school teacher will not impose his or her moral views about homosexuality in the classroom. Giving your teen guidelines on the subject of homosexual activity is a task for you, the parent, to carry out in accordance with the faith of your choice.⁷

⁴ 42 U.S.C. 710(b).

⁵ See, e.g., the Department of Health and Human Services’ “Guidance Regarding Curriculum Content” for grantees under the Community Based Abstinence Education program, *available at* www.acf.hhs.gov/programs/fysb/content/abstinence/cbaeguidance.htm.

⁶ “How to Respond to Criticism: THE TRUTH ABOUT FACTS,” (Portland: Northwest Family Services, 2001), *accessed at* www.nwfs.org, *via* www.communityactionkit.org/reviews/FACTS.html.

⁷ Sex Respect Parent Guide (2001), p. 47, *via* www.communityactionkit.org/reviews/SexRespect.html.

Frequently, it is not only marriage, but any interaction of a romantic or sexual nature that these programs portray as solely heterosexual. For example, the program "Navigator: Finding Your Way to A Healthy and Successful Future," includes an activity called "Opposite Sex" in which the teacher divides students into male and female groups and instructs them to list the ways that dating members of the opposite sex is difficult.⁸ By ignoring the existence of GLBT people, these federally-funded programs provide no meaningful education to a segment of the student population subject, due to "isolation and lack of support," to "higher rates of emotional distress, suicide attempts, and risky sexual behavior and substance use...compared to heterosexual students."⁹ It is unacceptable that these programs, designed to prepare our young people to deal with sexuality, ignore a vulnerable student population because the issue is deemed by some as too controversial.

Denigrating GLBT People

In addition to simply excluding GLBT youth, some programs go even further, teaching youth that GLBT people are destined for lives of unhappiness and disease. The Abstinence Clearinghouse, a self-styled national resource for "abstinence-only" programs, states in its "Abstinence 101" publication:

Research shows the homosexual lifestyle is not a healthy alternative for males or females. The male and female body are not anatomically suited to accommodate sexual relations with members of the same sex. Sexual practices in the homosexual lifestyle are considered very dangerous for disease, infection, etc. This lifestyle should not be encouraged as healthy or as an equal alternative to marriage.¹⁰

This anti-GLBT bias is often presented within distorted information regarding transmission of sexually transmitted diseases, especially HIV. For example, the "Sex Respect" curriculum, in briefly discussing anal intercourse, contends that "[t]here is another form of sexual activity that causes an especially high risk of HIV infection. In such activity body openings are used in ways for which they were not designed."¹¹ Another program, "Facing Reality," explains to teachers and parents:

Many homosexual activists are frustrated and desperate over their own situation and those of loved ones. Many are dying, in part, due to ignorance. Educators who struggle to overcome ignorance and instill self-mastery in their students will inevitably lead them to recognize that some people with AIDS are now suffering because of the choices they made.¹²

There is no excuse for the continued use of federal taxpayer dollars to fund programs that not only exclude GLBT youth, but also contain such inflammatory and insulting language. Denigrating GLBT youth, and providing false and prejudicial information to their classmates, in no way prepares students to handle sexual activity in a healthy and responsible way.

⁸ Navigator Guide Book, Project Reality (2001), p. 71, *via* www.communityactionkit.org/reviews/Navigator.html.

⁹ "Just the Facts About Sexual Orientation & Youth," American Academy of Pediatrics et al (2008), *available at* www.apa.org/pi/lgbt/publications/justthefacts.pdf.

¹⁰ Abstinence 101, The Abstinence Clearinghouse (2005), cited *via* Letter from Rep. Henry A. Waxman to The Honorable David M. Walker (Oct. 6, 2005), *available at* oversight.house.gov/Documents/20051006114033-87692.pdf.

¹¹ Sex Respect Student Workbook (2001), p. 63, *via* www.communityactionkit.org/reviews/SexRespect.html.

¹² Facing Reality Parent-Teacher Guide (1998), p. 19, *via* www.siecus.org/policy/in_their_own_words.pdf.

Failing to Provide Prevention Information to an At-Risk Population

Despite repeated assertions that GLBT people are at high risk for HIV infection, “abstinence-only” programs fail to provide accurate information regarding methods of preventing transmission of sexually transmitted diseases. The Centers for Disease Control has indeed noted that young people, especially young gay and bisexual men in communities of color, are at a high risk for HIV infection.¹³ Yet, “abstinence-only” program educators are not permitted to discuss the proper use of contraception, including condoms, as a way to reduce risk of contracting HIV or other sexually transmitted diseases. In fact, only failure rates of condoms can be discussed.¹⁴ Furthermore, many “abstinence-only” programs present false or misleading information about HIV, including that the virus can be transmitted by skin-to-skin contact and that the virus can exist undetected in the body – despite HIV testing—for up to ten years.¹⁵ Coupled with the exclusion of, as well as misinformation about, GLBT youth, the lack of meaningful or accurate information regarding prevention of sexually transmitted diseases ensures that “abstinence-only” programs provide little, if anything, for GLBT students.

Conclusion

GLBT youth already face prejudice, discrimination and even violence, in the classroom and in society at large, simply because of who they are. They should not be subjected to the additional indignity of “abstinence-only” programs, paid for by federal taxpayer dollars, which ignore and demean them and their relationships. They should not be left unprepared to deal with the difficult questions, and real health concerns, that sexual activity can present. As you have heard today, “abstinence-only” programs are failing all of our young people. But the additional harm they cause GLBT youth cannot be overstated. On behalf of the Human Rights Campaign, I implore you to end federal funding of unproven “abstinence-only” programs and ensure that all of America’s youth have access to comprehensive, meaningful and respectful sexuality education.

¹³ “HIV/AIDS Among Youth,” Centers of Disease Control, *available at* www.cdc.gov/hiv/resources/Factsheets/youth.htm

¹⁴ See note 4, above.

¹⁵ See note 11, above.

**Statement by Healthy Teen Network on the Public Health and Ethical Concerns
with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive
Sexuality Education**

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

Healthy Teen Network (HTN) is the only national membership network that serves as a leader, a national voice, and a comprehensive educational resource to professionals working in the area of adolescent reproductive health - specifically teen pregnancy prevention, teen parenting, and related issues. HTN uniquely impacts over 20,000 constituents including, health-professionals, teens, and families through its comprehensive approach and its direct and immediate links to a grassroots network of reproductive health care professionals and organizations throughout our nation's communities.

Healthy Teen Network strongly believes youth can make responsible decisions about sexuality, pregnancy and parenting, as well as be effective parents when they have complete, accurate, and appropriate information, skills, resources and support. While HTN supports the value in abstinence as part of an appropriate approach to sexuality education, particularly for younger children, HTN strongly believes that abstinence-only programs deny adolescents critical information they need to stay healthy and safe.

Abstinence-only programs are unproven to be effective in reducing sexual risk-taking and/or teen pregnancy. Recent studies, including one federally funded evaluation released by Mathematica Research in 2007, have shown that many of the curricula used in abstinence-only programs misrepresent or use outdated information, perpetuate gender stereotypes, and flat-out ignore medical facts.

Aside from being unproven, abstinence-only programs are often biased and rely on messages of fear and shame. Abstinence-only programs often teach that sexual activity before marriage is shameful and/or physically and psychologically harmful. However, the majority of youth will become sexually active before marriage and many will never – or cannot legally – marry. Sexually active youth, youth who have been abused, non-heterosexual youth, and/or young parents may find little value in abstinence-only-until-marriage messages due to their life experiences. Fear and shame-based messages pushing abstinence as the only acceptable behavior do not help to empower these youth to grow into healthy and responsible adults.

Conversely, comprehensive sexuality education programs are proven effective at delaying onset of sexual activity among youth while abstinence-only programs are not. Comprehensive sexuality education programs present abstinence as the most effective prevention method for pregnancy and sexually transmitted infections (STIs). Comprehensive sexuality education programs also discuss basic and accurate information

regarding contraception, safer sex, and disease-prevention methods in order to give young people all the information they need to stay healthy and safe.

In addition, comprehensive sexuality education provides a complete message. It provides developmentally appropriate coverage of anatomy, sexual behaviors, pregnancy and disease prevention methods, healthy relationships, and gender roles.

Public opinion polls have consistently shown that parents of middle school and high school students support comprehensive sexuality education.

- 93% and 91% respectively believe that it is very important or somewhat important to have sexuality education as part of the school curriculum.¹
- 72% and 65% respectively believe that the federal government should fund comprehensive sexuality education programs.²
- 73% of adults and 65% of teens wish for more information about both abstinence and birth control or protection in schools.³

Yet, despite a lack of scientific evidence to support the effectiveness of abstinence-only programs along with their potential harm to youth, as well as an overwhelming support for comprehensive sexuality education, federal funding for abstinence-only programs has markedly increased under the Bush Administration.

Youth deserve better than this. Spending more money on abstinence-only-until-marriage programs – programs proven to fail our youth – is not money well spent and not what your constituents want! *Healty Teen Network urges Congress to end funding of abstinence-only-until-marriage programs and to fund programs that promote science-based approaches to comprehensive sexuality education.*

¹ Sexuality Information and Education Council of the United States. (2005). On our side: Public support for comprehensive sexuality education. Retrieved June 12, 2007, from http://www.siecus.org/policy/public_support.pdf.

² Ibid.

³ Albert, B. (2007). With one voice 2007: America's adults and teens sound off about teen pregnancy. Washington, DC: National Campaign to Prevent Teen Pregnancy.



**Statement of the Illinois Caucus for Adolescent
Health (ICAH) on the Public Health and
Ethical Concerns with Abstinence-Only-Until-
Marriage Programs and the Need for
Comprehensive Sexuality Education**

Committee on Oversight and Government Reform

**Submitted for the Record
April 22, 2008**

The Illinois Caucus for Adolescent Health (ICAH) was founded in 1977 as the Illinois Caucus on Teenage Pregnancy. Today, working in partnership with youth, ICAH's primary mission is to advance sound policies and practices that promote a positive approach to adolescent sexual health and parenting. ICAH's strategies to support this mission include development of young leaders, policy analysis and development, advocacy, grassroots organizing, and training of both youth and adults.

ICAH wishes to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective, inaccurate and insufficient programs. There is a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth. We are committed to using sound scientific evidence and promoting the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Abstinence-only-until-marriage programs are doing a serious disservice to our young people. While it is vital to develop students' skills to remaining abstinence, it should not be at the expense of providing truthful, medically accurate and age-appropriate information about overall sexual health. Recent reports have highlighted alarming rates of sexually transmitted infections and births among teens. Unfortunately, our state and federal governments continue to misdirect public funds into abstinence-only-until-marriage programs. These programs continually prove to be insufficient, inaccurate, and ineffective. Our schools are left ill equipped to ensure healthy learning environments and educate young people about their sexual health.

We need sexual health education programs that cover the topics of puberty, sexual assault, anatomy, healthy relationships, the basics of reproduction, and many additional topics recommended by medical and public health experts. We need to shift the focus of the current debate about sexual health education and stop putting so much emphasis on abstinence and condoms at the expense of other important issues that impact a young person's sexual health and development. We also do not need programs that discredit the health benefits of condoms and contraceptives in order to promote the idea of abstinence.

At this time of fiscal crises at the state and federal levels, it is unconscionable that we would waste public money on programs that don't work, are riddled with inaccuracies, and fail to meet the educational needs of our youth.

We urge the Committee to call for an immediate stop to all funding for abstinence-only programs. Title V and Community Based Abstinence Education (CBAE) grants waste tax dollars on programs that are inaccurate, ineffective and insufficient.

Evidence has been mounting that abstinence-only programs are *ineffective*. Last year, a Congressionally mandated evaluation conducted by Mathematica Policy Research Inc. of federally funded programs showed that these programs had no impact on student behavior. Students in abstinence-only programs were no less likely to engage in sexually activity, have fewer sexual partners, or use a condom more often. Countless studies conducted by independent evaluators and abstinence-only providers themselves back these findings up by demonstrating no change in student behavior. Conversely, study after study demonstrate that teens who receive comprehensive sex education that includes information about abstinence and birth control, including condoms, are more likely to delay sexual activity, have fewer partners and use protection when they do become sexually active.

Abstinence-only programs have also been shown to be *insufficient*. In a review by Illinois experts of the curricula being used in Illinois schools, the curricula most frequently used in classrooms and paid for through federal abstinence-only funding, ranked in the bottom third when matched up with the standards and components for school-based sexual health education recommended by the national medical and public health associations. The federal government needs to invest in responsible approaches to sexual health education that help young people be healthy, make responsible choices, and be good learners.

Abstinence-only programs funded by millions of taxpayer dollars consistently prove to be *inaccurate*. Rep. Henry Waxman's report (2004) on federally funded abstinence-only programs found that they contained medically inaccurate and misleading information. With recent reports of alarming rates of sexuality transmitted infections and rising birth rates among teens, our federal government needs to make sure tax dollars are invested in programs that empower youth with accurate and reliable information, not made up statistics and lies. *In presentations given this last year in Illinois schools diverse as Quincy, Chicago, Naperville, and Champaign, federally funded abstinence-only speakers told students that the holes in condoms were larger than the HIV virus.*

We urge your committee to recommend that the current Title V and CBAE programs be terminated, and the federal government fully fund a comprehensive sexual health education program. The abstinence-only experiment has failed. It is time to make a strategic and sound investment in comprehensive sexual health education because it supports our broader public health and education policies, supports American families, and empowers the next generation of Americans to make responsible choices that will impact them today and in the future.

Cynthia Wolfson
Illinois State Public Affairs Chair
National Council of Jewish Women
April 22, 2008

Abstinence-only sex education often imposes one particular religious point of view about sex on all students regardless of their own religious traditions. The government has no business funding the promotion of a religious agenda. It is patronizing to suggest young people cannot be trusted with the truth, but should be fed misinformation to “protect” them. In order to make responsible, healthy decisions, young people need medically accurate, age-appropriate information about sex and sexuality. Recent polling shows 80% of Americans overwhelmingly support comprehensive sex ed in high school and 60% in middle school. A small minority should not be allowed to impose its religious beliefs on the entire nation.

Comprehensive sex education teaches that abstinence is the only way to avoid pregnancy and sexually transmitted infections (STIs), but also provides accurate information about contraceptive options so that individuals can make informed life decisions. Abstinence-only programs, according to the Congressional report of April 2007, do not have statistically significant impact on the rate of sexual abstinence, the number of sexual partners, or the age at which sexually experienced youth first engage in sexual intercourse. These programs ignore the needs of gay, lesbian bisexual and transgender students. For young people who are already sexually active, there is no meaningful dialogue at all. Teens need facts about STIs, not scary lies. They need to learn negotiation and communication skills, not “just say no.” They should learn about healthy relationships, a concept which is not addressed in abstinence-only programs.

For Congress to continue to fund programs that give misinformation to young people, leading to unintended consequences that negatively impact their lives, is unconscionable. We urge you to eliminate all funding for abstinence-only sex ed programs. Instead, please invest in medically accurate programs that respect the youth of our country.



Pro-Faith, Pro-Family, Pro-Choice

Statement of the Indiana Religious Coalition for Reproductive Choice (IRCRC) on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education

Committee on Oversight and Government Reform
 Submitted for the Record
 April 23, 2008

The Indiana Religious Coalition for Reproductive Choice (IRCRC) is a multi-faith organization dedicated to bringing the moral power of religious communities to ensure reproductive choice and health through education and advocacy.

As people of faith, we are concerned about the disturbing realities of HIV/AIDS, teenage pregnancy, sexually transmitted diseases, a high rate of suicide among gay and lesbian teens, and date rape.

In the state of Indiana, teenage girls experience a higher birthrate than the national average. The 2007 Indiana Youth Risk Behavior Survey, conducted by the Indiana State Department of Health, showed that while sexual activity among Indiana teens had increased, fewer teens were using condoms. The Survey states: "In Indiana, every hour a teenager contracts an STD and every day approximately 31 girls between the ages of 10-19 become pregnant."

Despite these disturbing trends, the state of Indiana continues to use unproven abstinence-only programs for teens. While most sex education programs teach the value of abstinence, abstinence-only programs do not provide basic information on reproductive health such as methods of preventing sexually transmitted diseases or pregnancy.

A recent survey of Indiana public school teachers, counselors, and nurses conducted by the Health Foundation of Greater Indianapolis and the Sexual Health Research Working Group at Indiana University showed that many important subjects are not being taught in school. Over half of schools are not teaching students about HIV/AIDS, sexually transmitted diseases, contraception, or sexual decision-making.

Also, research shows that young people are not being taught about these matters at home. Many parents feel inadequately informed and/or are uncomfortable discussing these topics. A recent survey of Indiana parents showed that more than 25% of parents never or rarely discussed important topics with their teenagers such as sexual health checkups, sexually transmitted infections, condoms, or birth control.

We want to help youth become responsible, healthy, whole persons. The challenge of guiding youth into sexually healthy adulthood is complex and requires the involvement of parents, faith communities, and

schools. When it comes to schools, however, people in many major faith traditions support comprehensive sexuality education. We believe that sexuality education that is provided to our young people should be accurate and medically-based, and that information on abstinence, contraception and STD prevention is included.

In addition, many abstinence-only programs oppose reproductive choice and women's equality and seek to make narrow religious beliefs the law of the land. These viewpoints don't represent most people of faith, who overwhelmingly support providing accurate, unbiased information about sexuality.

Abstinence-only programs are not just inadequate, but they are actually harmful. The youth of our nation, including Indiana teens, deserve better. We ask our government's leaders to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, grounded in science, and reflect mainstream values.



Testimony of Julie F. Kay
Senior Staff Attorney
Legal Momentum

Hearing: Assessing the Evidence of Domestic Abstinence-Only Programs

The Committee on Oversight and Government Reform

April 23, 2008

Overview

Founded in 1970, Legal Momentum is the nation's oldest legal advocacy organization dedicated to advancing the rights of women and girls. Legal Momentum's Sexuality and Family Rights program promotes women's autonomy, protects women's sexual and reproductive rights, and works to expose policies that limit these rights.

The need for effective, accurate and high-quality sexuality education, free from the bias and political ideology that drives abstinence-only programs, is clear. Legal Momentum believes that teenagers must be given honest and comprehensive information about the risks of sexual activity—and how to responsibly handle those risks if they do decide to become sexually active. Young women and girls in particular need to be empowered with positive messages and accurate information that give them the confidence and ability to make healthy and informed sexual and relationship choices throughout their lives.

In September 2006, Legal Momentum, in partnership with the Human Rights Program at Harvard Law School and the Program on International Health and Human Rights at the Harvard School of Public Health, convened a roundtable of experts from a range of disciplines to discuss abstinence-only programs and their particular impact on women and girls. The daylong meeting was prompted by the dramatic increase in federal funding for these programs and the growing evidence that they are ineffective at best, and harmful at worst.

As an outgrowth of that meeting, Legal Momentum released its recent report, *Sex, Lies & Stereotypes: How Abstinence-Only Programs Harm Women and Girls* (available at <http://www.legalmomentum.org/report2008>). The report draws on the work of the experts who took part in the roundtable, broader academic research, and Legal Momentum's original research into the history, funding, and implementation of abstinence-only programs. It provides the most comprehensive report to date on the abstinence-only movement, and is the first extended inquiry into the gender harms of this approach to sexuality education. This testimony is based on the findings in our report.

Abstinence-only programs rest on the faulty premise that young men and women will never have sex during the average 12–15 years between puberty and presumed heterosexual marriage. Research shows that the vast majority of people do not wait until marriage to have sex: by age 44, 95% of people have had sex before marriage.¹ Thus, they actively deprive young people of information they need to avoid the adverse consequences of sexual activity during these critical years of young adulthood. Even those few individuals who remain abstinent until marriage are left with no tools with which to communicate with their partners about sexual issues or to go about intelligently planning their families once they do marry.

¹See Lawrence B. Finer, *Trends in Premarital Sex in the United States 1954–2003*, 122 *Pub. Health Rep.* 73, 78 (2007).

When youth schooled by abstinence-only programs do become sexually active, the programs' anti-condom messages may actually discourage them from practicing safe sex, making the negative information the programs offer about contraception and disease prevention particularly dangerous. Such messages deny young people the opportunity to receive vital education to protect their health and well-being and, in particular, impede girls' ability to avoid unwanted pregnancy and sexually transmitted infections ("STIs"), to which they are more biologically susceptible.

The law that governs federally funded abstinence-only programs requires them to teach that sex outside of heterosexual marriage, at any age and under any circumstances, is inherently dangerous and wrong. Abstaining from sexual activity until marriage is presented as the only effective and acceptable way to prevent unwanted pregnancy and STIs.

Despite the fact that over \$1.5 billion in federal and state funding has been allocated for abstinence-only programs since they began in 1982, conclusive, reliable, scientific evidence shows that abstinence-only programs are ineffective at persuading adolescents to remain abstinent until marriage. Moreover, research has shown that even if some abstinence-only programs do temporarily delay sexual activity, these programs may result in greater long-term harm. Seventeen states no longer participate in the Title V abstinence-only-until-marriage program, declining to provide state matching funds.

Increasingly, government abstinence-only funding is being allocated to inexperienced, ideologically motivated, conservative, and anti-abortion groups while, in contrast, comprehensive sex education programs have been effectively precluded from federal funding. The serious negative public health consequences, particularly for women and girls, are of great concern.

Censoring and Distorting Reproductive Health Information

Abstinence-only programs deprive women and girls of critical reproductive health information, with dangerous and even deadly consequences. By keeping young people ignorant about their sexual and reproductive health, abstinence-only programming endangers them, putting them at unnecessary risk of STIs by refusing to educate them about safe sex; it particularly endangers young women, leaving them unable to take control of their own reproductive capacity by failing to provide information about contraception. For women of color, the absence of accurate sexual health information is particularly damaging given the high rates of HIV infection in their communities, while the gender stereotypes promoted by the programs exacerbate racial as well as sexual inequalities.

Abstinence-only programs frequently fail to provide basic biological and reproductive health information. Abstinence-only programs often consider basic biology as over-sexualized and prefer to withhold information about students' own bodies and development. For example, the federally-funded Abstinence Clearinghouse recommends against including detailed anatomical diagrams or pictures in curricula and states that

“diagrams of internal organs are acceptable, but images or pictures of external genitalia in any form, whether diseased or healthy, can be detrimental to the health of young men and women’s minds.” There is no evidence to support this claim.

When programs do contain anatomical information, the curricula often focus on the female body, turning it into a treacherous and terrifying place through a fear-based portrayal of sexual activity and STIs. The potential consequences of STIs for women are often deliberately exaggerated -- infertility is commonly cited -- and treatment information is frequently left out. Anti-abortion bias is also manifested in the curricula’s medically inaccurate discussions of pregnancy and assertions about when life begins, and their inclusion of falsehoods about the safety of abortion.

The most grievous aspect of how these curricula discuss STIs is their usual failure to discuss how most STIs can easily be prevented and treated or cured. The importance of condom use and early detection to preserve women’s health is rarely, if ever, mentioned. This approach reinforces the stigma associated with STIs and can discourage students from getting tested or seeking medical attention. Because recent figures from the Centers for Disease Control and Prevention (CDC) show that at least one in four teenage girls nationwide has an STI, with rates even higher for women of color, it is imperative that we offer a more effective approach to disease prevention than abstinence-only.

Abstinence-only programs fail, as well, to address teenage pregnancy. The U.S. still has the highest teen pregnancy rate in the industrialized world although until recently the teen birthrate had declined steadily -- a decline that had been attributed to increased contraceptive use by sexually active teens. The most recent data, however, indicate a 3% rise in the teenage birthrate, the first such increase since 1991. Approximately 750,000 teenage girls become pregnant each year, and nearly one-third of all American women will become pregnant by age 20. Teen mothers are more likely to be economically disadvantaged than their peers who do not bear children and are less likely to complete their schooling and take advantage of better work opportunities. Teen pregnancy and teen births also place a tremendous financial burden on the rest of society.

In order to resume the decline in rates of teen pregnancy, it is critical that young people learn about the proper use of contraceptives *before* they begin to engage in sexual activity. People who practice contraception from their first sexual experiences are more likely to continue these practices throughout their lives. Yet abstinence-only programs deliberately withhold contraception information, wrongly believing such information will confuse teenagers and encourage sexual activity.

Harmful Stereotypes Aimed at Women and Girls

Even if abstinence-only programs were effective, the particular harms these programs cause to women and girls makes it unethical to teach them to young people. By using biased and misleading information, employing scare tactics aimed at young women, and promoting a view of human sexuality and relationships that presents gender stereotypes as truth and homophobic sentiments as fact, abstinence-only programs particularly target

women and girls. Legal Momentum’s report, *Sex, Lies & Stereotypes*, includes substantial evidence about how abstinence-only curricula frequently employ outdated gender stereotypes, portraying girls as naturally chaste and casting them as the gatekeepers of rampant male sexuality. By making sex education into abstinence education, abstinence-only programs fail to genuinely address critical issues such as sexual behavior, sexual orientation, and sexual violence or coercion.

As Erin, a young woman from Oregon, told Legal Momentum about her experience participating in an abstinence-only program:

Because we didn’t have accurate information about what was healthy and what wasn’t, I endured some awful situations because I didn’t know the difference. We didn’t talk about respect, boundaries, and sexual communication. So the myth of “boys push and girls resist” informed everything. We never talked about consent because with abstinence curriculum you shouldn’t consent.

Most abstinence-only texts fail to meaningfully discuss rape, sexual assault, or coercion, and even fewer give guidance to victims of sexual violence. Further, when responsibility for male sexual feeling is placed on young women and girls, it removes male responsibility and, in instances of sexual harassment and assault, harmfully blames the victim and excuses the perpetrator. Moreover, there is no acknowledgement that some teens may not experience any sexual feelings, or may be attracted to members of the same sex.

These texts ask girls constantly to monitor their own behavior and to be responsible for dressing in a way that ensures that male sexuality is kept in check. Their tone is condescending to both girls and boys, and fails to provide real guidance to teens about how they can develop healthy relationships of all kinds, whether sexual or not.

The sexist stereotypes that are so prevalent in abstinence-only education are particularly harmful for young women during adolescence. This “hidden curriculum” on gender—teaching men and women “proper” gender roles as a necessary, but unacknowledged, part of teaching abstinence-only—portrays women as socially and sexually submissive and strips them of ownership of their own ambitions and desires. For young women, there is already a strong stigma attached to female sexual agency. Research shows that many young women feel that they lack the power to make autonomous sexual decisions, a shortcoming that often leads to risky, unhealthy, and unwanted sexual experiences. Many girls fear that if they broach the topic of safe sex with their partners, they will be thought of as promiscuous and be rejected and ostracized as a result.

These narrow and outdated gender stereotypes ignore the diversity of gender roles and family structures common in the U.S. today. Many programs also perpetuate sexist and racist stereotypes about women of color. When teachers and other adults present such stereotypes as fact, students are less likely to recognize gender discrimination, more likely to excuse acts of male sexual aggression (and less likely to recognize instances where males are victims of sexual violence), and less able to develop as ambitious,

intelligent, and healthy young adults. Indeed, the gender stereotypes taught in abstinence-only programs are dangerous not only because they undermine female sexual decision-making, but also because they limit opportunities and negatively affect societal expectations for men and women alike.

Stigmatizing Homosexuality

Abstinence-only programs also deliberately stigmatize LGBT (lesbian, gay, bisexual, transgender) youth and families. These programs are required by the federal funding guidelines to instruct students that heterosexual marriage is the “expected standard” for sexuality, and that having sexual relationships or children outside of marriage is harmful. Perpetuating such prejudice is damaging to teens who identify as LGBT or are struggling with their sexuality, and to children in LGBT-headed families.

In addition, many abstinence-only programs conflate being gay with being HIV-positive, diseased, or disease-prone. Negative portrayals of homosexuality in abstinence-only programs can contribute to school harassment and violence as well as to discrimination against LGBT youth. More broadly, they send the message to young adults that discrimination against LGBT individuals is acceptable, thus implicitly (and often explicitly) undermining state and local anti-discrimination laws.

The stigmatization of homosexuality in abstinence-only education is no accident. Because the federal abstinence-only funding definition requires funded programs to emphasize that a “mutually faithful relationship in the context of marriage is the expected standard of human sexual activity” and to emphasize the “harmful psychological and physical effects” of sexual activity outside of marriage, funded programs must either avoid the issue of homosexuality entirely or treat it negatively.

Stigmatizing Single-Parent Families

The emphasis on marriage in abstinence-only curricula also has a detrimental impact on the millions of children born and raised outside of marital relationships. Under federal law, funded programs must teach that bearing children out of wedlock is “harmful” to children, parents, families, and society, and that a monogamous relationship in the context of marriage is the only acceptable expression of human sexuality.

This rhetoric is of no minor concern. In 2004, 35% of all births were to unmarried parents. The federal abstinence-only funding definition sends a clear message about these children, stating: “Bearing children out of wedlock is likely to have harmful consequences for the child, the child’s parents, and society.” This immediately stigmatizes the millions of children born to unwed parents, teaching them that their very existence is bad for society, and that their parents were wrong to have them.

Moreover, in the past decade, the percentage of children living with both parents has dropped, while the percentage living in single-parent households has increased. By 2006, nearly one-quarter (23%) of children lived with only their mothers, 5% lived with only

their fathers, and 5% lived with neither of their parents. Many children in the 12.2 million single-parent families in the U.S. live with or have overnight visits from a parent's boyfriend or girlfriend. Sixteen percent of children living with single fathers and 10% of children living with single mothers also lived with their parent's cohabiting partner. The funding definition stigmatizes all of these families and relationships by declaring that monogamy is the "expected standard" and that any sex outside of marriage is likely to be harmful. The extent of the harm to children's respect for themselves and their parents from this condemnation and shame is unknown.

Conclusion

Abstinence-only programs in the U.S. and worldwide are facing increasing scrutiny by state and national governments, public health experts, women's rights advocates, and concerned parents and young people. Challenges to these programs, through legislative efforts, community initiatives, and legal action, are seen nationwide. It is time for the federal government to stop funding these ineffective and harmful programs and to seek to ensure that young people receive accurate and complete sexual and reproductive health information and services.



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April 22, 2008

Metro TeenAIDS Organizational Statement

The Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education

**Committee on Oversight and Government Reform
Submitted for the Record**

Metro TeenAIDS is the only local organization in Washington, DC whose sole purpose is to fight the HIV/AIDS epidemic by, for, and with young people. In a city with the highest rate of new AIDS cases in the entire country and HIV infection rates among young people that have tripled in the last five years compared with the five years before that, K-12 comprehensive, age-appropriate, and medically accurate sexuality and HIV education is especially critical in stemming new HIV infections among District of Columbia youth.

In Washington, DC, ten percent of all new HIV infections in our city are currently among young people aged 13 to 24. And yet, the most recent Youth Risk Behavior Survey indicates that there has been a steady decline in the number of students who report receiving HIV/AIDS education in school. We clearly believe that a comprehensive approach to sex and HIV education will positively impact the current and future health of our young people.

And we wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs.

We believe that there is a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. These principles lead Metro TeenAIDS' HIV prevention education and we believe they too should be part of our country's core principles for HIV and sexuality education.

To this end, we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs. Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years even though no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally funded study of abstinence-only-until-marriage

April 22, 2008

Metro TeenAIDS Organizational Statement

programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-marriage programs have achieved their goal to increase rates of sexual abstinence--the entire supposed purpose of the programs. This report followed the findings from 13 states that have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful.

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, which discussed what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.

And further, a report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the already significant body of knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs.

These programs are not supported by any of the leading national or international public health and medical organizations. Every major national medical and public health organization supports a comprehensive approach to sexuality education. These include the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, the American Public Health Association, the Institute of Medicine, the National Institutes of Health, and the Society for Adolescent Medicine. And many local Washington, DC organizations such as the Metropolitan Washington Public Health Association and the DC Chapter of the American Academy of Pediatrics have explicitly supported a comprehensive approach. And new academic standards for health education adopted by the District of Columbia State Board of Education this past December are comprehensive and – while placing a strong emphasis on abstinence – are clearly not abstinence-only. Our city has endorsed the health standards and DC citizens too are firmly in support.

We believe that youth in throughout the United States – and especially ones here in our nation's capital – deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.

Sincerely, Metro TeenAIDS



"Domestic Abstinence-Only Programs: Assessing the Evidence"

Testimony Presented by

Nancy Keenan
President
NARAL Pro-Choice America

U.S. House of Representatives
Committee on Oversight and Government Reform

April 23, 2008

On behalf of NARAL Pro-Choice America and the pro-choice American majority we represent, I am honored to submit this testimony to the committee. I appreciate the efforts of the committee, and particularly Chairman Henry Waxman, for holding this oversight hearing to review and assess the federal government's ill-advised expenditures on risky and discredited abstinence-only-until-marriage programs.

Today's hearing could not be held at a more important time. Our nation is facing a crisis in adolescent reproductive health: The United States has the highest rate of teen pregnancy in the Western industrialized world. Nearly one-third of teenage girls become pregnant before reaching the age of 20 – and almost 750,000 pregnancies occur annually among teens aged 15 to 19. The teen-birth rate rose three percent in 2006 – the first increase in the last 15 years – and the CDC recently reported that one in four teenage girls has a sexually transmitted infection (STI).

Unfortunately, the Bush administration continues to turn a blind eye to the situation, letting ideology – not science – drive our public-policy response to these twin epidemics of teen pregnancy and STI/HIV infections. Not only does the president's FY'09 budget request yet another sharp increase in funding for discredited "abstinence-only" programs, but making matters even worse, he proposes deep cuts to HIV/AIDS and STI prevention programs as well.

Teaching teens about abstinence is a critical part of a well-rounded and effective sex-education program. But abstinence by itself is not sufficient. Young people deserve complete and accurate

information about their reproductive health, including abstinence, pregnancy prevention, and STD/HIV prevention. Only when teens have reliable information about their reproductive health can they make informed and appropriate decisions.

To date, the federal government has squandered more than \$1.5 billion in taxpayer dollars on “abstinence-only” programs. This huge expenditure conflicts with the vast preponderance of scientific and medical research, which clearly demonstrates that “abstinence-only” programs are not proven effective and may in fact result in riskier behavior by teenagers. In April 2007, the independent research firm Mathematica Policy Research Inc. released a study – commissioned by the U.S. Department of Health and Human Services – concluding that students in “abstinence-only” programs are no more likely to abstain from sex, delay initiation of sex, or have fewer sexual partners than students who did not participate. Moreover, at least 13 states have evaluated their federally funded “abstinence-only” programs and not a single one found positive, long-term impact. Even worse, due to the programs’ emphasis on contraceptive failure rates as opposed to proper and consistent use, the evaluations showed the programs had some negative effects on young people’s willingness to use contraception.

Not only do these programs not help our teens abstain from sex, many are rife with scientific inaccuracies, factual errors, and troubling biases that put our teens at greater risk for unintended pregnancy and sexually transmitted diseases. A 2004 House Government Reform Committee report found that more than two-thirds of Community-Based Abstinence Education programs used curricula that “contain false, misleading or distorted information about reproductive health,” such as that

condoms fail more often than they actually do, that sweat and tears can transmit HIV, and that women need “financial support” while men need “admiration.” (Please see attachment for a list of the most outrageous quotes being taught in “abstinence-only” classrooms.)

Furthermore, the programs likely do not comply with existing federal law. In October 2006, the U. S. Government Accountability Office (GAO) served notice to the Bush administration that literature distributed by federally funded “abstinence-only” programs is by law required to contain medically accurate information about the effectiveness of condoms in preventing STIs. In a letter to Michael Leavitt, Secretary of Health and Human Services (HHS), the GAO dismissed a baseless Bush administration claim that materials provided by such programs did not fall within the scope of the law, which was passed in 2000. The GAO recommended “that HHS reexamine its position and adopt measures to ensure that, where applicable, abstinence education materials comply with this requirement.” To our knowledge, HHS has simply ignored this recommendation.

Equally troubling are the findings of a second GAO report – released in November 2006 – concluding that HHS provides little oversight of federally funded “abstinence-only” programs. Assessing the accuracy and effectiveness of such programs, the GAO found that the Administration for Children and Families, which distributes the vast majority of “abstinence-only” dollars, “does not review its grantees’ education materials for scientific accuracy and does not require grantees of either program to review their own materials for scientific accuracy.” The GAO further concluded that, “because of these limitations, ACF cannot be assured that the materials used in its State and Community-Based Programs are accurate.” These are startling revelations about an utterly unacceptable state of affairs.

In sum, by denying adolescents complete information and by censoring teachers, “abstinence-only” programs endanger our youth. The programs can harm teens by putting them at risk of pregnancy and STIs. They fail to provide information about contraception beyond failure rates, and, in some cases, provide misinformation. Without complete and accurate information, some teens therefore may forgo contraceptive use, jeopardizing their health and exacerbating the public-health crisis we face today in adolescent health.

Responsible, age-appropriate sex education, on the other hand, does work – and research proves that more comprehensive programs that discuss both abstinence and contraception have positive effects. In 2001, the National Campaign to Prevent Teen Pregnancy concluded that sex- and HIV-education programs that discuss both abstinence and contraception delay the onset of sex, reduce the frequency of sex, and increase contraceptive use. Moreover, the organization’s research dispels many of the myths that opponents of responsible sex education frequently claim. The research proves that traditional sex-education programs do not hasten the onset of sex, do not increase the frequency of sex, and do not increase the number of partners. Furthermore, the National Academy of Sciences’ Institute of Medicine also has concluded that sex-education programs in schools do not increase sexual activity among teenagers. In sum, there is a clear scientific consensus on this point; claims to the contrary are simply untrue.

Given the evidence, our nation’s leading medical and public-health organizations all support responsible and comprehensive sex education, including the American Academy of Pediatrics, the

American Medical Association, the National Education Association, and the American Public Health Association, among others. Moreover, poll after poll indicates that the American public overwhelmingly supports honest and traditional sex education as well. In fact, a 2004 poll revealed that only seven percent of Americans believe teachers should not provide sex education in schools, and another survey found that seven in ten Americans oppose the use of federal funds to promote the “abstinence-only” approach and censor information about condoms and contraception.

Given the high stakes facing teens, the fact that almost half of all teens aged 15 to 19 in the United States have had sex, and the overwhelming evidence, it is clear that “abstinence-only” programs are misleading at best, and dangerous at worst. Congress should enact policies that effectively and responsibly address the current crisis in adolescent reproductive health. Federal funds should be directed to responsible sex-education programs that provide teens with the information and skills they need to protect themselves and that have demonstrated positive results. Our young people – and taxpayers – deserve programs that work, not ideology dressed up as pseudo-science.

Again, I commend Chairman Waxman for his leadership in holding today’s hearing, and I hope that the evidence reviewed and assessed here today will help us all – lawmakers, public-health leaders, parents, teachers, and researchers - chart a more responsible course to address our nation’s alarming crisis in adolescent-reproductive health.



20 OUTRAGEOUS EXCERPTS FROM "ABSTINENCE-ONLY" PROGRAMS

Your federal tax dollars are paying for programs that include the following statements:

1. One curriculum incorrectly lists "exposure to sweat and tears" as risk factors for HIV transmission."¹
2. "The liberation movement has produced some aggressive girls today."²
3. "At the least, the chances of getting pregnant with a condom are 1 out of 6."³ *Widely respected research shows that, used consistently and correctly, condoms are 99.9 percent effective in reducing the risk of pregnancy and STD transmission.*⁴
4. "Married people have lower rates of suicide, increased recovery from illness, lower incidence of mental disorders, and less need for health care. Marriage increases the demonstration of character traits necessary for successful living, such as sacrifice, humility, flexibility, empathy, and ability to delay gratification."⁵
5. "Men are sexually like microwaves and women sexually are like crock pots. A woman is stimulated more by touch and romantic words. She feels far more attracted by a man's personality while a man is stimulated by sight. A man is usually less discriminating about those to whom he is physically attracted."⁶
6. "Relying on condoms is like playing Russian roulette. The first player spins the cylinder, points the gun to his/her head, and pulls the trigger. He/she has only one in six chances of being killed. But if one continues to perform this act, the chamber with the bullet will ultimately fall into position under the hammer, and the game ends as one of the players dies."⁷
7. "Marriage, not condoms, will protect you physically and emotionally."⁸
8. "Women gauge their happiness and judge their success by their relationships. Men's happiness and success hinge on their accomplishments."⁹
9. While a man needs little or no preparation for sex, a woman often needs hours of emotional and mental preparation."¹⁰
10. "Infectious syphilis rates have more than doubled among teens since the mid-1980s"¹¹ *According to the Centers for Disease Control and Prevention, 1999 saw the lowest annual number of cases reported since 1957.*¹²
11. "Studies clearly show a large male advantage in visual-spatial abilities and higher mathematical reasoning. Every social explanation has been exhausted – this is innate. Only 20 percent of American girls in elementary grades reach the average level of male performance in tests of spatial ability."¹³
12. "A young man's natural desire for sex is already strong due to testosterone, the powerful male growth hormone." Young women in the class are told: "females are becoming culturally conditioned to fantasize about sex as well."¹⁴

13. "Guys are more able to focus on one activity at a time and may not connect feelings with actions. Girls access both sides of the brain at once, so they often experience feelings and emotions as part of every situation."¹⁵
14. "Because they generally become aroused less easily, females are in a good position to help young men learn balance in a relationship by keeping intimacy in perspective."¹⁶
15. In another un-cited lesson, students are told "if she is a young teen, pregnant for the first time, there is a chance the abortion will cause heavy damage to her reproductive organs. Heavy loss of blood, infection and puncturing of the uterus may all lead to future pregnancy problems."¹⁷ *Contraceptive Technology reports, "compared with child birth and other surgical procedures, legal abortions are remarkably safe."*¹⁸
16. In one program, sexual activity is compared to fire through a session where students are told to picture a fire in a fireplace and brainstorm adjectives to describe it. Suggested responses include "warm" and "safe." This picture is said to represent sexual activity in marriage. In contrast, students are told that sex outside of marriage is like a fire on a hillside. Suggested descriptors for this include "out of control," "loss," "dangerous," and death."¹⁹
17. "Following abortion, women are more prone to suicide and therefore need extra support from family and health professionals."²⁰ *Even anti-choice former Surgeon General C. Everett Koop, who under the direction of President Reagan exhaustively studied the issue, found no evidence of harmful effects from legal abortion. Dr. Koop concluded that "the data do not support the premise that abortion does or does not cause or contribute to psychological problems."*²¹
18. "Most contraceptive methods require consistent and correct usage in order to achieve high effectiveness. The vast majority of teenagers do not yet have the maturity needed for that kind of behavior."²²
19. "Chlamydia can be diagnosed through a simple blood test."²³ *According to the CDC's STD Information Hotline, there is currently no blood test that can diagnose chlamydia. Rather, this infection is diagnosed through cultures or urine tests.*²⁴
20. In an analogy designed to keep high schoolers from engaging in any level of sexual activity, students are told, "Scientists discovered that if they put a frog in a bucket of hot water, it would jump out immediately, But if they put the frog in a bucket of cool water and heated the water slowly, they could cook the frog. The frog was lulled into a false security. It could never decide at what point the water became too hot."²⁵

¹ Special Investigations Division, U.S. House of Representatives, *The Content of Federally Funded Abstinence-Only Education Programs*, (2004) p. ii.

² Mast, Colleen Kelly. *Sex Respect: The Option of True Sexual Freedom*, Student Workbook. Respect Incorporated. Bradley, IL. 1997 Revised Edition. p. 85.

³ Roach, Nancy and LeAnna Benn. *Me, My World, My Future*, Revised HIV material. Teen-Aid, Spokane, WA. 1998 Edition. p. 257.

⁴ P. Kestelman and J. Trussell, "Efficacy of the Simultaneous Use of Condoms and Spermicide," *Family Planning Perspectives*, Sep./Oct. 1991, vol. 23, no. 5, p. 227.

⁵ *Why Am I Tempted (WAIT) Training*, Workshop Manual. Choosing the Best, Inc. Marietta, GA. 1996 Edition. p. 27.

⁶ *Why Am I Tempted (WAIT) Training*, Workshop Manual. Choosing the Best, Inc. Marietta, GA. 1996 Edition. p. 40.

⁷ Roach, Nancy and LeAnna Benn. *Me, My World, My Future*, Revised HIV material. Teen-Aid, Spokane, WA. 1998 Edition. p. 258.

⁸ CLUE 2000: *Creating Love and Uplifting Esteem*, "The Price of Promiscuity." Pure Love Alliance, New York, NY. 2000 Edition. p. 5.

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- ⁹ Special Investigations Division, U.S. House of Representatives, *The Content of Federally Funded Abstinence-Only Education Programs*, (2004) p. 16.
- ¹⁰ *Why Am I Tempted (WAIT) Training*, Workshop Manual. Choosing the Best, Inc. Marietta, GA. 1996 Edition. p. 199.
- ¹¹ Mast, Colleen Kelly. *Sex Respect: The Option of True Sexual Freedom*, Student Workbook. Respect Incorporated. Bradley, IL. 1997 Revised Edition. p. 36.
- ¹² Division of STD Prevention, STD Surveillance, 1999. (Department of Health and Human Services. Center for Disease Control and Prevention. Atlanta, Georgia. September 2000.) p. 7.
- ¹³ *Why Am I Tempted (WAIT) Training*, Workshop Manual. Choosing the Best, Inc. Marietta, GA. 1996 Edition. p. 40.
- ¹⁴ Mast, Colleen Kelly. *Sex Respect: The Option of True Sexual Freedom*, Student Workbook. Respect Incorporated. Bradley, IL. 1997 Revised Edition. p. 6.
- ¹⁵ Cook, Bruce. *Choosing The Best Life*, Leader Guide. Choosing the Best, Inc. Marietta, GA. 1998 Revised Edition. p. 7.
- ¹⁶ Mast, Colleen Kelly. *Sex Respect: The Option of True Sexual Freedom*, Student Workbook. Respect Incorporated. Bradley, IL. 1997 Revised Edition. p. 86.
- ¹⁷ Mast, Colleen Kelly. *Sex Respect: The Option of True Sexual Freedom*, Student Workbook. Respect Incorporated. Bradley, IL. 1997 Revised Edition. p. 85.
- ¹⁸ Hatcher, et al., *Contraceptive Technology*, p. 693.
- ¹⁹ *Why Am I Tempted (WAIT) Training*, Workshop Manual. Choosing the Best, Inc. Marietta, GA. 1996 Edition. p. 76.
- ²⁰ Roach, Nancy and LeAnna Benn. *Me, My World, My Future*, Student Workbook. Teen-Aid, Spokane, WA. 1998 Edition. p. 157.
- ²¹ Letter from C. Everett Koop, Surgeon General Dep't of Health & Human Services, to Ronald Reagan, President of the United States (Jan. 9, 1989).
- ²² Fuller, Rose, Janet McLaughlin and Andrew Asato. *Family Accountability Communicating Teen Sexuality (FACTS)*, Teacher's Guide. Northwest Family Services, Portland, OR. 2000 Edition. p. 98.
- ²³ Cook, Bruce. *Choosing the Best PATH*, Leader Guide. Choosing the Best, Inc. Marietta, GA. 1998 Revised Edition. p. 11.
- ²⁴ M. Batchelder and M. Kempner, "Keeping Our Youth 'Scared Chaste' SEICUS Curriculum Review: Choosing The BEST Path". p. 5.
- ²⁵ Fuller Rose, Janet McLaughlin and Andrew Asato. *Family Accountability Communicating Teen Sexuality (FACTS)*, Teacher's Guide. Northwest Family Services, Portland, OR. 2000 Edition. p. 76.

Statement of Sarah S. Brown, CEO, The National Campaign to Prevent Teen and Unplanned Pregnancy

Comment Submission to the Committee on Oversight and Government Reform

Hearing on Domestic Abstinence-Only Programs: Assessing the Evidence

April 23, 2008

On behalf of the National Campaign to Prevent Teen and Unplanned Pregnancy, I am pleased to submit comments to the Committee on Oversight and Government Reform as it investigates the existing evidence about the impact of two principle types of United States sex education programs. These two types of programs are often referred to as comprehensive sex education and abstinence-only sex education.

The National Campaign is a nonprofit, nonpartisan organization whose mission is to improve the lives and future prospects of children and families and, in particular, to help ensure that children are born into stable, two-parent families who are committed to and ready for the demanding task of raising the next generation. Our specific strategy for reaching this goal is to prevent teen pregnancy and unplanned pregnancy among single, young adults. We support a combination of responsible values and behavior by both men and women and responsible policies in both the public and private sectors.

We approach teen and unplanned pregnancy prevention not only as an important way to improve the prospects for this generation of young people and their children, but also as a powerful way to make progress on other critical issues facing the nation. If we succeed, child and family well-being will improve. In particular, there will be less poverty, more opportunities for young men and women to complete their education or achieve other life goals, fewer abortions, a reduced burden on taxpayers, and a stronger nation. For example, although teen childbearing cost taxpayers \$9.1 billion nationally in 2004, the one-third decline in teen childbearing between 1991 and 2004 *saved* taxpayers \$6.7 billion in 2004 alone.¹

Trends in Teen Pregnancy

After years of high and often increasing levels, since the early 1990s the teen pregnancy and birth rates have declined steadily in all states and among all ethnic and racial groups. However, despite the nation's success in meeting the National Campaign's initial challenge to reduce teen pregnancy by one-third over a decade, there is much work to be done. In 2006, the National Campaign issued another challenge for the nation to again reduce teen pregnancy rates an additional one-third by 2015. It is still the case that the United States has the highest rates of teen pregnancy and birth among comparable countries in the industrialized world.² Three in 10 teen girls gets pregnant at least once before the age of 20, resulting in 729,000 teen pregnancies and well over 400,000 teen births each year³. Additionally, it should be noted that progress has not been uniform among all ethnic and racial groups: 53 percent of Latina teens and 51 percent of African American teen girls will become pregnant at least once before age 20. Finally, data suggests that we cannot afford to become complacent: teen birth rates have increased recently for

the first time in 15 years. According to the National Center for Health Statistics, the teen birth rate increased three percent between 2005 and 2006.

Teen Pregnancy's Link to Other Social Issues

It is critically important that we redouble our efforts to help more young people avoid early pregnancy and childbearing because these issues are closely linked to a host of other significant social problems, including poverty and income disparity, child well-being, out-of-wedlock births, and education, to name just a few. For example:

- A child born to an unmarried teen who has not completed high school is nine times more likely to grow up in poverty than if that same child was born to a married couple who had completed high school and delayed childbearing until at least age 20.⁴
- The children of teen mothers are more likely to be born prematurely and at low birthweight⁵ and are two times more likely to suffer abuse and neglect⁶ compared to children of older mothers.
- Children in single-parent families are more likely to get pregnant as teens than their peers who grow up with two parents.⁷ In fact, teen girls without fathers are twice as likely to be sexually active at an early age and are seven times more likely to get pregnant than their peers with both parents in the home.⁸
- Less than half of mothers (40 percent) who have a child before they turn 18 ever graduate from high school and less than two percent of those teen mothers have a college degree by age 30, compared to three-quarters and nine percent, respectively, of young women who wait until age 20 or 21 to have children.⁹

Why are the Rates Declining?

One of the questions we are most frequently asked at the Campaign is, “why have the rates been declining?” The short answer is that teen pregnancy rates are declining because of less sex and more contraception. That is, a smaller proportion of teens are having sex, and those who are sexually active are using contraception more consistently. Because of data limitations, however, it is difficult to determine the *precise* contribution of each of these factors to the decline in teen pregnancy. We do know that sexual activity among teens is down 14 percent since 1991. Less than half (47 percent) of teens have ever had sex, which is a change since 1991 when the majority (54 percent) of teens reported having had sex.¹⁰ And for those who are sexually active, there has been a dramatic 47 percent increase in the use of condoms.¹¹

Given that teens are already behaving in more careful ways—having less sex and using contraception more—the interesting question is: why are they doing so? If we knew what led to this added caution, we could build on those insights to accelerate the decline. Most experts believe that teen pregnancy rates have declined because of some combination of the following:

- Greater public and private efforts to prevent teen pregnancy. States have dramatically increased their efforts to reduce teen pregnancy. At present, there are some 41 teen pregnancy coalitions at the state level, up from 32 in 1995.¹²
- Fear of AIDS and other sexually transmitted diseases. In conversations with the National Campaign, teens say time and again that fear of sexually transmitted diseases (STDs), and AIDS in particular, factors heavily into their decisions about sex.
- The availability of especially effective contraceptives.
- New messages about work and child support embedded in welfare reform. The 1996 welfare reform law contained several important messages. To young women, it said, “if you become a mother, this will not relieve of you an obligation to finish school and support yourself and your family through work or marriage. And any special assistance you receive will be time-limited.” To young men, it said, “if you father a child out-of-wedlock, you will be responsible for supporting that child.”¹³

What Works to Prevent Teen Pregnancy?

While many factors have undoubtedly contributed to the decline in teen pregnancy and birth rates, part of the credit surely goes to the many pregnancy and STD/HIV prevention programs in place nationwide. There is now persuasive evidence that a limited number of programs can delay sexual activity, improve contraceptive use among sexually active teens, and/or prevent teen pregnancy. The strongest evidence stems from program evaluations that are experimental in nature—that is, participants are randomly assigned to treatment and control groups—and focus on changes in *behavior* of program participants rather than just changes in attitudes, knowledge or behavioral intent. Less powerful but still important evidence also comes from using quasi-experimental designs.

In November 2007, the National Campaign released *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, a comprehensive research review by Douglas Kirby, PhD. *Emerging Answers 2007 (EA 2007)* identifies 15 programs with *strong evidence of success*. Seven are classified as sex education programs, two are community service learning programs, two are programs with several components, two involve ways clinicians interact with patients, and one is a parent-teen program. *EA 2007* also identifies 17 characteristics of effective programs and asserts that the single most important characteristic is repeated clear and consistent messages about sex and contraceptive use.

Although the debate as to which type of sex education program is most appropriate for teens endures, *EA 2007* also provides more contextual evidence about both abstinence-only and comprehensive sex education. One of the signature findings of *EA 2007* is that a wide variety of comprehensive sex education programs—that is, programs that include abstinence messages but also give extensive and accurate information about contraception and condoms—have evidence showing that they are able to raise the age of first intercourse, increase contraceptive and condom use among sexually active youth, and/or actually reduce teen pregnancy and the risk of STDs.

Of the 48 comprehensive programs that were reviewed, more than two-thirds (69 percent) reduced risky sexual behavior by improving one or more types of behavior, and 38 percent improved two or more types of behavior. Another significant finding is that no comprehensive program hastened the initiation of sex or increased the frequency of sex among teens.

EA 2007 documents that in contrast to comprehensive programs, there is not sufficient evidence at present to suggest that abstinence-only programs—programs that stress abstinence as the only acceptable form of sexual activity before marriage and include either no information on contraception or condoms, or information that mainly emphasizes problems, side effects, and failure—delay the initiation of sex, hasten the return to abstinence, or reduce the number of sexual partners. Similar findings were released by Mathematica in April 2007 when the federally funded research showed that four promising abstinence-only programs had no behavioral impact when rigorously evaluated using an experimental design.

According to *EA 2007*, many abstinence programs improved teens' attitudes towards abstinence and/or their intentions to abstain, but those improvements did not translate into changes in behavior. However, it is critical to recognize that it is impossible to generalize about the effectiveness of abstinence-only programs as an intervention strategy because only a small number of abstinence-only programs have been evaluated to date and those that have been evaluated do not necessarily reflect the great diversity of abstinence-only programs currently offered.

Research about what works to help teens avoid sex is continually growing. Since the original comprehensive review *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* was released in 2001, the number of studies measuring program impact has increased by 50 percent, their methodological rigor has improved substantially, and additional studies on the behavior that affects teen pregnancy and sexually transmitted diseases as well as the factors affecting such behavior have been published.

We encourage those who want to learn more to review *What Works 2008: Curriculum-Based Programs that Prevent Teen Pregnancy*, an overview of what is known about carefully evaluated interventions to help prevent teen pregnancy. For more extensive materials on this topic, please visit www.TheNationalCampaign.org.

Implications for Federal Policy

The reality is that most Americans do not see abstinence and contraception as an either/or proposition. The American public—both adults and teens—remain deeply committed to encouraging teens to delay sexual activity *and* to providing young people with information about contraception when they become sexually active. In fact, over 90 percent of both adults and teens agree that teens should be given a strong message that they should not have sex until they are at least out of high school, and the clear majority of adults (73 percent) and teens (56 percent) wish teens were getting more information about both abstinence and contraception.¹⁴

However, to date, there is no federal funding dedicated exclusively for education or programs to prevent teen pregnancy that focus both on abstinence and contraception. Thus far, the only major investment by the federal government in sex education has been in abstinence-only education, which has not produced sufficient evidence to justify the large investment at the expense of other approaches for which there is stronger evidence. Consequently, states and communities have been limited in their ability to employ and sustain a range of teen pregnancy prevention programs that reach a significant number of teens.

The National Campaign has long believed that it is important to give states and communities adequate flexibility to pursue strategies that respect diverse local values and cultures. The evidence base and knowledge about what works to prevent teen pregnancy is growing, and it is important to invest in replicating programs that have evidence of changing teens' behavior. It is also apparent that more research is needed to continue to broaden the menu of options. Simply put, the federal government should direct investments to carefully develop and evaluate both abstinence-only and comprehensive programs so that communities have a range of high quality, evidence-based approaches to preventing teen pregnancy. Regardless of the focus of a particular program, the National Campaign also firmly believes that the content of all teen pregnancy prevention programs should be honest and medically accurate.

Programs Cannot Do It All

While effective programs to reduce teen pregnancy exist and should be expanded, it is unrealistic and unfair to assume that community programs alone will solve the problems of too-early pregnancy and parenthood entirely. Only a fraction of teens are enrolled in programs, and many community-based programs are small, fragile, and often given too few financial resources to do their important job as well as they would like.

Making progress on preventing teen pregnancy requires not only better programs but also broader efforts to influence values and popular culture. Teen pregnancy is rooted in broad social phenomena, including the images portrayed in the media, the values articulated by parents and other adults, and popular teen culture most of all. It is for this reason that the National Campaign works on many fronts to prevent teen pregnancy, including cultivating relationships with such key sectors as the entertainment and news media, faith communities, policymakers, the business community, state and local leaders, parents, and both teens themselves.

Recommendations

- 1. Congress should allow states and communities flexibility in supporting medically accurate interventions designed to prevent teen pregnancy; such flexibility respects local values and cultures.**
- 2. Congress should invest a significant amount of funding to develop and assess the effectiveness of a range of programs that are designed to reduce teen pregnancy; abstinence programs as well as those that provide complete information about contraception should be included in this research and demonstration commitment.**

3. **Congress should fund a national resource center to collect and disseminate information about what works to prevent teen pregnancy. A national resource center would provide easy access for people to get information about the latest research evidence, as well as promising practices.**
4. **Congress should invest resources in a large-scale effort to reach teens and young adults where they are, which includes working through various forms of media (including entertainment media, online communities, wireless devices and more). Funding should also be provided for a non-profit organization to facilitate this work.**

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**Statement of the National Partnership for Women & Families on the Public Health
and Ethical Concerns with Abstinence-Only-Until-Marriage Programs**

**Submitted for the Record
April 23, 2008**

The National Partnership for Women & Families is pleased to submit a statement for today's hearing in the House Committee on Oversight and Government Reform, "Domestic Abstinence-Only Programs: Assessing the Evidence." Our statement highlights a few of the reasons – practical, public health, and ethical – to question continuing the public investment in ideologically driven abstinence-only-until-marriage programs. These programs promote abstinence from sexual activity, often providing incomplete and/or misleading information about contraception and sexually transmitted infections (STIs). They also prescribe unrealistic, marriage-focused goals that run counter to the life choices of virtually all Americans.

Certainly, the National Partnership recognizes that abstinence, especially for young teens, is the healthiest choice. We strongly support encouraging teens to postpone sexual activity and we know that parents, health care providers, and other responsible adults have critical roles to play in instilling values and educating children and teens about sexual development and responsible behavior and decision-making.

At the same time, it is critical that Congress acknowledge the growing body of evidence that confirms that abstinence-only programs are not effective at delaying sexual initiation, preventing unwanted pregnancy, or reducing STIs. Federal and state governments have invested more than \$1.3 billion in these programs since 1997 and evidence shows that they are at best, ineffective, and at worst, dangerous to America's youth. Programs that refuse or fail to teach our youth how to protect themselves against unwanted pregnancy and sexually transmitted infections

leave them more vulnerable to unintended pregnancy, HIV/AIDS and other diseases. In addition, abstinence-only programs also offer little to teens who are already sexually active, encourage further stigmatization of those who may be gay, lesbian, bisexual, or transgender, and put health educators in the untenable and unethical position of having to withhold vital information.

Program Requirements Are Not Evidence-Based.

Federal abstinence-only programs must adhere to a stringent eight-point definition of education that requires funded programs to have the “exclusive purpose of teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.” They must teach, among other things, that “sexual activity outside of marriage may have harmful psychological and physical effects” and that “a mutually faithful monogamous relationship in the context of marriage is the expected standard for all school-age children.”¹

This eight-point definition isn’t grounded in evidence-based, public health or social science research. Rather, it promotes a socially conservative “values” agenda put forward by members of Congress who were focused more on ideology than on what was best for young people. Program guidance explicitly prohibits any discussion of contraceptives, except for failure rates, even though there is no credible evidence for the premise that underlies that guidance -- that teaching young people about contraceptives encourages them to be sexually active. The administration chose to go even further in specifying that Section 510(b) abstinence grants to states target individuals up to age 29 – a policy which attempts to dictate the sexual behavior of adults.

Parents Don’t Support Abstinence-Only Education.

The vast majority of parents favor sex education that is comprehensive, medically accurate, and age-appropriate – with good reason. Parents see such courses and content as

supplementing, not supplanting, their discussions at home. They want their children to be taught the benefits of delaying the onset of intimate sexual relationships until they are mature and responsible and to be given the information and skills they need to use condoms and contraception when they choose to become sexually active.

According to a poll conducted in 2003 by the Kaiser Family Foundation, National Public Radio, and Harvard University, only 15 percent of Americans believe that schools should only teach abstinence from sexual intercourse and should not provide information on condoms and other contraception.² A March 2007 poll of registered voters conducted by the National Women's Law Center and Planned Parenthood Federation of America yielded similar results, with more than three out of four respondents preferring comprehensive sex education curricula, while only 14 percent supported teaching "abstinence only" in public schools.³

Most parents believe that teens are capable of absorbing a two-pronged message: abstinence from sexual activity is best until you are in a committed, loving relationship, but if and when you engage in sexual activity, be responsible and know how to protect yourself and your partner.

The abstinence until marriage agenda that abstinence-only programs promote runs counter to the life choices of almost all Americans.

- *The present median age of sexual initiation is 17.*
- *5 percent of teenagers become pregnant each year and by the time they turn 20, 30% of teens have become pregnant. The vast majority of those pregnancies were unintentional.⁴*
- *47 percent of all high schools students report having sex at least once and 63 percent saying they have engaged in sex by the spring semester of their senior year.⁵*
- *The average age of marriage is 25 to 26 for women and 27 to 28 for men, meaning that the length of time between sexual onset and marriage is eight to 10 years on average.⁶*
- *More than 90 percent of Americans have sex before marriage, according to the government's own National Center for Health Statistics.⁷*

- *The gap between sexual onset and marriage has increased across time and premarital sex is an almost universal practice. Even among those who abstained from sex until age 20 or older, 81 percent have had premarital sex by age 44.*⁸
- *By age 30, about half of U.S. women have cohabited outside of marriage.*⁹
- *The number of Americans who are unmarried and single has been growing steadily in recent years, reaching 89.8 million in 2005, and including 41 percent of all U.S. residents age 18 and older. In 2005, 55 million households were headed by unmarried men or women -- 49 percent of households nationwide; and 12.9 million single parents lived with their children.*¹⁰

Government-sponsored programs should fill the information gap, not make it worse.

Given that so many students will not abstain from sex, programs have an obligation to help teens understand the risks and responsibilities that come with sexual activity. Survey after survey indicates that adolescents have a tremendous unmet need for information related to sexuality, contraception, STIs, and making sexual decisions.

A nationwide survey conducted by the Kaiser Family Foundation and *Seventeen Magazine* found considerable gaps in teens' knowledge. The survey found that many teens hold misconceptions and harbor unnecessary and unfounded fears – such as the belief that contraception can cause infertility or birth defects. Nearly 20 percent of surveyed teens underestimated the effectiveness of the contraceptive patch or ring, and more than 25 percent said they believed that emergency contraception causes abortion. Few teens understood the effectiveness of the male condom in preventing STIs, including HIV. In addition, more than 25 percent of the teens did not know that oral contraception provides no protection against sexually transmitted diseases.¹¹

The government-sponsored abstinence evaluation conducted by Mathematica Policy Research confirmed that teens have important gaps in knowledge of STIs. The study found that on average, youth got only about half the answers correct regarding the health consequences of STIs.¹²

The March 2008 CDC data on sexually transmitted infections reinforces the need for medically accurate information and greater utilization of health service.

CDC's data on sexually transmitted infections is a sobering reminder that teenage girls need better information, as well as more screening and treatment. The fact that at least one in four teenage girls nationwide – more than three million teens – has a sexually transmitted infection is a measure of our failure. We should be taking money from the abstinence-only programs that don't work, and instead putting it into sexuality and prevention programs that will reduce these appalling numbers.

Given that the health effects of STIs for women – from infertility to cervical cancer – are particularly severe, there is no time to waste. STI screening, vaccination and other prevention strategies for sexually active women should be among our highest public health priorities, especially since an estimated half of all new HIV infections occur in people under age 25.¹³

For Health Care Providers, Withholding Information is Unethical.

Health care providers and health educators have ethical obligations to provide accurate health information. Patients and students have a right to the most accurate and complete information – information that can help them young people achieve good health outcomes. Current federal abstinence laws and guidelines are ethically problematic because they limit the information – including accurate information about contraception and safer sex – available to young people. So it is not surprising that many highly respected national organizations support comprehensive sex education, including the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Medical Association, American Public Health Association, National Campaign to Prevent Teen Pregnancy, National Education Association, National Medical Association, National School Boards Association, and the Society for Adolescent Medicine, among many others.¹⁴

Abstinence-only-until-marriage as an alternative to birth control is highly ineffective.

Like other methods, abstinence-only-until-marriage works if 'used' consistently and correctly. Common sense as well as available research, suggests that in the real world, it can and does fail routinely.

Researchers in a recent study of teens who made a public pledge to abstain until marriage questioned the youth again six years after they made the pledge. They found that more than 60 percent had broken their vow to remain abstinent until marriage. They also found that teens who took virginity pledges begin engaging in vaginal intercourse later than non-pledging teens, but pledgers were more likely to engage in oral or anal sex than non-pledging virgin teens and less likely to use condoms once they become sexually active. Pledgers were much less likely than non-pledgers to use contraception the first time they had sex and also were less likely than other teens to have undergone STI testing and to know their STI status. As a result, the STI rates between pledgers and non-pledgers were statistically similar.¹⁵

Recent drops in adolescent pregnancy are largely a function of contraceptive use rather than abstinence-only education.

Improved contraceptive use is responsible for 86 percent of the decline in the U.S. adolescent pregnancy rate between 1995 and 2002.¹⁶ Only 14 percent of the change among 15- to 19-year-old women was attributable to a decrease in the percentage who were sexually active.¹⁷

Even though the birth rate for teenagers fell to 40.4 births per 1,000 women aged 15-19 in 2005, the lowest in 65 years,¹⁸ the United States continues to have the highest teenage birth rate of any of the world's developed nations.¹⁹

The \$1.3 billion in federal and state expenditures for abstinence-only programs is money poorly spent.

The claims made by abstinence-only proponents - that comprehensive sexuality education promotes promiscuity, hastens the initiation of sex or increases its frequency, and sends a confusing message to adolescents – are specious. A congressionally-mandated study conducted for the Department of Health and Human Services by Mathematic Policy Research and released last year reviewed four separate abstinence programs. Youth in the four programs were no more likely than other youth to have abstained from sex in the four to six years after they began participating in the study. Youth in both groups who reported having sex had similar numbers of sexual partners and had initiated sex at the same average age.²⁰

A review of federally funded programs by researcher Doug Kirby released in November of 2007 found that programs that focused exclusively on abstinence did not affect teen sexual behavior. The report found that, "At present there does not exist any strong evidence that any abstinence program delays the initiation of sex, hastens the return to abstinence or reduces the number of sexual partners" among teenagers. The study found that while abstinence-only efforts appear to have little positive impact, more comprehensive sex education programs were having "positive outcomes" including teenagers "delaying the initiation of sex, reducing the frequency of sex, reducing the number of sexual partners and increasing condom or contraceptive use." "Two-thirds of the 48 comprehensive programs that supported both abstinence and the use of condoms and contraceptives for sexually active teens had positive behavior effect," the report found. Such programs improved teens' knowledge about the risks and consequences of pregnancy and sexually transmitted diseases, and gave them greater "confidence in their ability to say 'no' to unwanted sex." Just this month, a report in the *Journal of Adolescent Health* concluded that abstinence-only programs have "no significant effect" on "delaying the initiation of sexual activity or in reducing the risk for teen pregnancy" and STIs. Authors added that comprehensive

sexuality education programs significantly reduced the risk of pregnancy when compared with abstinence-only education or no sexuality education at all. Comprehensive sex education also was associated with a marginally reduced likelihood of a teen becoming sexually active, when compared with no sex education. Researchers note that, because their findings indicated a decreased likelihood of pregnancy among teens who received comprehensive sex education, adolescents who received abstinence-only education might "engage in higher risk behaviors once they initiate sexual activity." Although further research is needed to examine the effects of formal sex education, the study's findings "suggest that formal comprehensive sex education programs reduce the risk for teen pregnancy without increasing the likelihood that adolescents will engage in sexual activity," and these findings "confirm results from randomized controlled trials that abstinence-only programs have minimal effect on sexual risk behavior."

An earlier report issued in December of 2004 by the Minority Staff of the House Committee on Government Reform found that more than two-thirds of abstinence-programs funded under Title V are using curricula with multiple scientific and medical inaccuracies. These curricula contained misinformation about condoms, abortion, and basic scientific facts, such as:

- *"tears" and "sweat" can transmit HIV;*
- *condoms do not help prevent the spread of STDs;*
- *5% to 10% of women, who have legal abortions will become sterile;*
- *a 43-day-old fetus is a "thinking person".*

Many also blurred religion and science and presented gender stereotypes as fact.²¹

Many states and well-regarded researchers have conducted evaluations and arrived at similar conclusions. Scott Frank of Case Western Reserve University School of Medicine in Cleveland found that the curricula used in Ohio's abstinence-only programs – offered in 85 out of 88 counties – contained false and misleading information about abortion and contraception. It also found that the curricula reinforced gender stereotypes and notions about sex that are not

based in science. One program told teens they should "be prepared to die" if they use condoms because they are likely to fall off or break, according to Frank's study.²²

States Are Turning Down Funding.

The most compelling verdict on the program comes from the states – 17 of which have turned down Title V abstinence funds even in the face of economic downturns that have left them scrambling for resources. Many have based their decisions on the growing number of state and national evaluations that call into question the efficacy and accuracy of abstinence-only programs.

It is past time for the federal government to stop funding ideologically-based abstinence-only programs that are failing our young people, and instead use those resources to fund comprehensive sexuality education programs that will help reduce unintended pregnancy, reduce the spread of sexually transmitted infections including HIV/AIDS, and help young people make responsible choices.

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Testimony of Judy Waxman
Vice President for Health and Reproductive Rights, National Women's Law
Center

Committee on Oversight and Government Reform
April 23, 2008

Chairman Waxman and members of the Committee on Oversight and Government Reform, thank you for this opportunity to provide written testimony on behalf of the National Women's Law Center. As a non-profit organization dedicated to expanding the possibilities for women and girls in this country since 1972, we would like to express our concerns to the Committee regarding the effect of abstinence-only-until marriage programs ("abstinence-only programs") on the health and well-being of young women in America.

Young people in the United States—particularly young women—need education and information to prevent unintended pregnancies and sexually transmitted infections (STIs). Each year, 750,000 adolescent females in the U.S. become pregnant,ⁱ and 15-24 year olds report more than 9 million cases of sexually transmitted infections (STIs).ⁱⁱ Teen pregnancy rates are far higher in the U.S. than in most other developed country,ⁱⁱⁱ and the Centers for Disease Control and Prevention (CDC) recently announced that one in four young women, and one in *two* young black women, between the ages of 14 and 19 have an STI.^{iv} Young women, particularly young women of color, bear the burden of unintended pregnancies and a disproportionate share of STIs.

Unfortunately, abstinence-only programs fail to provide—and, in fact, undermine—the information and education young people need to make responsible, healthy decisions. Rather than address the growing need for public health interventions, abstinence-only programs undermine the very messages young people need to make responsible, healthy decisions.

The weight of the evidence indicates that abstinence-only programs fail to prevent adolescents from engaging in sexual activity outside of marriage, the primary objective of abstinence-only education; nor do they increase the likelihood that teens will practice safer sex methods when they do become sexually active. The latter effect is unsurprising, as abstinence-only programs specifically exclude from their curricula information about contraceptives—a critical part of any public health effort to prevent teen pregnancy and STIs—save for their failure rates. Furthermore, the information that abstinence-only programs do provide about contraception and other reproductive health services has been found to be inaccurate and misleading, thus undermining young people's confidence in contraception and knowledge about how to properly employ it when they do become sexually active. Abstinence-only programs promote stereotypes about gender and relationships that may compromise young women's confidence in their ability to make responsible, pro-active decisions about their sexual health and alienate youths at especially high risk for problems relating to sexual health.

Comprehensive sex education, in contrast, provides young people with information and education to make responsible decisions about sexual health. It acknowledges the severity of the crisis of adolescent sexual health in the U.S. and offers intuitive and effective solutions that get to the root of the problem. Americans recognize that adolescents need an intervention that *works* and strongly support comprehensive sex education.

Young Women in the U.S. Suffer from High Rates of Unintended Pregnancy and Sexually Transmitted Infections

Young people, particularly young women, are in critical need of information and education that will help them prevent an unintended pregnancy and protect against STIs. While the teen pregnancy rate in the United States has diminished since 1990^v—largely due to more consistent contraceptive use among adolescents^{vi}—it remains significantly higher than in comparable nations,^{vii} and continues to disproportionately burden young women of color.^{viii} Meanwhile, rates of STI incidence among U.S. teens are soaring: 15-24 year-olds account for nearly 50 percent of all new STIs each year,^{ix} with rates dramatically higher than that of teens in comparable European nations.^x One in four young women, and one in two young black women, between the ages of 14-19 suffer from an STI.^{xi}

Young women generally do not intend to become pregnant—indeed, 82 percent of teen pregnancies are unintended^{xii}—yet each year, 75 pregnancies occur per 1,000 women ages 15-19.^{xiii} Pregnancy at a young age can severely limit a young woman’s ability to complete her education and subsequently find a well-paying job. One-quarter to one-third of high school dropouts cite pregnancy or parenting as a factor in their decision to leave school.^{xiv}

Sexually transmitted infections can also have a long-term impact on young people. Chlamydia and gonorrhea can result in infertility and chronic pain, and certain strains of Human Papillomavirus (HPV) may lead to persistent infection that can progress to cervical cancer in women.^{xv} Half of the new HIV infections in America each year occur among youths ages 15-24.^{xvi}

There are, additionally, vast racial and ethnic disparities in the incidence of STIs and unintended pregnancies, with women of color disproportionately at risk. In 2001, the Chlamydia rate among African-American women ages 15 to 19 was nearly seven times higher than among white females (8,483 and 1,276 per 100,000 females), and 75 percent of all reported cases of gonorrhea occurred among African Americans.^{xvii} In 2005, HIV infection was the leading cause of death for black women (including African-American women) aged 25–34 years^{xviii}, though black and Hispanic women represent 24% of all US women,^{xix} women in these 2 groups accounted for 82% (8,807/10,774) of the estimated total of AIDS diagnoses for women in 2005.^{xx} Black females have the highest teen pregnancy rate (134 per 1,000 women aged 15-19 in 2005), followed by Hispanics (131 per 1,000) and then non-Hispanic whites (48 per 1,000).^{xxi}

Abstinence-Only Programs Undermine Adolescents’—Particularly Young Women’s—Ability to Make Responsible Decisions about Sexual Health

Rather than addressing this critical public health need through comprehensive sex education that has been proven effective, the federal government has wasted more than \$1.5 billion on abstinence-only programs that have failed our teens.^{xxii}

History of Federal Funding for Abstinence-Only Programs

The ideological and legislative foundations for abstinence-only programs were established in 1981, when President Reagan signed The Adolescent Family Life Act (AFLA) into law as part of the Omnibus Reconciliation Act.^{xxiii} Since that time, the federal investment in abstinence-only programs has grown nearly 6,000 percent from \$4 million in 1982 to more than \$240 million in fiscal year 2008, despite a lack of research proving their effectiveness.^{xxiv}

There are currently three federal funding streams for abstinence-only programs. Title V, Section 510 of the Social Security Act defines “abstinence education” and provides funds to states to promote abstinence-only messages.^{xxv} Since 1998, \$50 million in Title V federal funds have been allocated to state governments to fund media promoting abstinence-only-until-marriage or to be distributed to local sub-grantees. For every \$4 in federal funds, states must match with \$3, bringing the annual total of abstinence-only funding through Title V to \$87.5 million.^{xxvi}

The Community-Based Abstinence Education (CBAE) program awards federal grants directly to abstinence-only programs.^{xxvii} The CBAE was formerly administered within the U.S. Department of Health and Human Services (HHS) by the Maternal and Child Health Bureau and is currently administered by the Administration for Children and Families (ACF).^{xxviii} Funding for CBAE began in fiscal year 2001 at \$20 million. By fiscal year 2007, funding had increased over 450% to a total of \$113 million.^{xxix}

The Adolescent Family Life Act (AFLA) has received more than \$125 million since 1982. In fiscal year 2008, AFLA’s abstinence-only education received \$13 million through this program.^{xxx}

Since the passage of the Social Security Act in 1996, all federal abstinence-only programs have been required to comply with the stringent eight-point definition in Title V of the Social Security Act.^{xxxi} Abstinence education, as defined by the statute, requires programs to teach that “sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects,” and that “a mutually faithful monogamous relationship in [the] context of marriage is the expected standard of sexual activity.”^{xxxii} In addition, federally funded abstinence-only programs are expressly prohibited from providing any information to adolescents about the proper usage of contraceptives or their proven efficacy in preventing unintended pregnancy and, for certain contraceptive devices, the transmission of STIs.^{xxxiii} At the same time, they are specifically required to inform participants of contraceptive failure rates.^{xxxiv}

The Weight of the Evidence Indicates that Abstinence-Only Programs are Ineffective

Despite the fact that the federal government has channeled \$1.5 billion to such programs in the last ten years, the overwhelming weight of the evidence fails to support abstinence-only programs. A series of studies have documented the failure of abstinence-only programs to prevent adolescents from engaging in sexual activity outside of marriage, the primary objective of abstinence-only education, or to increase the likelihood that teens will practice safer sex methods when they do become sexually active.

In 1997, Congress authorized funds for a comprehensive study of abstinence-only programs. The results of that study, conducted by Mathematica Policy Research, were released a decade later. The study found that youths in abstinence-only programs were “no more likely” to have abstained from sex than peers who did not participate in abstinence-only programs, and youths in both groups had “similar numbers” of sexual partners and “had initiated sex at the same mean age.”^{xxxv}

In 2001, a study on the sexual behaviors of youths who had taken “virginity pledges,” a key component of many abstinence-only programs, found that while some of the pledgers did delay sexual initiation by an average of 18 months, they were one-third less likely to use contraception when they did become sexually active than peers who had not taken the pledge.^{xxxvi} Further research demonstrated that, among virgins, male and female pledgers were six times more likely to have had oral sex than non-pledgers, and male pledgers were four times more likely to have had anal sex than their peers who had not pledged.^{xxxvii}

State evaluations have likewise determined that abstinence-only programs are ineffective. In a 2003 study in Pennsylvania, the researchers concluded that, “taken as a whole, this initiative was largely ineffective in reducing sexual onset and promoting attitudes and skills consistent with sexual abstinence.”^{xxxviii} In 2004, researchers in Texas noted, “We didn’t see any strong indications these programs were having an impact in the direction desired.”^{xxxix} In a 2004 study of Kansas youth, the researchers found “no changes...for participants’ actual or intended behavior; such as whether they planned to wait until marriage to have sex...rather than focusing on Abstinence-Only-Until-Marriage, data suggests that including information on contraceptive use may be more effective at decreasing teen pregnancies.”^{xl}

Abstinence-only programs provide incomplete information about contraceptives that leaves young people unprepared

Abstinence-only programs provide adolescents with incomplete information about contraceptives, a critical part of any public health effort to prevent teen pregnancy and sexually transmitted infections. By excluding from their curricula information on the benefits of, and how to properly utilize, contraception, these programs leave young people unprepared to engage in protective measures when they do become sexually active.

Women and girls are disproportionately affected by the consequences of unprotected sexual activity. Most women have the potential to become pregnant for over 30 years of their

lives, and for approximately three-quarters of her reproductive life, the average woman is trying to postpone or avoid pregnancy.^{xii} Young people, particularly women, need information about, and access to, contraception and other safer sex supplies in order to protect against STIs, prevent unintended pregnancies, and control the timing and spacing of their pregnancies. Contraception is basic health care for women that reduces the incidence of maternal death, and prevents low birth weight babies and infant mortality.^{xiii} Yet abstinence-only programs specifically censor and distort this crucial information for young women.

Abstinence-only programs provide inaccurate and misleading information that undermines young people's confidence in contraception when they do become sexually active.

What information abstinence-only programs do provide about contraception and other reproductive health issues has been shown to be medically inaccurate, highly exaggerated and misleading.^{xliii} For example, many of the curricula include grossly exaggerated failure rates for condoms,^{xliv} provide false information about the risks of abortion,^{xlv} and treat subjective, moral judgments as scientific fact. For example, one curriculum used by eight CBAE grantees refers to a 43 day-old fetus as a "thinking person."^{xlvi} Another curriculum used by seven grantees asks rhetorically "could condoms be just another stupid idea?"^{xlvii} This misleading and inaccurate information undermines young women's confidence in supplies proven to be highly effective in preventing unplanned pregnancies and the transmission of STIs, including HIV/AIDS.^{xlviii}

Abstinence-only programs promote gender stereotypes that may undermine young women's confidence and self-efficacy

Many abstinence-only curricula advance gender stereotypes that reinforce outdated notions of male and female social and sexual roles and teach young women that they are responsible for containing young males' aggressive sexual desires and needs. Inculcating American youth with narrow and regressive values about gender and sexuality undermines efforts to achieve true gender equality and may diminish a young woman's self-efficacy, thus compromising her ability to make responsible, pro-active decisions about and for her sexual health.

Many of the curricula contain stereotypes that devalue girls' achievements and ambitions. For example, nineteen CBAE grantees use a curriculum that lists "Financial Support" as one of the "5 Major Needs of Women," and "Domestic Support" as one of the "5 Major Needs of Men."^{xlix} Others portray stereotypes about males' overwhelming sexuality and female's sensitivity as biological fact.^l These curricula also suggest that boys are helpless in the face of their uncontrollable sexual urges and women and girls must defend against this male aggression through chastity and self-discipline. Several of the curricula go so far as to instruct young women to dress modestly to protect against overwhelming male sexuality.^{li} This type of logic offers an erroneous biological "excuse" for perpetrators of sexual harassment and violence. It suggests that victims of sexual harassment and violence are at least partially responsible for the attack made against them. Additionally, these stereotypes

undermine the ability of teachers and students to recognize incidence when males are victims of sexual harassment or violence.ⁱⁱⁱ

These stereotypes are especially dangerous when viewed alongside curricula that represent women as helpless, passive and dependent on men,ⁱⁱⁱ as they may diminish young women's ability to confidently and assertively reject sexual advances. Researchers of a 2004 study on abstinence-only programs in Kansas found, for example, that after participating in abstinence-only programs, significantly fewer students surveyed felt they "have the right to refuse to have sex with someone."^{iv}

Abstinence-only programs may cause adolescent females concerned about being viewed as promiscuous to avoid voicing questions or concerns about sexual activity to teachers, parents or health care providers; taking preventive measures to protect themselves from unplanned pregnancies or STI transmission; seeking treatment if they do contract an STI; or voicing sexual desires, fears or rejection to future partners.^{iv} Taken together, the promotion of gender stereotypes in abstinence-only curricula further undermines young women's ability to make responsible, informed decisions about sexual health.

Abstinence-only programs alienate youth populations at the highest risk for sexual health issues by stigmatizing people from non-traditional families.

The eight-point definition of abstinence-only-until-marriage education stigmatizes adolescents living in families without two, heterosexual parents and adolescents who do not foresee themselves one day living in a traditional family structure. In particular, the definition discriminates against women and girls—particularly women and girls of color—who disproportionately bear the burden of out-of-wedlock childbirth,^{vi} and gay, lesbian, bisexual and transgender (GLBT) youths, for whom marriage is likely not an option and who are thus left with no "approved" outlet for their sexuality. Youths of color and GLBT youths are two broad communities at particularly high risk for sexual health-related issues.^{vii} Instead of recognizing the needs of these adolescents and catering to their unique circumstances, abstinence-only programs stigmatize or ignore them.

Comprehensive sex education provides young people with information and education to make responsible decisions.

Rather than continuing to fund ineffective and damaging abstinence-only programs, Congress should invest instead in comprehensive sex education programs that address the public health challenges our young people face. Like abstinence-only programs, comprehensive sex education programs stress the importance of abstinence and emphasize that it is the only guaranteed way to avoid many serious health consequences that can result from intercourse. However, comprehensive sex education programs also discuss the comparative safety risks and advantages of different contraceptive methods, teach teens how to avoid unintended pregnancy and sexually transmitted infections, including HIV/AIDS, and help teens learn healthy decision-making and communication skills.

Numerous studies have found certain comprehensive sex education programs to be highly effective in delaying initiation of sex, reducing number of sexual partners, reducing incidence of unprotected sex and increasing condom usage among American youth, in addition to other positive results.^{lviii} Additionally, most Americans support comprehensive sex education and feel unfavorably toward abstinence-only programs. In fact, 76 percent of voters, including decisive majorities of Independents, Republicans, red-state voters, Catholics, Evangelicals, and seniors—strongly support teaching comprehensive sex education in public schools (89 percent strongly or somewhat favor).^{lix}

Conclusion

Young people are struggling to bear the physical, social and economic consequences of unprotected sexual activity. Unfortunately, abstinence-only programs are failing to meet the needs of American teens. The National Women’s Law Center thanks the Committee for providing much-needed oversight of these failed programs, and urges Congress to provide funding for the comprehensive sex education Americans want and deserve. Additionally, I would like to thank Julia Kaye at the National Women’s Law Center for helping with this testimony. She is available to answer questions at jkaye@nwl.org.

ⁱ GUTTMACHER INSTITUTE, IN BRIEF: FACTS ON AMERICAN TEENS’ SEXUAL AND REPRODUCTIVE HEALTH (2006), available at http://www.guttmacher.org/pubs/fb_ATSRH.html#n25 [hereinafter “In Brief”].

ⁱⁱ H. Weinstock et al., *Sexually Transmitted Diseases Among American Youth: Incidence and Prevalence Estimates*, PERSP. ON SEX. REPROD. HEALTH, Jan. 2004, 36(1), at 6–10 [Hereinafter “Weinstock Paper”].

ⁱⁱⁱ Jacqueline E. Darroch et al., Guttmacher Institute, *Teenage Sexual and Reproductive Behavior in Developed Countries: Can More Progress Be Made?*, OCCASIONAL REPORT 3 (2001), available at http://www.guttmacher.org/pubs/eurosynth_rpt.pdf [Hereinafter “Occasional Report 3”].

^{iv} Press Release, *Nationally Representative CDC Study Finds 1 in 4 Teenage Girls Has a Sexually Transmitted Disease* (March 11, 2008), available at <http://www.cdc.gov/STDCConference/2008/media/release-11march2008.htm> [Hereinafter “Press Release”].

^v See In Brief.

^{vi} Jacqueline E. Darroch and Susheela Singh, Guttmacher Institute, *Why is Teenage Pregnancy Declining? The Roles of Abstinence, Sexual Activity and Contraceptive Use*, OCCASIONAL REPORT 1 (1999) [Hereinafter “Occasional Report 1”].

^{vii} See Occasional Report 3.

^{viii} See In Brief.

^{ix} See Weinstock Paper.

^x SUE ALFORD, ADVOCATES FOR YOUTH, ADOLESCENTS— AT RISK FOR SEXUALLY TRANSMITTED INFECTIONS FACT SHEET (2003), available at <http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fssti.htm> [Hereinafter “Adolescents Fact sheet”].

^{xi} See Press Release.

^{xii} L.B. Finer et al., *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, PERSP. ON SEX. REPROD. HEALTH, June 2006, 38(2), at 90–96, citing In Brief.

^{xiii} See In Brief.

^{xiv} Peter D. Hart Research Associates, *Gates Foundation Dropouts Survey* (Sept/Oct 2005); NELS:1988, NCES, “Dropout Rates in the United States: 1994.”

^{xv} See Weinstock Paper.

^{xvi} See In Brief.

^{xvii} See Adolescents Fact sheet, citing CDC, SEXUALLY TRANSMITTED DISEASE SURVEILLANCE, 2001 (2002).

- ^{xviii} CDC, HIV/AIDS AMONG WOMEN (June 2007), *available at* <http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm> [Hereinafter “CDC Fact sheet”]
- ^{xix} See CDC Fact sheet, *citing* NATIONAL CENTER FOR HEALTH STATISTICS, BRIDGED-RACE VINTAGE 2005 POSTCENSAL POPULATION ESTIMATES FOR JULY 1, 2000–JULY 2005, BY YEAR, COUNTY, SINGLE-YEAR AGE, BRIDGED-RACE, HISPANIC ORIGIN, AND SEX, *available at* <http://www.cdc.gov/nchs/about/major/dvs/popbridge/datadoc.htm#vintage2005>.
- ^{xx} See CDC Fact sheet, *citing*, CDC, HIV/AIDS Surveillance Report 2006: Cases of HIV Infection and AIDS in the United States (2006).
- ^{xxi} See In Brief.
- ^{xxii} SIECUS, A BRIEF HISTORY OF FEDERAL FUNDING FOR ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS, *available at* <http://www.siecus.org/policy/states/2005/Explanation.pdf> [Hereinafter “History of Abstinence-Only Programs”].
- ^{xxiii} 42 U.S.C. §§ 300z et seq. AFLA, Title XX of the Public Health Service Act, authorizes HHS to make grants for demonstration projects to help communities provide appropriate care and prevention services in easily accessible locations. The term “prevention services” is defined as necessary services to prevent adolescent sexual relations. 42 U.S.C. § 300z-1(a)(8).
- ^{xxiv} See History of Abstinence-Only Programs.
- ^{xxv} 42 U.S.C. § 710. Programs funded by Title V target “those groups which are most likely to bear children out-of-wedlock.” 42 U.S.C. 710(b)(1).
- ^{xxvi} REBECCA A. MAYNARD ET AL., MATHEMATICA POLICY RESEARCH, FIRST-YEAR IMPACTS OF FOUR TITLE V, SECTION 510 ABSTINENCE EDUCATION PROGRAMS (2005), *available at* <http://aspe.hhs.gov/hsp/05/abstinence/report.pdf> [Hereinafter “Mathematica Research”].
- ^{xxvii} AMERICAN PUBLIC HEALTH ASSOCIATION, STATE REFUSAL OF FEDERAL FUNDING FOR ABSTINENCE-ONLY EDUCATION 159807 (2007), *available at* http://apha.confex.com/apha/135am/techprogram/paper_159807.htm.
- ^{xxviii} 42 U.S.C. § 1310. This section authorizes HHS to make grants to states, local governments, and other entities for a wide range of demonstration projects.
- ^{xxviii} See History of Abstinence-Only Programs.
- ^{xxix} *Id.*
- ^{xxx} *Id.*
- ^{xxxi} While the “abstinence education” definition is only located in Title V, annual appropriations acts and program announcements have extended the definition to the CBAE and AFLA grants. See Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2006, Pub. L. 109-149. See also Notice, Department of Health and Human Services, Office of the Secretary, Availability of Funds for Adolescent Family Life Demonstration Projects, 69 Fed. Reg. 17,888-89 (April 5, 2004); Announcement, Department of Health and Human Services, Administration for Children and Families, *Community-Based Abstinence Education Program, Funding Opportunities FY 2006*, p. 2.
- ^{xxxii} 42 U.S.C. § 710(b)(2).
- ^{xxxiii} NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WORKSHOP SUMMARY: SCIENTIFIC EVIDENCE ON CONDOM EFFECTIVENESS FOR SEXUALLY TRANSMITTED DISEASES (July 20, 2001), *available at* <http://www3.niaid.nih.gov/research/topics/STI/pdf/condomreport.pdf>; MAYO FOUNDATION FOR MEDICAL EDUCATION AND RESEARCH (MFMER), BIRTH CONTROL GUIDE (Jan. 25, 2008), *available at* <http://www.mayoclinic.com/print/birth-control/B199999/PAGE=all&METHOD=print>.
- ^{xxxiv} Funding Opportunity: Community-Based Abstinence Education, 70 Fed. Reg. 29,318, 29,320, 29,321, 29,324 (May 20, 2005); See ACF, Funding Opportunity: Community-Based Abstinence Education (Jan. 26, 2006), at 1, 7-8, 15, 27, *available at* <http://www.acf.hhs.gov/grants/pdf/HHS-2006-ACF-ACYF-AE-0099.pdf>.
- ^{xxxv} See Mathematica Research at p. xvii.
- ^{xxxvi} SIECUS, WHAT THE RESEARCH SAYS... (Oct. 2007), *available at* http://www.siecus.org/policy/research_says.pdf [Hereinafter “What the Research Says”], *citing* Peter Bearman and Hanah Brückner, *Promising the Future: Virginity Pledges and the Transition to First Intercourse*, 106.4 AM. J. OF SOC. 859-912 (2001).
- ^{xxxvii} See What the Research Says, *citing* Bearman and Brückner, *The Relationship Between Virginity Pledges in Adolescence and STD Acquisition in Young Adulthood*, National STD Prevention Conference (Philadelphia, PA), Mar. 9, 2004.

- ^{xxxviii} EDWARD SMITH ET AL., EVALUATION OF THE PENNSYLVANIA ABSTINENCE EDUCATION AND RELATED SERVICES INITIATIVES: 1998-2002 10 (2003), available at <http://www.dsf.health.state.pa.us/health/lib/health/familyhealth/evaluationpaabstinence1998-20021.pdf>.
- ^{xxxix} See What the Research Says, citing PATRICIA GOODSON ET AL., ABSTINENCE EDUCATION EVALUATION PHASE 5: TECHNICAL REPORT 170-172 (2004).
- ^{xl} See What the Research Says, citing TED CARTER, EVALUATION REPORT FOR THE KANSAS ABSTINENCE EDUCATION PROGRAM 19 (2004) [Hereinafter "Carter Report"].
- ^{xli} GUTTMACHER INSTITUTE, FULFILLING THE PROMISE: PUBLIC POLICY AND U.S. FAMILY PLANNING CLINICS (2000), available at http://findarticles.com/p/articles/mi_m0KCT/is_2000_Jan_1/ai_n18611137.
- ^{xlii} Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes, A Meta-analysis*, JAMA 2006; 295: 1809-1823.
- ^{xliii} STAFF OF THE HOUSE COMM. ON GOVERNMENT REFORM, SPECIAL INVESTIGATIONS DIVISION, 108TH CONG., REPORT ON THE CONTENT OF FEDERALLY FUNDED ABSTINENCE-ONLY EDUCATION PROGRAMS, at i. (2004) [Hereinafter the "Waxman Report"].
- ^{xliv} A curriculum used by seven CBAE grantees states: "[i]n heterosexual sex, condoms fail to prevent HIV approximately 31% of the time." See Waxman Report, citing Why kNOW, 91.
- ^{xlv} Another curriculum, used by eight CBAE grantees, states: "[s]tudies show that five to ten percent of women will never again be pregnant after having a legal abortion." See Waxman Report, citing Me, My World, My Future, Teacher Manual, 157.
- ^{xlvi} See Waxman Report, citing Me, My World, My Future, Teacher Manual, 77.
- ^{xlvii} JULIE F. KAY ET AL., LEGAL MOMENTUM, SEX, LIES & STEREOTYPES: HOW ABSTINENCE-ONLY PROGRAMS HARM WOMEN AND GIRLS (2008), available at http://legalm.convio.net/site/DocServer/SexLies_Stereotypes2008.pdf?docID=1001 [Hereinafter "Sex, Lies & Stereotypes"], citing KRIS FRAINIE, 90 WHY KNOW ABSTINENCE EDUCATION PROGRAMS: CURRICULUM FOR SIXTH GRADE THROUGH HIGH SCHOOL (Teacher's Manual) (2002).
- ^{xlviii} NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WORKSHOP SUMMARY: SCIENTIFIC EVIDENCE ON CONDOM EFFECTIVENESS FOR SEXUALLY TRANSMITTED DISEASES (July 20, 2001).
- ^{xlix} See Waxman Report, citing WAIT Training, 199.
- ^l See Sex, Lies & Stereotypes, citing ROSE FULLER & JANET MCLAUGHLIN, FACTS AND REASONS 28 (Teacher's Manual) (2000); CHOOSING THE BEST, CHOOSING THE BEST LIFE: LEADER GUIDE 7 (2003).
- ⁱⁱ See Sex, Lies & Stereotypes, citing Letter from Steven Brown, Executive Director, Rhode Island ACLU, to Peter McWalters, Comm'r, R.I. Dep't of Educ. (Sept. 21, 2005), available at http://www.riaclu.org/documents/sex_ed_letter.pdf.
- ⁱⁱⁱ See Sex, Lies & Stereotypes, at 22.
- ⁱⁱⁱⁱ See Waxman Report, citing WHY KNOW ABSTINENCE EDUCATION, WHY KNOW 59 (2004).
- ^{lv} See What the Research Says, citing Carter Report.
- ^{lvi} See Sex, Lies & Stereotypes, citing Janet Holland et al., Sex, Gender and Power: Young Women's Sexuality in the Shadow of AIDS, 12 SOC. OF HEALTH & ILLNESS 336, 350 (1990); Ralph J. DiClemente et al., Predictors of Inconsistent Contraceptive Use Among Adolescent Girls: Findings from a Prospective Study, 39 J. OF ADOLESCENT HEALTH 43, 49 (2006); Lynne Hillier et al., "When You Carry Condoms All the Boys Think You Want It": Negotiating Competing Discourses About Safe Sex, 21 J. OF ADOLESCENCE 15, 29 (1998); SHARON THOMPSON, GOING ALL THE WAY: TEENAGE GIRLS' TALES OF SEX, ROMANCE, AND PREGNANCY (1996); Hélène A.C.M. Voeten et al., Gender Differences in Health Care—Seeking Behavior for Sexually Transmitted Diseases: A Population-Based Study in Nairobi, Kenya, 31 SEXUALLY TRANSMITTED DISEASES 265, 272 (2004).
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- ^{lviii} JENNIFER AUGUSTINE, SUE ALFORD, AND NAHNAHSHA DEAS, ADVOCATES FOR YOUTH, YOUTH OF COLOR—AT DISPROPORTIONATE RISK OF NEGATIVE SEXUAL HEALTH OUTCOMES (2004), available at <http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fsyouthcolor.htm>; HEALTHY TEEN NETWORK, THE UNIQUE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF GAY, LESBIAN, BISEXUAL, TRANSGENDER AND QUESTIONING (LGBTQ) YOUTH FACT SHEET, available at

<http://www.healthyteennetwork.org/vertical/Sites/%7BB4D0CC76-CF78-4784-BA7C-5D0436F6040C%7D/uploads/%7B516EF85D-49FA-4F3F-B562-FA918CF9ED58%7D.PDF>.

^{lviii} SUE ALFORD, ADVOCATES FOR YOUTH, SCIENCE & SUCCESS: PROGRAMS THAT WORK TO PREVENT TEEN PREGNANCY, HIV AND SEXUALLY TRANSMITTED INFECTION FACT SHEET (2007), *available at* <http://www.advocatesforyouth.org/publications/ScienceSuccessES.pdf>.

^{lix} Peter D. Hart Research Associates, *Research Overview for Planned Parenthood /National Women's Law Center*, at 14-15 (Apr. 2007) (on file with NWLC).



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Statement of Nancy Ratzan, President of the National Council of Jewish
Women on Abstinence-Only-Until-Marriage Programs

Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008

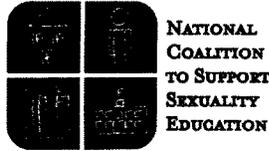
On behalf of the 90,000 members and supporters of the National Council of Jewish Women, I would like to thank Chairman Waxman and the Committee on Oversight and Government Reform for holding this hearing to highlight the moral, ethical, and public health concerns with abstinence-only-until-marriage programs.

The National Council of Jewish Women believes in and resolves to work for comprehensive human sexuality education programs in public schools. In 2007, we initiated Plan A: NCJW's Campaign for Contraceptive Access to secure and protect women's and girl's access to contraceptive information and options. As part of this campaign, NCJW members from around the country have assessed the status of sexuality education in their communities. NCJW members in Pennsylvania, Florida, Texas, Minnesota, Tennessee, and many other states, have seen firsthand how abstinence-only-until marriage programs fail to meet the needs of young people.

In too many schools, students receive incomplete, medically inaccurate sexuality education. As a religiously affiliated organization committed to the separation between religion and state, NCJW is particularly concerned that abstinence-only-until-marriage programs, using federal taxpayer dollars, frequently seek to impose one particular religious viewpoint about sex on all students, regardless of their individual religious traditions. It is critical that science and public health—not religious views or ideologies—determine the sexuality education that young people receive in our country's public schools.

In order to make responsible, healthy decisions, young people need—and society has a moral obligation to provide—medically accurate, age-appropriate information about sex and sexuality. Comprehensive sexuality education teaches that abstinence is the only sure way to avoid pregnancy and sexually transmitted infections (STIs), but also provides accurate information about contraceptive options so that individuals can make informed life decisions.

The National Council of Jewish Women (NCJW) is a grassroots organization of volunteers and advocates who turn progressive ideals into action. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms. For this reason and those detailed above, on behalf of NCJW, I strongly urge Congress to eliminate all federal funding for abstinence-only-until marriage programs. A small minority must not be allowed to impose its religious beliefs about sexuality education upon all Americans. This not only violates the constitutional separation of religion and state, but endangers the health and lives of our nation's young people.



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Statement of the National Coalition to Support Sexuality Education (NCSSE) on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

The National Coalition to Support Sexuality Education (NCSSE) is a coalition of over 155 leading national organizations that support age-appropriate, medically accurate sexuality education for all children and youth in the United States. Members of NCSSE represent a broad constituency of education advocates and professionals, health care professionals, religious leaders, child and health advocates, and policy organizations.

As organizations concerned about the health and education of our nation's young people, the undersigned organizations of NCSSE wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs. There is a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. We are committed to using sound scientific evidence and promoting the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years even though no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally funded study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-marriage programs have achieved their goal to increase rates of sexual abstinence—the entire supposed purpose of the programs. This report followed the findings from 13 states that have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful.

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, which discussed what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.

Furthermore, a report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the already significant body of knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs.

These programs are not supported by any of the leading national or international public health and medical organizations. Every major medical and public health organization, many of whom are NCSSE members, supports a comprehensive approach to sexuality education. These include the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, the American Public Health Association, the Institute of Medicine, the National Institutes of Health, and the Society for Adolescent Medicine, among others. Several, including the American Public Health Association, the Institute of Medicine, and the Society for Adolescent Medicine, have gone so far as to call for the repeal of current abstinence-only-until-marriage programs and funding.

In addition, on November 21, 2007, ten public-health researchers sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid urging Congress to reduce or eliminate federal support for abstinence-only-until-marriage programs, in part because the programs have “multiple scientific and ethical errors.” We strongly support the researchers’ conclusion that abstinence-only-until-marriage programs withhold “potentially life-saving information” about birth control and ignore the health needs of lesbian, gay, bisexual, and transgender (LGBT) youth. The letter focused on the large body of evidence showing that abstinence-only-until-marriage programs are ineffective in getting young people to delay sexual initiation, noting that, “Recent reports in professional publications by the authors of this letter have highlighted multiple deficiencies in federal abstinence-only programs.”

America’s youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.

Advocates for Youth
 AIDS Action
 AIDS Alliance for Children, Youth & Families
 The AIDS Institute
 American Academy of HIV Medicine
 American Association of Sexuality Educators, Counselors & Therapists
 The American Civil Liberties Union
 American College of Obstetricians and Gynecologists
 American Social Health Association
 Answer, Rutgers University
 Community HIV/AIDS Mobilization Project (CHAMP)
 Gay Men’s Health Crisis

Gay, Lesbian and Straight Education Network (GLSEN)
Healthy Teen Network
Human Rights Campaign
Legal Momentum
Ms. Foundation for Women
NARAL Pro-Choice America
National Alliance of State & Territorial AIDS Directors
National Association of County and City Health Officials (NACCHO)
National Coalition for LGBT Health
National Council of Jewish Women
National Family Planning and Reproductive Health Association
The National Gay and Lesbian Task Force Action Fund
National Partnership for Women & Families
National Women's Law Center
Our Bodies Ourselves
Parents, Families and Friends of Lesbians and Gays (PFLAG) National
People For the American Way
Physicians for Reproductive Choice and Health
Planned Parenthood Federation of America
Population Connection
Pro-Choice Public Education Project
Religious Institute on Sexual Morality, Justice, and Healing
Sexuality Information and Education Council of the United States (SIECUS)
Sierra Club
The Society for the Scientific Study of Sexuality
Unitarian Universalist Association of Congregations
United Church of Christ
Women of Reform Judaism
The Woodhull Freedom Foundation

National
Family Planning
& Reproductive Health Association

Statement of Mary Jane Gallagher, President & CEO
National Family Planning & Reproductive Health Association

House Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008

The National Family Planning & Reproductive Health Association (NFPRHA) is a membership organization representing the nation's dedicated family planning providers – public health departments, hospitals, general health providers and stand-alone reproductive health caregivers. Our goal is to prevent unwanted pregnancies and reduce the need for abortion by providing the education, contraception, counseling and preventive health services people need to act responsibly, stay healthy, and plan for strong families.

As President and CEO of NFPRHA, I want to thank Chairman Waxman for convening this historic hearing to assess the scientific evidence surrounding the effectiveness of abstinence-only programs at reducing the rate of unintended pregnancies and sexually transmitted infections in our teens. I applaud the Committee for its efforts today, and appreciate the opportunity to share my concerns about what I believe to be the serious ethical and public health concerns with abstinence-only programs.

In the last 25 years, more than \$1.5 billion has been spent on federally funded abstinence-only programs, despite overwhelming evidence showing that these programs are not broadly effective at delaying the onset of sexual behavior, reducing the number of sexual partners, or increasing contraceptive use. In April 2007, a Congressionally-mandated study by Mathematica Policy Research, Inc. found no evidence that abstinence-only programs funded through Title V had any impact on the age of first sex or the number of partners.¹ In November of this year, a meta-analysis of teen pregnancy prevention programs conducted between 1990 and 2007 found that “[i]n sum, studies of abstinence programs have not produced sufficient evidence to justify their widespread dissemination.”²

Today's hearing about the ineffectiveness of abstinence-only programs could not be more timely, or critical. We recently learned from a CDC study that today, one in four teenage girls is infected with a sexually transmitted disease – nearly 3.2 million teen girls

Helping people act responsibly, stay healthy and plan for strong families

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nationwide.³³ The majority of American teens have sex by the time they reach the end of high school, and more than 750,000 teens become pregnant each year.³⁴ Teen pregnancy and sexually transmitted infection rates are higher in the United States than anywhere else in the developed world, and teen pregnancy alone costs Federal, state and local governments \$9.1 billion annually.³⁵ It is unconscionable that we allow this to happen in the richest country in the world, and it truly constitutes a public health crisis.

Abstinence-only programs are clearly not the answer. By continuing to throw money away in support of ineffective programs, we are failing in our responsibility to keep our teens safe and give them the best possible chance to succeed. Young people deserve straight talk about sex so they can make smart, informed decisions about their sexual behavior and its outcomes. If Congress is serious about providing our youth with real solutions to help them delay sexual activity and prevent unintended pregnancies and sexually transmitted infections, it will de-fund abstinence-only programs.

³³ Trenholm, Christopher, et. al., *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report*, (Trenton, NJ: Mathematica Policy Research, Inc., April 2007). (online at <http://www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf>)

³⁴ Kirby, Doug, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases* (2007). (online at http://www.thenationalcampaign.org/EA2007/EA2007_full.pdf).

³⁵ Forhan, Sara et. al., "Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis Among Female Adolescents in the United States: Data from the National Health and Nutritional Examination Survey (NHANES) 2003-2004," (Presented at the National STD Prevention Conference, Washington, DC, March 2008).

³⁶ Centers for Disease Control and Prevention, *Youth Risk Behavior Surveillance—United States, 2005*, MMWR (June 9, 2006) (online at <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5505a1.htm>).

³⁷ The National Campaign to Prevent Teen and Unplanned Pregnancy, *Linking Teen Pregnancy Prevention to Other Critical Social Issues* (online at <http://www.teenpregnancy.org/wim/pdf/introduction.pdf>)

³⁸ The National Campaign to Prevent Teen and Unplanned Pregnancy, *By the Numbers: the Public Costs of Teen Childbearing* (online at http://www.teenpregnancy.org/costs/pdf/report/BTN_Executive_Summary.pdf)

Collaborative for Comprehensive School-Age Health

Statement of the Collaborative for Comprehensive School-Age Health on the Public Health and Ethical Concerns Regarding Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education

Committee on Oversight and Government Reform

Submitted for the Record, April 23, 2008

The Collaborative for Comprehensive School-Age Health is a coalition of more than 80 officials representing local governments, youth-serving agencies, schools, faith-based organizations, health care providers, foundations, and education programs in Northeast Ohio. The Collaborative advocates for best practices, supportive policies, and community mobilization efforts that promote sexual health; and for the provision of age-appropriate comprehensive abstinence-inclusive sexuality education. The Collaborative has been particularly active in the design and implementation of the Cleveland Metropolitan School District's groundbreaking program, now in its second year, to provide universal access to comprehensive reproductive health education in grades K-12.

As members of a Collaborative that has since its inception been a strong promoter of comprehensive sexuality education, the undersigned organizations wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these programs that have been medically and scientifically proven ineffective.

We are committed to promoting the health and social welfare of our community's youth and we wish to express profound concern over possible continued federal funding for abstinence-only-until-marriage programs. We are similarly committed to promoting adoption of comprehensive sexuality education which has proven to be more effective in meeting the needs of all youth. Unlike abstinence-only programs, comprehensive sexuality education is evidence based, and free of gender and sexual orientation bias.

Over the past 25 years, Congress has spent over \$ 1.5 billion on abstinence-only-until-marriage programs, yet no study in a professional peer-reviewed journal has found these programs to be broadly effective. Scientific evidence simply does not support an abstinence-only-until-marriage approach. A 2007 study conducted by Mathematica Policy Research Inc. on behalf of the U.S Department of Health and Human Services; found that abstinence-only-until-marriage programs are ineffective. Of the four programs that the study handpicked to show positive results, none succeeded. One of the key findings of the study was the fact that there was no evidence that abstinence-only-until-marriage programs increased rates of sexual abstinence—the stated purpose of the programs: “Findings indicate that youth in the program group were no more likely to abstain from sex their control group counterparts; among those who reported having had sex, program and

control group had similar numbers of sexual partners and had initiated sex at the same mean age.” The report concluded, “Finally there were no differences in potential consequences of teen sex, including pregnancies, births and reported STDs.”

In addition, a July 2007 “meta-study” published in the *British Medical Journal* found that abstinence-only programs do not positively impact the rates of HIV infection or sexual behavior. If anything, these programs have continued to negatively impact young people’s sexual health. For instance according to research published in the 2001 *American Journal of Sociology* on virginity pledges, it was found that young people who took a virginity pledge were one-third less likely to use contraception when they did become sexually active than their peers who had not pledged. In addition, the pledgers had the same rate of sexually transmitted diseases as their peers who had not pledged.

Furthermore, numerous state evaluations have failed to find abstinence-only programs effective. In 2003, Pennsylvania’s evaluation found that, “taken as a whole, this initiative was largely ineffective in reducing sexual onset and promoting attitudes and skills consistent with sexual abstinence.” Another study, this by Minnesota Department of Health, found that sexual activity doubled among Junior High school participants in the state’s Education Now and Babies Later (ENABL) program at three schools between 2001 and 2002. And in Ohio, Dr. Scott Frank, Director of the Masters in Public Health Program at the Case Western Reserve University Medical School conducted a study surveying the content of abstinence-only-until-marriage curricula in use statewide. Released in June of 2005, Dr. Frank’s study revealed that those curricula “contain false information about contraceptives; contain false information about abortion; misrepresent religious convictions as scientific fact; perpetuate destructive, inaccurate gender stereotypes; do not portray the risks related to sexual activity in a scientifically accurate manner; disregard the needs of the youth at risk for STDS and pregnancy; do not provide information for Lesbian, Gay, Bisexual, Transgender (LGBT) populations; and stand in contrast to the desire of the majority of parents, who want children to receive education about both abstinence *and* about prevention of pregnancy and sexually transmitted disease.”

We specifically wish to share data from the greater Cleveland area which further indicates the failure of abstinence-only programs in reducing high risk youth behavior and the spread of HIV/AIDS and other sexually transmitted diseases. According to the Cuyahoga County Youth Risk Behavior Report for 2006-2007, 39.8 percent of teens in Cuyahoga County admitted to having sex and close to 80 percent of those teens first had sexual intercourse between the ages of 13 and 16. Rates of chlamydia and gonorrhea have increased significantly as well and most of these cases are among teens 15-19 and people under 30. The implementation of the Cleveland Metropolitan School District’s groundbreaking program to provide universal access to comprehensive reproductive health education in grades K-12 has gone a long way to prove that comprehensive sexuality education is much needed and more appropriate.

In June, 2007, Ohio’s Governor Ted Strickland made an evidence-based decision to veto abstinence-only-until-marriage funding in the state budget, after his office reviewed the growing evidence that such programs do not work, promote gender bias, exclude gay and

lesbian youth, and contain inaccurate information. The Collaborative was actively involved in supporting Governor Strickland's decision to veto abstinence-only funds.

In support of his decision Governor Ted Strickland asserted that abstinence education has an important place but only in the context of a comprehensive approach to sexuality education. The Governor noted that these programs are not working, and he refused to reapply for a program that is using our tax dollars toward something that does not work. Ohio was one of only eight states to reject this funding as of March of 2007. This decision resulted in a cascade of other states that in the weeks and months afterwards followed suit.

Ohio youth and America's youth deserve the best possible reproductive health and sexuality knowledge to be able to socially equip and protect them. There is no other proven method of preventing unintended teen pregnancies and sexually transmitted diseases, including HIV/AIDS other than comprehensive sexuality education. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, based on science, and reflect mainstream values.

Collaborative for Comprehensive School-Age Health

AGAPE Program of Antioch Baptist Church
 AIDS Taskforce of Greater Cleveland
 BeechBrook
 Big Brothers Big Sisters-Cleveland
 Bellefaire JCB
 The Beyond Identities Community Center
 The Brush Foundation
 Case Western Reserve University, Division of Adolescent Health and Family Medicine
 Christian Community, Inc.
 City of Cleveland Department of Public Health
 Cleveland Metropolitan School District
 The Cleveland Foundation
 Cleveland Clinic, Section of Adolescent Medicine
 Community Endeavors
 Cuyahoga County Board of Health
 Family Planning Associates of Northeast Ohio
 The Free Medical Clinic of Greater Cleveland
 The George Gund Foundation
 Lesbian, Gay, Bisexual & Transgender Community Center of Greater Cleveland
 MetroHealth Hospital, Division of Adolescent Medicine
 NARAL Ohio
 National Council of Jewish Women
 Ohio Religious Coalition for Reproductive Choice
 Planned Parenthood of Northeast Ohio
 Preterm
 United Church of Christ
 YWCA of Cleveland

April 22, 2008

OHIO RELIGIOUS COALITION FOR REPRODUCTIVE CHOICE
P.O. BOX 82204, COLUMBUS, OH 43214
614.221.3636 800.587.2330 (Toll-free in Ohio) ohiorc@sbcbglobal.net

April 22, 2008

To the Committee on Oversight and Government Reform
 U.S. House of Representatives
 Washington, D.C.

To the Honorable Representatives on the Oversight and Government Reform Committee,

The Ohio Religious Coalition for Reproductive Choice strongly supports your move to examine the effectiveness of, and the wisdom of paying for, the abstinence-only-until-marriage sex education programs that have been used in Ohio schools for the last seven years.

As people of faith, we feel a responsibility for informing young people about sexuality with medically accurate information and in-depth discussion of human relationships that prepares them for real life. Many religious denominations, including United Church of Christ, Union for Reform Judaism, Presbyterian Church (USA), the United Methodist Church, and the Unitarian Universalist Association, have developed faith-based, age-appropriate comprehensive sexuality education programs which are taught to young people in their congregations.

A national poll of voters commissioned by the Religious Coalition for Reproductive Choice, of which we are a state affiliate, found that Americans of all faiths want responsible sexuality education taught in schools. *Seventy-three percent of anti-choice voters, 73% of Catholics, 57% of Baptists, and 67% of Christian fundamentalists and evangelicals said they favor teaching comprehensive sexuality education.* Support is similarly high among Protestant and Jewish religious leaders. A Religious Coalition survey of nearly 500 clergy showed that more than 90% believe individuals can benefit from discussions of sexuality issues in their congregations.

Abstinence-only sex education in schools has proved to be a dismal failure. Several studies have shown it does not meet its own goals: to delay sexual activity. Dr. Frank of Case Western College of Medicine in Cleveland, Ohio published a study showing the programs approved for use in Ohio contain outright falsehoods, misleading portrayals of disease and pregnancy prevention, gender stereotypes, and give no help to LGBT teens in our state, which does not allow same sex marriage. Because it does not teach prevention of sexually transmitted disease or pregnancy, it leaves ignorant teens vulnerable to disease and unwanted pregnancies when they do decide to become sexually active.

What is worse, the program has cost millions of federal dollars from our tax monies and of matching dollars from the taxes paid by Ohioans. Governor Ted Strickland has wisely rejected federal abstinence-only monies and has included some funding (but not enough) in the budget for comprehensive sex education. In addition, Mayor Jackson of Cleveland, the head of the Cleveland city school system, has taken independent action and instituted comprehensive sexuality education from kindergarten through high school, using private funding and city taxes, but without benefit of federal and state funds. He took this unusual and bold step, because on the 25th anniversary last year of the first AIDS cases in the U.S., his own health department had recorded statistically proved increases in STDs and STIs, as well as increases in teen pregnancies.

Please act upon the evidence that is sure to come out in these hearings. Please eliminate funding for abstinence-only sex education and endorse the REAL Act, which would provide federal funding for comprehensive sex education.

Sincerely,

Barbara Avery, Director
 Ohio Religious Coalition for Reproductive Choice

April 22, 2008

To the Committee on Oversight and Government Reform:

The Pennsylvanians for Responsible Sex Education (PARSE) coalition is comprised of 35 organizations and individuals dedicated to the instruction of age-appropriate, comprehensive, evidence-based sex education for all Pennsylvania youth. We support sex education that provides instruction on both abstinence and how to protect against unintended pregnancy and sexually transmitted diseases (STDs), in an effort to help all teens make healthy decisions if and when they decide to have sex. Decades of peer-reviewed research has clearly demonstrated that programs that include information about both abstinence and the effective use of contraception reduce sexual risk-taking and pregnancy among teens.¹

Currently, the prevalence of medically-inaccurate abstinence-only-until-marriage programs, insufficient teacher training, inadequate standards for sex education, and a complete lack of funding for comprehensive sex education put Pennsylvanian teens at risk. Many teens receive incorrect or incomplete information through abstinence-only programs that fail to offer information on how to prevent unintended pregnancy or STDs beyond instructing teens to abstain. According to a recent study by researchers at Yale and Columbia Universities, 88 percent of teenagers who pledge to remain abstinent before marriage break that pledge and when they do have sex, they are less likely than other teens to use condoms or be tested for STDs.² In some schools, sex education is not even taught. The current state of sex education in Pennsylvania is unacceptable. Our teens deserve better.

PARSE actively works to increase the number of programs that provide unbiased, age-appropriate, medically accurate sex education to teens while also working to eliminate dangerous medically-inaccurate and ineffective abstinence-only programs in the state.

Attached please find a letter sent to the superintendents of all 501 Pennsylvania school districts advocating for, and providing information about, comprehensive sexuality education and why it should be provided to youth. The letter was supported by a number of state health and advocacy organizations: Pennsylvania Coalition to Prevent Teen Pregnancy; Pennsylvania Section of the American College of Obstetricians and Gynecologists (ACOG); Pennsylvania Chapter of the American Academy of Pediatrics; Adagio Health Inc.; Family Planning Council, Philadelphia, PA; Family Health Council of Central Pennsylvania; Maternal and Family Health Services, Inc.; American Civil Liberties Union of Pennsylvania

We encourage you to work collaboratively to ensure comprehensive sexuality education is supported, and to oppose any federal spending for abstinence-only-until-marriage programs.

Thank You,

PARSE

AIDS Law Project
Attic Youth Center
CHOICE
Christian Association of the University of Pennsylvania
Clara Bell Duvall Reproductive Freedom Project of the ACLU of Pennsylvania
Family Planning Council
Maternal & Family Health Association
National Council of Jewish Women, Pennsylvania
Pennsylvania Coalition to Prevent Teen Pregnancy
Planned Parenthood of Central Pennsylvania
Planned Parenthood of Southeastern Pennsylvania
Planned Parenthood of Western Pennsylvania
Planned Parenthood Pennsylvania Advocates
Stop HIV

¹ Douglas Kirby, *The Nat'l Campaign to Prevent Teen Pregnancy, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, Summary at 16 (2001).

² H. Brückner and P. Bearman, *After the Promise: the STD Consequences of Adolescent Virginity Pledges*, 36 *Journal of Adolescent Health* at 271-278 (2005).



**Pennsylvania Coalition
to Prevent Teen Pregnancy**

3461 Market St. • Suite 200 • Camp Hill, PA 17011- 4412
(717) 761-7380 • Fax (717) 763-4779

April 21, 2008

For over a decade the Pennsylvania Coalition to Prevent Teen Pregnancy has advocated comprehensive sexuality education, recognizing that educating about abstinence and contraception were legitimate strategies to prevent teen pregnancy. We have based our opinion on available scientific evidence, the endorsement of major health and medical organizations, our experiences working with teens in a variety of professional capacities, and our belief that teens have the right to information that can protect them. We have opposed abstinence-only education for the following reasons:

1. The major medical and health organization in the US agree that it is not good public health policy to deprive young people of information that prevents pregnancy and disease.
2. Abstinence-only programs do not reflect the views or the behavior of most Americans.
3. Some abstinence-only programs are fear-based, factually inaccurate, and use religion to promote their message.
4. Most importantly, there is an absence of solid research documenting their effectiveness. Countless studies on both the federal and state level have consistently concluded that these programs are ineffective. Pennsylvania's own four-year evaluation of its abstinence-only initiative concluded that these programs were "ineffective in reducing sexual onset" and recommended a more comprehensive approach.

Only 15% of parents support abstinence-only-until-marriage programs. However, these programs continue to be the sole school sex education programs funded by the federal government. We should not be spending precious resources on programs that don't work, especially during times of massive budget deficits. We encourage you to work with your colleagues to support comprehensive sexuality education and to oppose federal spending for abstinence-only-until-marriage programs.

Sincerely,

Joe Fay, Executive Director
PCPTP



April 23, 2008

The Honorable Henry Waxman, Chairman
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the record of
Domestic Abstinence-Only Programs: Assessing the Evidence

Dear Chairman Waxman:

Equality, fairness, and freedom from discrimination are fundamental components of the American way, and People For the American Way (PFAW) is dedicated to promoting fair and equal treatment of all Americans. Thus, PFAW supports a woman's right to privacy and reproductive choice, and views comprehensive sex education as part of the effort to stop the spread of sexually transmitted diseases and prevent unwanted pregnancies.

Unfortunately, President Bush has repeatedly avowed his unwavering support for excluding discussion of birth control and disease prevention from sex education in schools. Anti-choice leaders continue to advocate for "abstinence-only-until-marriage" ("abstinence-only") programs that put youth at risk and deny students the information necessary to make their own decisions about sex and reproduction and ultimately prevent abortions.

PFAW strongly opposes "abstinence-only" programs. While we recognize that sex education programs should include discussion of abstinence, we cannot ignore the reality facing teenagers today and, therefore, oppose programs that focus solely on this method of birth control and disease prevention. Comprehensive sex education should also include discussion of birth control and disease prevention for sexually active students.

Sincerely,

A handwritten signature in black ink, appearing to read "Tanya Clay House".

Tanya Clay House
Directory, Public Policy



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**Statement of Public Health Solutions on the Public Health and Ethical Concerns with
Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education**

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

Founded in 1957, Public Health Solutions (formerly Medical and Health Research Association of New York City, Inc.) is one of New York City's largest nonprofits. Public Health Solutions' unique and flexible administrative framework supports collaboration with New York City Department of Health and Mental Hygiene and related City, State, and federal agencies in the development and implementation of programs responsive to emerging health needs, and in evaluation of these programs to ensure their continued effectiveness. Public Health Solutions addresses some of the most serious and urgent public health challenges facing the city and the nation: children at risk of developmental disabilities and chronic health problems, women with little or no access to health care, family planning or prenatal services; families in need of food and nutritional guidance; and people with HIV/AIDS, and those at high risk of becoming HIV infected who need preventive education.

As a provider of family planning and prenatal services and an agency that strives, through its many programs, to improve overall public health, Public Health Solutions is concerned about the health and education of our nation's young people. We wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs. There is a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. In our own services, we are committed to using sound scientific evidence and promoting the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years, even though no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally-funded study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-marriage programs have achieved their goal to increase rates of sexual abstinence--the entire supposed purpose of the programs. This report followed the findings from 13 states that have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful.

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, which discussed what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.

*Formerly Medical and Health Research Association
of New York City, Inc. (MHRA)*

Statement of Public Health Solutions
To The Committee on Oversight and Government Reform
April 23, 2008
Page 2

Furthermore, a report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the already significant body of knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs.

These programs are not supported by any of the leading national or international public health and medical organizations. Every major medical and public health organization supports a comprehensive approach to sexuality education. These include the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, the American Public Health Association, the Institute of Medicine, the National Institutes of Health, and the Society for Adolescent Medicine, among others. Several, including the American Public Health Association, the Institute of Medicine, and the Society for Adolescent Medicine, have gone so far as to call for the repeal of current abstinence-only-until-marriage programs and funding.

In addition, on November 21, 2007, ten public health researchers sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid urging Congress to reduce or eliminate federal support for abstinence-only-until-marriage programs, in part because the programs have "multiple scientific and ethical errors." We strongly support the researchers' conclusion that abstinence-only-until-marriage programs withhold "potentially life-saving information" about birth control and ignore the health needs of lesbian, gay, bisexual, and transgender (LGBT) youth. The letter focused on the large body of evidence showing that abstinence-only-until-marriage programs are ineffective in getting young people to delay sexual initiation, noting that, "Recent reports in professional publications by the authors of this letter have highlighted multiple deficiencies in federal abstinence-only programs."

America's youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.



Statement by Brian E. Dixon
Vice President for Media and Government Relation
Population Connection
To the
House Committee on Oversight and Government Reform
April 23, 2008

Chairman Waxman, thank you for convening this important hearing. For more than a decade, abstinence-only programs have received taxpayer dollars with little accountability and no oversight by Congress. Population Connection is grateful for your efforts to call public attention to the many problems with the continuing funding for abstinence-only programs.

With more 70,000 members and supporters across the United States, Population Connection is America's largest grassroots organization dedicated to addressing the challenges posed by population growth both globally and here at home.

The United States has the fastest growing population in the industrialized world. In 2006, our population reached 300 million, and it is likely to hit 450 million by 2050. As we consider solutions to the climate change problem, it's important to note that Americans are by far the greatest contributors to carbon emissions. And population growth is the driving factor behind increased emissions in the United States. In fact, between 1990 and 2004, U.S. emissions increased by 18 percent – the same increase that we saw in population.

On a local level, communities all across the country are struggling with the impacts of this growth. From coast to coast, you see spontaneous movements calling for slow growth or smart growth or no growth. Roads are too congested, schools are too crowded, open space is being devoured and people see that their quality of life is being undermined.

But population growth is a national issue that requires national solutions. Our growth is being driven in large part by the twin problems of teenage pregnancy and unintended pregnancy. The United States has the highest rates of each in the industrialized world.

More than thirty percent of women in this country will become pregnant before reaching 20 years of age. Fully one-third of all births every year are the result of unintended pregnancy. One in four teenage girls live with a sexually transmitted infection – among African American girls, it's one in two. These troubling statistics share a common link: they are the result of a failed sex education policy in the United States.

Instead of real solutions, the federal government has spent more than a billion dollars over the past decade on dangerous, misleading and ineffective abstinence-only programs.

Study after study has shown that abstinence-only programs are misguided. Seventeen states have opted out of taking federal funds through the Title V state based program after seeing no benefits.

Abstinence-only programs have no better ally and champion than the Bush Administration. But even a study commissioned by the Department of Health and Human Services, and conducted by Mathematica Policy Research, found no evidence that abstinence-only programs had resulted in an increase in sexual abstinence—the stated purpose of the programs. In fact, students in the abstinence-only programs were found to have first had sex at a similar age and with similar numbers of sexual partners as their peers who were not in the programs. This federally-funded report was released after 13 states had evaluated their abstinence-only programs, finding them ineffective and even harmful.

Other evaluations, including one led by Chairman Waxman, have found that these programs are riddled with medical and scientific inaccuracies. Indeed, many of the curricula being funded with federal taxpayer dollars are based on little more than medical misinformation, glib slogans and outdated gender stereotypes.

There is no question that abstinence is a healthy choice for young people, and we should be supporting programs that help them delay sexual activity. It's equally important, though, to ensure that they have the information they need to make healthy and responsible choices once they do become sexually active. And we know that as a prevention method, abstinence fails nearly one hundred percent of the time.

What happens then? Well, for far too many young people exposed to federally funded abstinence programs, they are ill-equipped. They have been fed inaccurate information about condoms and other contraceptives, so they may be less likely to use them. They have been made to feel that sexual activity is something to be ashamed of, so they may be less likely to actually talk to parents or doctors or to their partners.

That's why nearly all of the leading medical and public-health organizations – including the American Medical Association, the American Public Health Association, the American Academy of Pediatrics, and the Society for Adolescent Medicine -- oppose abstinence-only programs. The National Academy of Sciences' Institute of Medicine has even criticized the federal government's investment of hundreds of millions of dollars in the programs as "poor fiscal and public health policy."

The verdict on these programs is in: they don't work. The overwhelming weight of the evidence shows that they don't reduce teen pregnancy or the spread of sexually transmitted infections. They don't even lead to significant delays in adolescent sexual activity.

It's time for Congress to end funding for these failed programs.




Planned Parenthood® Federation of America
Clergy Advisory Board
Statement in Support Of
Comprehensive, Medically Accurate, and Age-Appropriate Sex Education


As clergy, we have a responsibility to remind our congregations, our communities, and our elected leaders that our religious traditions view the body and the physical world as a sacred arena in which God acts. We believe that God blessed human beings with the opportunity to bear children as a sign not only of the sacredness of life but also as a sign of our capacity for God's gift of sexual intimacy.

The gift of sexuality is God-given, and so, too, is the moral imperative that we instruct our children, with due allowance for their age, so that they will understand their bodies and make wise choices about their sexual life, including the choice to be abstinent.

As religious leaders from many faiths, we counsel young people as they grapple with social pressures and difficult decisions. We spend time with families and teens through religious instruction, youth activities, confirmation, Bar and Bat Mitzvah, and much, much more. We know that many of our youth are not getting the honest facts they need about sex. We believe it is immoral to lie to our children by giving them inadequate and inaccurate sex education or abstinence-only programs that fail to teach our teens how to prevent pregnancy and how to protect themselves from infections and abuse. As a result, in the name of morality, our young people are contracting sexually transmitted infections at unprecedented rates, having children that they are not prepared to care for, or dying from HIV/AIDS. Scientific data demonstrates that comprehensive sex education can delay first intercourse, reduce the number of sexual partners, and increase the use of condoms and contraception.¹ Comprehensive sex education is a proven good; it would be morally wrong to withhold a proven medical benefit from our children.

When we are honest with our teens, they will respond to our candor by being honest with us. Comprehensive sex education strengthens family communication. When there is sound conversation about a sensitive matter like sex, teens will know who they can turn to, especially in their time of need. Stronger family ties, a benefit of comprehensive sex education, will serve teens and their loved ones well.

Public funding that exclusively supports abstinence-only programs discriminates against many religious denominations that support comprehensive sex education. Many of our houses of worship provide age-appropriate, medically-accurate, comprehensive sex education; we have led such programs ourselves. These programs emphasize abstinence as the best way to keep oneself safe and healthy. Many young people take this path and we offer them our support and encouragement. However, experience shows that in any group

¹ Kirby D. *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen Pregnancy, 2007.

of teens, some will turn in a different direction — we are morally responsible for them as well.

This year alone, nearly four million teenagers will contract sexually transmitted infections and an additional 750,000 will become pregnant. For the sake of our young people, we urge Congress and state legislatures to heed the expert conclusions that abstinence-only programs do not stop or even delay teenagers from having sex nor do they have any positive impact on reported rates of pregnancy and sexually transmitted infections.²

As clergy seeking to improve the well-being of the young people we serve, we want to see comprehensive sex education become a reality. We believe that providing comprehensive sex education is a moral imperative for a responsible and just society in the care and instruction of our youth. Anything less is to fall far short of our moral obligation to the health and well-being of the young lives entrusted to us by God.

The Planned Parenthood Federation of America Clergy Advisory Board (CAB), launched in 1994, leads a national effort to increase public awareness of the theological and moral basis for advocating reproductive health and justice. CAB members are dedicated pro-choice clergy from different denominations and communities throughout the U.S. who work with Planned Parenthood at the national and state levels to further the goal of full reproductive freedom for all women and men.

Rev. Paula Gravelle, Chair
Watervliet, NY (Lutheran)

Rev. Jill McAllister, Vice-Chair
Kalamazoo, MI (UUA)

Rev. Mark Asman
Santa Barbara, CA (Episcopalian)

Rev. Thomas R. Davis
Saratoga, NY (UCC)

Rev. Consuelo Donahue
San Antonio, TX (Presbyterian)

Rev. Janet Eggleston
Hoopeston, IL (Methodist)

Rev. Vincent Lachina
Seattle, WA (Baptist)

Rev. Maria LaSala
New Haven, CT (Presbyterian)

Rev. William Levering
Schenectady, NY (Presbyterian)

Rev. Stephen Mather
Coronado, CA (Presbyterian)

Rev. Jane Emma Newall
Yakima, WA (MCC)

² Jayson, Sharon. "Sex Education Clash Churns Over Grants, Study: Abstinence Teaching Ineffective." *USA TODAY*, April 16, 2007, pp. 5D.

Kalamazoo, MI (Presbyterian)

Rabbi Sally Priesand
Ocean Township, NJ

Rev. Paul Robinson
Medford, OR (UCC)

Rabbi Dennis Ross
Worcester, MA

Rev. Kelvin Sauls
Nashville, TN (Methodist)

Rev. Joanne Sizoo
Charlotte, NC (Presbyterian)

Aisha Sobh
Urbana, IL (Muslim)

Rev. Penny Willis
Washington, DC (UCC)

Statement of Planned Parenthood of Kansas and Mid-Missouri on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

Dear Committee Members,

Planned Parenthood of Kansas and Mid-Missouri is an organization committed to ensure that every individual has the knowledge, opportunity and freedom to make informed private decisions about reproductive and sexual health. As an organization concerned about the health and education of our nation's young people, we wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs. There is a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. We are committed to using sound scientific evidence and promoting the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Locally, abstinence-only-until-marriage funding is affecting the communities we serve at alarming levels. Missouri currently receives more than \$4,000,000 in Title V and CBAE funds and Kansas currently receives close to \$2,000,000. This funding encourages both of our state governments, as well as local school boards, to treat our young people as political pawns. The evidence of this has been made all too clear lately from the CDC report that shows that 1 in 4 teenage girls has a sexually transmitted infection and our local teen pregnancy rate in Kansas City has risen 13.1% since 2005 to 2006. In addition, public opinion overwhelmingly supports comprehensive sex education in public schools. A poll conducted in Missouri in 2007 by Peter D. Hart Research Associates shows that 76% of Missourians *strongly* support comprehensive sex education.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years even though no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally funded study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-marriage programs have achieved their goal to increase rates of sexual abstinence--the entire supposed purpose of the programs. This report followed the findings from 13 states that have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful.

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, which discussed what programs work in preventing teen pregnancy and sexually

transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.

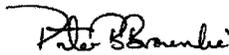
Additionally, a report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the already significant body of knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs.

These programs are not supported by any of the leading national or international public health and medical organizations. Every major medical and public health organization supports a comprehensive approach to sexuality education. These include the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, the American Public Health Association, the Institute of Medicine, the National Institutes of Health, and the Society for Adolescent Medicine, among others. Several, including the American Public Health Association, the Institute of Medicine, and the Society for Adolescent Medicine, have gone so far as to call for the repeal of current abstinence-only-until-marriage programs and funding.

Seventeen states have already rejected Title V funding due to the danger and harm that abstinence-only-until-marriage programs inflict on our young people. The only way to completely eradicate this danger for youth in the remaining 33 states is to acknowledge the overwhelming evidence in favor of comprehensive sex education and bring an end to the funding of Title V.

America's youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.

Sincerely,



Peter Brownlie
President/CEO
Planned Parenthood of Kansas and Mid-Missouri

**Statement from Planned Parenthood of Connecticut, Inc.
on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage
Programs and the Need for Comprehensive Sexuality Education**

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

Planned Parenthood of Connecticut, Inc. (PPC) is the largest provider of family planning and reproductive health care in Connecticut, operating 18 health centers in the state that annually provide services to about 70,000 patients, primarily young women. In addition, the Planned Parenthood mission includes empowering individuals to make reproductive health choices based on information, so our agency offers a wide range of training for parents and youth serving professionals (including teachers). PPC believes that in order to preserve access to services and information, we must engage in advocacy to promote reproductive justice in Connecticut, across the US, and globally.

Connecticut is among those states that, within the past year, has decided to forego the Title V abstinence grants which previously flowed through our State Department of Public Health.

However, there has historically been no funding in our state for comprehensive, age appropriate sexuality education. This year, the Connecticut General Assembly is likely, for the first time, to initiate a basic funding stream to offer incentive grants to school districts eager to do a better job providing medically-accurate, age-appropriate, comprehensive sex education (which includes mention of abstinence but also instruction about other methods of family planning and safer sex.) In the course of working on this issue, we have learned through public opinion polling that the voting public in our state is squarely in favor of comprehensive sex education. 83% of those we polled (using Lake Research Associates of Washington DC) were strongly in favor of a comprehensive approach. Only 14% of voters felt that "abstinence until marriage" education was acceptable.

Support for sex education crossed demographic groups in Connecticut and was bi-partisan in nature. Many cited serious concern for teens who are already sexually active, and according to recent CDC statistics, all too likely to be infected by sexually transmitted diseases.

We would like to add the voice of Planned Parenthood of Connecticut to those raised in opposition to federal abstinence-until-marriage education funding. These programs have been soundly proven ineffective, and they are not in sync with the values of Connecticut educators, voters and policy makers, who prefer a comprehensive approach to sex education.



**PLANNED PARENTHOOD FEDERATION OF AMERICA
STATEMENT FOR THE U.S. HOUSE GOVERNMENT
REFORM COMMITTEE HEARING ON “DOMESTIC
ABSTINENCE-ONLY PROGRAMS: ASSESSING THE
EVIDENCE”**

Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008

As the nation’s most trusted reproductive healthcare provider, Planned Parenthood Federation of America boasts the largest network of sexuality educators and advocates for comprehensive sex education. In 2006, over 2,200 affiliate staff and volunteer educators provided educational programs to over 1.2 million individuals of all ages. We are pleased the Committee on Oversight and Government Reform will be holding a congressional hearing to address this critical issue entitled, “Domestic Abstinence-Only Programs; Assessing the Evidence” and we are equally pleased to submit the following testimony for the record.

In our 860 health centers across the country, Planned Parenthood providers and educators have seen firsthand the rising number of teen pregnancies and young adults infected with sexually transmitted infections (STIs). Every year, almost 750,000 girls aged 15–19 become pregnant. Most recently, an alarming study by the Centers for Disease Control and Prevention (CDC) showed that at least one in four teen girls has a sexually transmitted infection (STI). The study also found that African-American teenage girls were most severely affected. Nearly half of the young African-American women (48 percent) were infected with an STI, compared to 20 percent of young white women.

The most recent CDC study underscores what Planned Parenthood and those who work tirelessly to reduce the numbers of both STIs and unintended pregnancies already know too well: it is time for everyone who cares about teenagers to start focusing on common sense solutions that will protect teen health and safety. Federal funding must be directed towards programs which require grantees to provide age-appropriate, medically accurate information on the value of abstinence and the benefits and effective rates of contraceptives. Federal funding should also be based on models that are proven effective in reducing unintended pregnancy or transmission of STIs, including HIV.

It is clear that government intervention is needed to promote the health of American teens. National polling shows that the vast majority of Americans want to see Congress get at the root of the unintended pregnancy and teen-STI problem by expanding access to comprehensive sex education. In fact, 75% of voters would support policies that require public schools to teach comprehensive sex education that includes information about



contraception, abstinence, and how to avoid sexually transmitted infections such as HIV / AIDS.

Despite this clear mandate from voters, Congress has wasted nearly \$1.5 billion in public funds on proven-ineffective abstinence-only programs, and has not dedicated a federal funding stream for comprehensive sex education. At the same time, studies of abstinence-only programs are nearly unanimous in their conclusions that abstinence-only programs are not working to reduce the number of unintended teen pregnancies and the spread of sexually transmitted infections; and in fact, they may be contributing to the problem. An April 2007, federally-funded study released by the Department of Health and Human Services and conducted by Mathematica Policy Research, found that when compared to a control group, students who attended abstinence-only programs were no more likely to delay sexual activity or have fewer partners. Moreover, at least 17 states have evaluated their federally funded abstinence-only programs and not one found a positive, long-term impact.

The mounting public health concerns and weight of scientific evidence demonstrate that abstinence-only programs are dangerously out of touch with the reality of teens' lives. Comprehensive sex education is the only approach that has been proven to work in delaying the onset of sexual activity and reducing risky sexual behaviors by young people. Comprehensive sex education stresses abstinence and includes age-appropriate, medically accurate information about contraception. Giving teenagers access to full information is the only way to prevent health risks for young people and encourage them to make responsible, safe and healthy decisions.

America's leading medical and public health experts support responsible, comprehensive sex education, including the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Nurses Association, the Society for Adolescent Medicine, and the American Public Health Association.

As the nation's leading reproductive health care provider and educator, Planned Parenthood commends the committee for its efforts to address the evidence and analysis provided by impacted youth, government officials and public health professionals prepared to testify before the panel. As Congress re-evaluates the federal government's failed policy on abstinence-only programs, we are eager to work with you to reach the goal of providing quality, comprehensive sexuality education in every American public school and community.

Statement of the Religious Coalition for Reproductive Choice on Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education

House of Representatives

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

Mr. Chairman and Members of the Committee:

The Religious Coalition for Reproductive Choice (RCRC) appreciates this opportunity to submit testimony on the issue of abstinence-only programs.

RCRC is an interfaith alliance of national mainstream religious organizations dedicated to ensuring access to reproductive health care and achieving reproductive justice. For nearly 35 years, RCRC has brought together national religious and religiously affiliated organizations from 15 denominations and traditions. Our membership includes the Episcopal Church, the Presbyterian Church (USA), the United Church of Christ, the United Methodist Church (the General Board of Church and Society and Women's Division, General Board of Global Ministries), the Unitarian Universalist Association; and Reform, Reconstructionist and Conservative Judaism. RCRC is a strong voice on behalf of women of color, the poor, youth and other underserved populations.

Support of religious communities for comprehensive sexuality education

Major faith traditions representing millions of Americans support comprehensive sexuality education. In keeping with our nation's constitutional guarantee of freedom of religion, they oppose civil laws that would impose specific religious views about sexuality education on all Americans.

These faith communities take seriously their duty to instill a set of religious and moral values that will help guide young people to responsible life choices. They believe that it is the role of government to ensure that the nation's youth receive the facts - unblemished by ideology - that will protect them from disease and unintended pregnancy.

RCRC has compiled excerpts of official statements of religious denominations and traditions on the importance of sexuality education. We have attached a copy of the complete document, *Religious communities and sex education: in the Home, In the Congregation, in the Schools*, for your review. But to give you a brief sense of these statements, please consider the following:

United Methodist Church:

"Children, youth and adults need opportunities to discuss sexuality and learn from quality sex education materials in families, churches and schools."

United Synagogue of Conservative Judaism

“...supports comprehensive sex education...calls upon the U.S. Congress to cease funding of abstinence only education.”

Presbyterian Church (U.S.A.)

“...supports...comprehensive school health education that includes age and developmentally appropriate sexuality education in all grades...”

Muslim Women’s League

“Sex education can be taught in a way that informs young people about sexuality in scientific and moral terms.”

Episcopal Church

“...we encourage the members of this Church to give strong support to responsible local public and private school programs of education in human sexuality.”

How did you learn about sex?

Earlier this year, RCRC put out a request to “tell us your story: how did you learn about sex?” We received well over 300 responses from individuals around the country age 17 through 94. These replies offer thoughtful reflections and often intimate, sometimes painful, glimpses into personal lives.

Among other things, we found that what you learn - or don’t learn - as a young person can have life-long repercussions. And abstinence-only programs, by their design, leave out important health information.

If I had known what sex was, I would have understood what was happening to me when I was molested by a male relative beginning at age 8. - Deborah, 45

I wish I’d learned what intercourse was and how easy it is to get pregnant. - anon, 79

I wish I’d learned about STDs and the way in which they can be transmitted. I was under the impression that oral sex was safe, since you couldn’t get pregnant from it. - Miranda, 26

The good girl/bad girl images prevalent when I was young only served to instill a great deal of fear in me, which negatively impacted on my marriage for years. - anon, 57

Communities of color

In the year 2000, RCRC was honored to have former Surgeon General Joycelyn Elders address our annual National Black Religious Summit on Sexuality. According to Dr. Elders, “our problem with sexuality has contributed more to the poverty in the black community than anything else in our society. A pregnant teenager who does not finish high school or marry has an 80% likelihood of being poor.” She challenged Congress to “stop legislating morals and start teaching responsibility.” Now, it is eight years and

\$1.3 billion of abstinence-only education later and a low income woman is four times as likely to have an unintended pregnancy, five times as likely to have an unintended birth and more than four times as likely to have an abortion as her higher-income counterpart. It is the poor and communities of color who suffer from illogical and ineffective public policy.

RCRC addresses these issues through our National Black Church Initiative, a program begun in 1997 to “break the silence” about sex and sexuality in the African American community. The initiative assists Black clergy and laity in addressing teenage pregnancy, sexuality education and reproductive health within the context of African American religion and culture. We have worked in over 700 churches providing our “Keeping It Real!” faith based sexuality education curriculum to more than 7,000 young men and women. We have a similar faith based initiative, La Iniciativa Latina (LIL), which provides model programs on sexuality and reproductive health for Latino youth, adults and clergy in the context of Latino values, religion and culture.

But the answer to the nation’s high rate of unintended pregnancy and pandemic of sexually transmitted diseases does not rest with churches and non-profit organizations alone. Public schools must be part of the solution. We are morally compelled to empower our young people with the knowledge to make responsible decisions. As Dr. Elders so succinctly stated, “Vows of abstinence break more easily than latex condoms.” According to the CDC’s National Center for Health Statistics, in 2002, the pregnancy rates for black and Hispanic teenagers were each more than two and one-half times the rate for white teenagers. This is the reality.

One of the most compelling arguments for comprehensive sexuality education was made by a member of our youth program, a proud Pentecostal Christian from rural Mississippi. In a meeting with her Member of Congress, she explained that there was no sex education in her high school and a lot of girls in her class got “knocked up.” They did not graduate from high school. They did not marry. Their futures were compromised. But the impact of these unintended pregnancies goes well beyond the lives of these young women and their children. They contribute to the economic depression of their communities.

In conclusion

We believe that being of faith means being engaged in the world. And like it or not, the facts are clear: 95 percent of Americans have sex before marriage, 80 percent of teen pregnancies are unintended and each year, 25 percent of American teens contract an STD. We want our young people to be safe. For that to happen, they must be informed by comprehensive sex education. Offering them anything less is irresponsible, dangerous and wrong.

Religious Communities and Sex Education

In the Home • In the Congregation • In the Schools

In the tradition of *WE AFFIRM*, Religious Organizations Support Reproductive Choice, the Religious Coalition for Reproductive Choice has compiled excerpts of official statements of religious denominations and traditions on the importance of sexuality education. The URL or publication for each excerpt is noted.

Major faith traditions representing millions of Americans support comprehensive sexuality education. In keeping with our nation's constitutional guarantee of freedom of religion, they oppose civil laws that would impose specific religious views about sex education on all Americans.

The Religious Coalition for Reproductive Choice is a national organization of 40 religious groups and faith traditions committed to preserving reproductive choice as an integral part of religious freedom. Perspectives in this document come from both RCRC member and non-member organizations.

American Baptist Churches in the U.S.A.

"We are committed to providing programs of education and support to guide and nurture persons making choices about singleness, marriage, divorce, remarriage and parenthood."

"We are committed to working with others for public policies and practices which enhance the status of families and empower them to do their unique work of nurturing succeeding generations of citizens."

From the:
American Baptist Policy Statement on Family Life No. 7036:6, June 1984

Central Conference of American Rabbis

"... Experience with the Reform Movement's youth programs indicates that Reform Jewish youth are as sexually active as their peers. In addition, every scientific study that breaks down participants by religion shows the same results.

"Therefore, the Central Conference of American Rabbis resolves to:
Support federal, state, provincial, and local legislation to provide for the inclusion of comprehensive and age-appropriate sexuality education in the public schools on all levels (from grade school through high school), while opposing federal, state, provincial, and local funding exclusively for abstinence-only programs."

From:
Sexuality Education, Adopted by the 114th Annual Convention of the Central Conference Of American Rabbis (organized rabbinate of Reform Judaism) March 2003

Christian Church (Disciples of Christ)

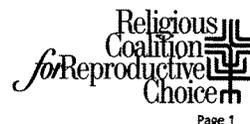
"THEREFORE, BE IT RESOLVED that the General Assembly of the Christian Church (Disciples of Christ) meeting in Ft. Worth, Texas, July 21-25, 2007, encourage all manifestations of the church to participate in proactive prevention by:
Engaging in age appropriate health and sexuality education paired with Christian spirituality for adults and youth."

From:
General Assembly Resolution NO. 0725 (SENSE-OF-THE-ASSEMBLY)
PROACTIVE PREVENTION: SEEKING COMMON GROUND ON THE ISSUE OF ABORTION

Church of the Brethren

"Education for family life is appropriate also within the public school. It is needed to supplement instruction in the home and church. Public school instruction should include information about the body, sex organs, and the reproductive system, but the emphasis should be on values and relationships. Teachers who are responsible for this task should be well trained and themselves be worthy models of mature and responsible sexuality. The church supports responsible family-life education in the public school as long as the religious commitment of all students and residents of the community is respected. Family-life education will not solve all sex, marriage, and family problems. The task requires the coordinated efforts of home, school, and church."

From:
Statement, 1983 Annual Conference Human Sexuality from a Christian Perspective, Family-Life Education 1983



Religious Communities and Sex Education

In the Home • In the Congregation • In the Schools

Episcopal Church

"Resolved, That the 73rd General Convention of the Episcopal Church strongly urge dioceses and congregations to provide a safe, hospitable environment for frank conversation with youth and young adults about human sexuality, to share and teach accurate information, and to promote dialogue, within the context of the Baptismal Covenant;"

From:
General Convention, Journal of the General Convention of...The Episcopal Church, Denver, 2000 (New York: General Convention, 2001), p. 202.

http://www.episcopalarchives.org/cgi-bin/acts/acts_resolution.pl?resolution=2000-A046

"Resolved, That we encourage the members of this Church to give strong support to responsible local public and private school programs of education in human sexuality."

From:
General Convention, Journal of the General Convention of...The Episcopal Church, Detroit, 1988 (New York: General Convention, 1989), p. 687. No. 1988-A089, 1989

Evangelical Lutheran Church of America

People of all ages need information and experience to understand and responsibly live out their sexual identity in the varied relationships of their lives -- as child or parent, sister or brother, spouse, friend, co-worker, neighbor, or stranger. This church affirms the importance of ordering society and educating youth and adults so that all might live in these relationships with mutual respect and responsibility.

Education about sexuality should emphasize monogamy, abstinence, and responsible sexual behavior, as well as practices intended to prevent the transmission of disease during sexual intercourse.

From:
Sexuality: Some Common Convictions Adopted by the Church Council of the Evangelical Lutheran Church in America on November 9, 1996.

Islam

"Islam is explicit about many aspects of human sexuality. Also, based on the numerous hadith showing the Prophet's willingness to discuss these matters openly, it should be obvious that education about matters related to sex is acceptable."

Islam, continued

"Explaining anatomy and the changes one's body experiences during puberty are essential for enabling young people to grow up with a healthy self-image. Also, in an age where sexual activity in many countries begins at an early age, Muslim adolescents must be informed to better enable them to deal with peer pressure. Sex education can be taught in a way that informs young people about sexuality in scientific and moral terms."

"Regardless of the challenges of each society, young people must be adequately informed. Also, in some Muslim communities, individuals are encouraged to marry at young ages. They need to be educated regarding sexuality prior to the marriage such that they know what to expect and can consider their options for birth control prior to consummating the marriage."

From:
An Islamic Perspective on Sexuality by Muslim Women's League
September 1999

Jewish Council for Public Affairs

The JCPA believes that public schools have an obligation to provide young people with accurate and effective sexuality education and, therefore, that current, ineffective abstinence-only-until marriage sexuality programs in public schools should be replaced by comprehensive, medically accurate, age-appropriate sexuality education that does not promote any particular religious viewpoint on sexuality.

From:
Task Force Concern on Comprehensive Sexuality Education in Public School
Adopted by the 2008 JCPA Plenum

Mennonite Church USA

"We call on pastors and congregational leaders to address issues of sexuality and appropriate sexual expression in sermons, in Sunday school classes, and in premarital counseling."

"We commit ourselves to provide Christian education about human sexuality for both young and old and to foster understanding of various means by which pregnancy can be prevented when it is not desired."

From:
Statement on Abortion Adopted by Mennonite Church USA Delegate Assembly Atlanta, Georgia
July 2003

Religious
Coalition
for Reproductive
Choice

Religious Communities and Sex Education

In the Home • In the Congregation • In the Schools

Presbyterian Church (U.S.A.)
The 206th General Assembly (1994):

1. Supports the United States Department of Health and Human Services and the U.S. Surgeon General in planning and implementing comprehensive school health education that includes age and developmentally appropriate sexuality education in all grades as a part of human growth and development curriculum for youth.

Presbyterian Church (U.S.A.), continued
2. Calls upon state legislatures to require that all schools provide comprehensive kindergarten through twelfth grade human growth and development education that is complete, factual, accurate, free of bias, and does not discriminate on the basis of sex, race, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation, or physical, mental, emotional, or learning disability.

From:
1994 Statement-PCUSA, 569-570 "The Challenge of Choice: 30 Years of Affirming Reproductive Choice; Presbyterians and Roe v. Wade, 1973 to 2003" November/December 2002

Reformed Church in America
General Synod recommended the following:
To request that regional synods and classes "develop regional and local strategies for sexuality education."

From:
Summary of General Synod Statements on Abortion (Minutes of the General Synod 1990, p. 101).

Unitarian Universalist Association
"WHEREAS the REAL Act (Responsible Education about Life) will establish the first ever federal funding stream for medically accurate, comprehensive sexuality education;

THEREFORE BE IT RESOLVED that the delegates of the 2007 General Assembly of the Unitarian Universalist Association call upon Congress to support passage of the REAL and PATHWAY Acts and urge member congregations and individual Unitarian Universalists to immediately petition congressional representatives to co-sponsor these bills;"

From:
Support Comprehensive Sexuality Education Legislation
2007 Action of Immediate Witness

Unitarian Universalist Association, continued
"Be It Further Resolved, that the 1994 General Assembly of the Unitarian Universalist Association urges member congregations to advocate the availability of comprehensive, objective, unbiased, up-to-date, age-appropriate, sexuality education curricula in public schools, including information about:

- The reproductive system and its functions;
- The proper use of all forms of contraception, including the option of abstinence;
- Sexually transmitted diseases, their prevention and treatments;
- Sexual abuse, sexual assault, sexual harassment, rape (including date rape), and incest, as well as their prevention and treatment through counseling, information, and resources;
- Pregnancy counseling and options including information about organizations such as Planned Parenthood and Birthright."

From:
Sexuality Education in Public Schools
1994 Resolution of Immediate Witness

United Church of Christ
IV. A STATEMENT OF CHRISTIAN CONVICTION

5. "Sex education beginning early in elementary school, as called for by the Surgeon General, is a major component of the effort to contain the AIDS pandemic. Curricula need to address the physical, social and ethical nature of human sexuality and teach skills for responsible personal decision-making."

6. "Government funding of research, service, education, treatment and prevention must become a global priority."

From:
A Pronouncement Health and Wholeness in the Midst of a Pandemic,
Adopted by the Sixteenth General Synod June 25-30, 1987

The United Methodist Church
"We recognize the continuing need for full, positive, age-appropriate and factual sex education opportunities for children, young people, and adults. The Church offers a unique opportunity to give quality guidance and education in this area."

From:
Human Sexuality The Book of Discipline of The United Methodist Church 2004

Religious
Coalition
for Reproductive
Choice

Religious Communities and Sex Education

In the Home • In the Congregation • In the Schools

United Methodist Church, continued

"Children, youth, and adults need opportunities to discuss sexuality and learn from quality sex education materials in families, churches and schools."

From:
Pornography and Sexual Violence Adopted 1988; Revised and Adopted
2000 The Book of Resolutions of the United Methodist Church
2004

The United Synagogue of Conservative Judaism

THEREFORE, BE IT RESOLVED that United Synagogue supports comprehensive sex education; Encourages parents to talk to their children about sexuality and sexual health in a Conservative Jewish context; Calls upon the U.S. Congress to cease funding of abstinence only education; Opposes funding of abstinence only education on federal, state, provincial and local levels; Encourages the support of the inclusion of components of age appropriate comprehensive sex education in public schools; and encourages components of age appropriate comprehensive sex education in Solomon Schechter schools, Camps Ramah, Kadima, USY and Koach.

The United Synagogue of Conservative Judaism, continued

BE IT FURTHER RESOLVED that United Synagogue will develop age-appropriate educational materials to be used in day schools, synagogue schools, youth groups and homes.

From:
Comprehensive Sex Education (2007)
Resolution passed at the international biennial convention 2007

National Council of the Churches of Christ in the U.S.A.

"The Committee assists participating denominations and organizations in:

- The life-long nurturing task of families
- Strengthening marriage, parenting and familial living through programs of education and leader development
- Addressing human sexuality throughout the life cycle
- Supporting families in a time of many cultural changes
- Providing remedial strategies for problems affecting families, preventative strategies for enhancing the health of families, and advocacy regarding public policies that impact families."

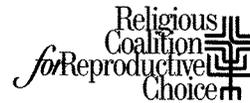
From:
Committee on Family Ministries and Human Sexuality, Education and Leadership Ministries Committee Mission

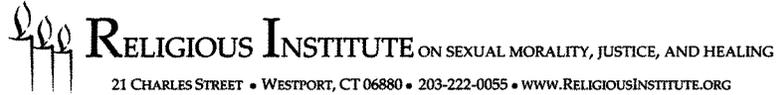
Religious Coalition for Reproductive Choice Member Organizations*

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Statement on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education
Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008

The Committee will hear from many organizations the strong public health arguments that support sexuality education and oppose abstinence-only-until marriage programs. As religious leaders, we ask you to also consider the moral and ethical foundations for supporting comprehensive sexuality education for the nation's youth.

As religious leaders, we believe young people should learn about their sexuality from their parents, faith communities, and school-based programs, not primarily from their peers or the entertainment media. We believe that programs must be age-appropriate, medically accurate, and truthful.

Young people need help in order to develop their capacity for moral discernment and a freely informed conscience. Education that respects and empowers young people has more integrity than many of the currently funded abstinence-only programs that are based on incomplete information, fear, and shame. Programs that teach abstinence exclusively and withhold information about pregnancy and sexually transmitted disease prevention fail too many of our young people.

Our sacred texts and theological commitments call us to truth telling. Young people need to know that "there is a time to embrace and a time to refrain from embracing" but they also require the skills to make moral and healthy decisions about relationships for themselves now and in the future. We call on you to support comprehensive sexuality education programs that honor the diversity of religious and moral values in the community. Such education teaches that decisions about sexual behaviors should be based on moral and ethical values, as well as considerations of physical and emotional health. It affirms the goodness of sexuality while acknowledging its risk, consequences and dangers, and it introduces with respect the differing sides of controversial issues. It includes information about abstinence, contraception, and STD prevention. There is an urgent need for a federal sexuality education program that reaches all young people, regardless of income, class, ethnicity, or sexual experience or orientation.

For more than 40 years, mainstream faith based traditions have called for federal and local support for sexuality education. In 1968, the National Council of Churches of Christ, the Synagogue

Council of America, and the United States Catholic Conference issued a joint call for churches and synagogues to become actively involved in sexuality education within their congregations and their communities. Today, more than 13 denominations have policies supporting sexuality education in their schools, including the Union for Reform Judaism, the United Church of Christ, the United Methodist Church, and the Church of the Brethren.

It is time for the federal government to support comprehensive sexuality education programs for youth and to cease funding programs that are not only ineffective but may put our children and teenagers at risk - for disease, for short changed futures, for denial of the gift of their sexuality. It is time to provide all our young people with accurate education that respects the diversity of values in a community. It is indeed a time to speak and a time to act. May our religious voices help you understand that it is also the only moral response.

Signed:

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Position paper

Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine

Summary

Abstinence from sexual intercourse represents a healthy choice for teenagers, as teenagers face considerable risk to their reproductive health from unintended pregnancy and sexually transmitted infections (STIs) including infection with the human immunodeficiency virus (HIV). Remaining abstinent, at least through high school, is strongly supported by parents and even by adolescents themselves. However, few Americans remain abstinent until marriage, many do not or cannot marry, and most initiate sexual intercourse and other sexual behaviors as adolescents. Abstinence as a behavioral goal is not the same as abstinence-only education programs. Abstinence from sexual intercourse, while theoretically fully protective, often fails to protect against pregnancy and disease in actual practice because abstinence is not maintained.

Providing “abstinence only” or “abstinence until marriage” messages as a sole option for teenagers is flawed from scientific and medical ethics viewpoints. Efforts to promote abstinence should be based on sound science. Although federal support of abstinence-only programs has grown rapidly since 1996, the evaluations of such programs find little evidence of efficacy in delaying initiation of sexual intercourse. Conversely, efforts to promote abstinence, when offered as part of comprehensive reproductive health promotion programs that provide information about contraceptive options and protection from STIs have successfully delayed initiation of sexual intercourse. Moreover, abstinence-only programs are ethically problematic, being inherently coercive and often providing misinformation and withholding information needed to make informed choices. In many communities, abstinence-only education (AOE) has been replacing comprehensive sexuality education. In some communities, AOE has become the basis for suppression of free speech in schools. Abstinence-only education programs provide incomplete and/or misleading information about contraceptives, or none at all, and are often insensitive to sexually active teenagers. Federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning youth,

as federal law limits the definition of marriage to heterosexual couples.

Schools and health care providers should encourage abstinence as an important option for teenagers. “Abstinence-only” as a basis for health policy and programs should be abandoned.

Background

Abstinence from sexual intercourse is an important behavioral strategy for preventing STIs and unwanted pregnancy among adolescents and adults. Sexually active teenagers face considerable risk to their reproductive health from unintended pregnancy and STIs including infection with HIV. Although health professionals often are primarily concerned with the potentially serious consequences of adolescent sexual behavior, we also recognize that sexuality is integral to human nature and has many positive mental health consequences.

Abstinence, as the term is used by program planners and policymakers, is often not clearly defined in behavioral terms, nor is the term used consistently. Abstinence may be defined in behavioral terms, such as “postponing sex” or “never had vaginal sex,” or refraining from further sexual intercourse if sexually experienced. Programmatically, abstinence is also frequently defined in moral terms, using language such as “chaste” or “virgin,” and framing abstinence as an attitude or a commitment in addition to a behavior [1]. Federal regulations for state abstinence education funding adopt a moral definition of abstinence, requiring that abstinence education “teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity” [2].

Although abstinence until marriage is the goal of many abstinence policies and programs, few Americans wait until marriage to initiate sexual intercourse. Recent data indicate that the median age at first intercourse for women was 17.4 years, whereas the median age at first marriage was 25.3 years [3,4]. For men, the corresponding median age at first intercourse was 17.7 years, whereas the age at first marriage was 27.1 years [3,4].

Although advocates of abstinence-only government policy have suggested that psychological harm is a consequence of sexual behavior during adolescence, there are no scientific data suggesting that consensual sex between adolescents is harmful. Mental health problems are associated with early sexual activity, but these studies suggest that sexual activity is a consequence not a cause of these mental health problems [5–8]. We know little about how the decision to remain abstinent until marriage may promote personal resilience or sexual function/dysfunction in adulthood.

Opinion polls suggest considerable support for abstinence as a public health goal, but also indicate strong support for education about contraception and for access to contraception for sexually active teenagers [9]. Most teens (94%) and adults (91%) think it is somewhat or very important for society to give teens a strong message that they should not have sex until they are at least out of high school [9]. However, most adults (75%) and teens (81%) want young people to receive more information about both abstinence and contraception [9].

Current federal policy and programs

The federal government has greatly expanded support for abstinence-only programs since 1996. This support includes funding to states provided under Section 510 of the Social Security Act, originally enacted in 1996, and under Community-Based Abstinence Education projects, funded through the Special Projects of Regional and National Significance (SPRANS) program established in 2000. These programs focus on a restricted vision of abstinence promotion and prohibit disseminating information on contraceptive services, sexual orientation and gender identity, and other aspects of human sexuality [10]. Federal funding language promotes a specific moral viewpoint, not a public health approach. These federal programs present questionable and inaccurate opinions as fact, and specifically prohibit information about healthy alternatives to abstinence such as condom and other contraceptive use.

Section 510 programs must have as their "exclusive purpose" the promotion of abstinence outside of marriage for people of any age and may not in any way advocate contraceptive use or discuss contraceptive methods except to emphasize their failure rates [10]. Section 510 provides an eight-point definition of abstinence-only education. Under Section 510, abstinence education is defined as *an educational or motivational program which:*

1. has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
2. teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;

3. teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
4. teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;
5. teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
6. teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
7. teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
8. teaches the importance of attaining self-sufficiency before engaging in sexual activity.

The initial implementation of Section 510 has allowed funded programs to emphasize different aspects of these eight points as long as the program did not contradict any of them. The intent of the SPRANS program has been more rigid: to create "authentic" abstinence-only programs, in response to concerns that states were using funds for "soft" activities such as media campaigns instead of direct classroom instruction and were targeting younger adolescents. Programs funded under SPRANS must teach all eight components of the federal definition, they must target 12–18-year-olds, and, except in limited circumstances, they cannot provide young people they serve with information about contraception or safer-sex practices, even with their own nonfederal funds. Funding for this program also bypasses the 510 program's state approval processes and makes grants directly to community-based organizations, including faith-based organizations. Virtually all the growth in funding since FY2001 has come in the SPRANS program.

Evaluations of abstinence-only education and comprehensive sexuality education programs in promoting abstinence

To demonstrate efficacy, evaluations of specific abstinence promotion programs must address a variety of methodological issues including clear definitions of abstinence, appropriate research design, measurement issues including social desirability bias, the use of behavioral changes and not just attitudes as outcomes, and biological outcomes such as STIs [11]. Two recent reviews [12,13] have evaluated the evidence supporting abstinence-only programs and comprehensive sexuality education programs designed to promote abstinence. Neither review found scientific evidence that abstinence-only programs demonstrate efficacy in delaying initiation of sexual intercourse. Likewise, research on adolescents taking virginity pledges suggest that failure rates

for the pledge are very high, especially when biological outcomes such as STIs are considered [14]. Although it has been suggested that abstinence-only education is 100% effective, these studies suggest that, in actual practice, efficacy may approach zero.

A recent Congressional committee report [15] found evidence of major errors and distortions of public health information in common abstinence-only curricula. Eleven of the 13 curricula contained false, misleading, or distorted information about reproductive health, including inaccurate information about contraceptive effectiveness and risks of abortion. The report found that several of the curricula handle stereotypes about girls and boys as scientific fact (e.g., portraying girls as weak or dependent or men as sexually aggressive and lacking emotional depth) or blur religious and scientific viewpoints.

A rigorous national evaluation of abstinence-only education is currently being conducted with support from the Department of Health and Human Services's Office of the Assistant Secretary for Planning and Evaluation [16].

Adverse impact of abstinence-only policies on sexuality education and other public programs

Although health professionals have broadly supported comprehensive sexuality education [17–20], increasingly abstinence-only education is replacing more comprehensive forms of sex education in the nation's schools. Recent reports describe teachers and students being censured for responding to questions or discussing sexuality topics that are not approved by the school administrators [21]. Data from the School Health Policies and Programs Study in 2000 found that 92% of middle and junior high schools and 96% of high schools taught abstinence as the best way to avoid pregnancy, HIV, and STIs; only 21% of middle schools and 55% of high schools taught how to correctly use a condom [22]. Between 1988 and 1999, there was a sharp decline in the percentage of teachers who supported teaching about birth control, abortion, and sexual orientation and in the percentages who actually taught these subjects [23]. In 1999, 23% of secondary school sexuality education teachers taught abstinence as the only way to prevent pregnancy and STIs, compared with only 2% who had done so in 1988. In 1999, one-quarter of sex education teachers said they were prohibited from teaching about contraception. Similar declines in school-based sexuality education are reported by teens [3]. In 2002, about one-third of teens 15–19-year-olds reported not having received any formal instruction about methods of birth control before turning 18.

Likewise, federal funding requirements in the Title X program and for HIV/AIDS prevention programs have increasingly focused on abstinence promotion [24]. Such requirements have redirected efforts from other important objectives.

Abstinence-only policies by the U.S. government have

also influenced global HIV prevention efforts. The President's Emergency Plan for AIDS Relief (PEPFAR), focusing on 15 HIV-afflicted countries in sub-Saharan Africa, the Caribbean and Asia, requires grantees to devote at least 33% of prevention spending to abstinence-until-marriage programs. The U.S. government policy has become a source for misinformation and censorship in these countries and also may have reduced condom availability and access to accurate HIV/AIDS information [25].

Abstinence-only sex education and sexually active and GLBTQ youth

Programs geared to adolescents who have not yet engaged in coitus systematically ignore sexually experienced adolescents, a group with different reproductive health needs who likely require a different approach to abstinence education [26]. Sexually experienced teens need access to complete and accurate information about contraception, legal rights to health care, and ways to access reproductive health services, none of which are provided in abstinence-only programs.

Likewise, federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning (GLBTQ) youth because federal law limits the definition of marriage to heterosexual couples. Approximately 2.5% of high school youth self-identify as gay, lesbian or bisexual [27] and as many as one in 10 teenagers struggle with issues regarding sexual orientation [28]. GLBTQ adolescents often are fearful of rejection or discrimination due to their orientation; they are frequently subjected to harassment, discrimination, and violence. Homophobia may contribute to health problems such as suicide, feelings of isolation and loneliness, HIV infection, substance abuse and violence among GLBTQ youth [29]. Abstinence-only sex education classes are unlikely to meet the health needs of GLBTQ youth, as they largely ignore issues surrounding homosexuality (except when discussing transmission of HIV/AIDS), and often stigmatize homosexuality as deviant and unnatural behavior [30].

The human right to sexual health information

Although abstinence is often presented as the moral choice for teenagers, the current federal approach to abstinence-only funding raises serious ethical and human rights concerns. Abstinence-only education policies have implications at a public and individual level. Access to complete and accurate HIV/AIDS and sexual health information is a basic human right and is essential to realizing the human right to the highest attainable standard of health. Governments have an obligation to provide accurate information to their citizens and eschew the provision of misinformation; such obligations extend to state-supported health education and health care services [31]. These legal guar-

antees are found in a number of international treaties, which provide that all people have the right to “seek, receive and impart information and ideas of all kinds,” including information about their health [32–34]. Access to accurate health information is a basic human right that has also been described in international statements on reproductive rights such as the Programme of Action of the International Conference on Population and Development—Cairo, 1994 [35]. These international treaties and statements clearly define the important responsibility of governments to provide accurate and complete information on sexual health to their citizens.

Ethical obligations of health care providers and health educators

Health care providers and health educators have ethical obligations to provide accurate health information. Patients and students have rights to accurate and complete information from health professionals. Health care providers may not withhold information from a patient in order to influence their health care choices. It is unethical to provide misinformation or withhold information about sexual health that teens need in order to protect themselves from STIs and unintended pregnancy. Withholding information on contraception to influence adolescents to become abstinent is inherently coercive and may cause teenagers to use ineffective (or no) protection against pregnancy and STIs. Current federal abstinence-only legislation is ethically problematic, as it excludes accurate information about contraception, misinforms by overemphasizing or misstating the risks of contraception, and fails to require the use of scientifically accurate information while promoting approaches of questionable value. Additionally, “abstinence until marriage” curricula are commonly provided to those teens who are already sexually experienced and to GLBTQ youth, ignoring their pressing needs for accurate information to protect their health. These ethical obligations to provide complete and accurate information also are the basis for the strong support among medical professionals for comprehensive sexuality education in schools [17–19] and recent state legislative attempts to require that these sexuality education programs provide medically accurate information (e.g., Cal. Education Code § 51933).

Positions of the Society for Adolescent Medicine (SAM)

- Abstinence is a healthy choice for adolescents. The choice for abstinence should not be coerced. SAM supports a comprehensive approach to sexual risk reduction including abstinence as well as correct and consistent use of condoms and contraception among teens who choose to be sexually active.

- Efforts to promote abstinence should be provided within health education programs that provide adolescents with complete and accurate information about sexual health, including information about concepts of healthy sexuality, sexual orientation and tolerance, personal responsibility, risks of HIV and other STIs and unwanted pregnancy, access to reproductive health care, and benefits and risks of condoms and other contraceptive methods.
- Individualized counseling about abstinence and sexual risk reduction are important components of clinical care for teenagers.
- Health educators and clinicians caring for adolescents should promote social and cultural sensitivity to sexually active youth and gay, lesbian, bisexual, transgendered and questioning youth. Health education curricula should also reflect such sensitivity.
- Governments and schools should eliminate censorship of information related to human sexual health.
- Government policy regarding sexual and reproductive health education should be science-based. Governments should increase support for evaluation of programs to promote abstinence and reduce sexual risk, including school-based interventions, media efforts and clinic-based interventions. Such evaluations should utilize rigorous research methods and should assess the behavioral impact as well as STIs and pregnancy outcomes. The results of such evaluations should be made available to the public in an expeditious manner.
- Current U.S. federal law and guidelines regarding abstinence-only funding are ethically flawed and interfere with fundamental human rights. Current federal funding requirements as outlined in Subsections A–H of Section 510 of the Social Security Act should be repealed. Current funding for abstinence-only programs should be replaced with funding for programs that offer comprehensive, medically accurate sexuality education.

Endorsement

This position paper has been endorsed by the American College Health Association.

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April 21, 2008

Dear Committee on Oversight and Government Reform:

We are the teen editors of *Sex, Etc.*, a national magazine and Web site, written by teens for teens on sexuality and sexual health. As teen advocates of comprehensive sexuality education, we are glad the committee is reviewing federal funding for abstinence-only-until-marriage programs.

We know that abstinence is the most effective way to prevent pregnancy and the spread of sexually transmitted diseases (STDs), and we think it's an important part of sexuality education. But by focusing only on abstinence, the failure rates of condoms and not offering accurate information to teens, abstinence-only-until-marriage programs leave teens in the dark.

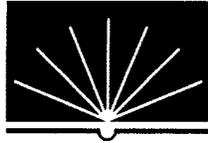
Nearly half of all 15-to 19-year-olds have had sex, according to the Guttmacher Institute. At Sexetc.org, we hear from many of these teens who don't have medically-accurate, unbiased information about birth control and protecting themselves from STDs. We get questions and comments from teen that range from "Can drinking Mountain Dew prevent pregnancy?" to "My boyfriend says I won't get pregnant if he only puts it in 95 percent." And sadly, most teens who write in to ask questions of our adult experts are only worried about pregnancy and not STDs, which might be one reason why an estimated one in four girls has an STD, according to the Centers for Disease Control and Prevention.

Teens—whether they're choosing to have sex or not—deserve accurate information about their bodies, birth control, pregnancy, sexually transmitted diseases and making decisions about sex. Sexuality is a natural and normal part of being human. And we know that the more information teens are given the more likely they are to choose to wait to have sex until they are ready to take responsibility for their sexual health.

This hearing is an important initial step in improving sexual health programs for teens. And we hope Congress chooses to fund comprehensive sexuality education that supports teens like us in making healthy decisions.

Sincerely,
The Editors of *Sex Etc.*





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April 21, 2008

Honorable Henry A. Waxman, Chair
Committee on Oversight and Government Reform
U.S. House of Representatives

Re: Abstinence-Only-Until-Marriage Programs
Statement for the record for April 23, 2008 hearing

Dear Chairman Waxman and members of the committee,

The Sargent Shriver National Center on Poverty Law is a national law and policy center that takes action to end poverty through policy development, communications and impact litigation. We are a multi-issue organization with expertise in a broad range of issues that affect low-income people of all ages, including health and education. We are writing to support the attached statement of the National Coalition to Support Sexuality Education (NCSSE) on the need for comprehensive sexuality education and to end federal funding of abstinence-only-until-marriage programs.

If you have any questions or concerns do not hesitate to contact me at 312-263-3830 ext. 238 or wendypollack@povertylaw.org. Thank you for your consideration.

Wendy Pollack
Director, Women's Law & Policy Project
Sargent Shriver National Center on Poverty Law

Statement of the National Coalition to Support Sexuality Education (NCSSE) on the Public Health and Ethical Concerns with Abstinence-Only-Until-Marriage Programs and the Need for Comprehensive Sexuality Education Committee on Oversight and Government Reform Submitted for the Record April 23, 2008

The National Coalition to Support Sexuality Education (NCSSE) is a coalition of over 155 leading national organizations that support age-appropriate, medically accurate sexuality education for all children and youth in the United States. Members of NCSSE represent a broad constituency of education advocates and professionals, health care professionals, religious leaders, child and health advocates, and policy organizations.

As organizations concerned about the health and education of our nation's young people, the undersigned organizations of NCSSE wish to share with the Committee our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight to bring an end to federal funding for these ineffective programs.

There is a true need for evidence-based, comprehensive sexuality education that meets the needs of all youth, and fully informs them about such topics as abstinence and contraception, among a variety of other topics. We are committed to using sound scientific evidence and promoting the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years even though no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally funded study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-marriage programs have achieved their goal to increase rates of sexual abstinence--the entire supposed purpose of the programs. This report followed the findings from 13 states that have evaluated their own

Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them to be harmful.

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, which discussed what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.

Furthermore, a report released by the non-partisan Government Accountability Office (GAO) in November 2006 added additional evidence to the already significant body of

knowledge that abstinence-only-until-marriage programs are providing very little oversight and have few mechanisms in place to measure the effectiveness of the programs.

These programs are not supported by any of the leading national or international public health and medical organizations. Every major medical and public health organization, many of whom are NCSSE members, supports a comprehensive approach to sexuality education. These include the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, the American Public Health Association, the Institute of Medicine, the National Institutes of Health, and the Society for Adolescent Medicine, among others. Several, including the American Public Health Association, the Institute of Medicine, and the Society for Adolescent Medicine, have gone so far as to call for the repeal of current abstinence-only-until-marriage programs and funding.

In addition, on November 21, 2007, ten public-health researchers sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid urging Congress to reduce or eliminate federal support for abstinence-only-until-marriage programs, in part because the programs have "multiple scientific and ethical errors." We strongly support the researchers' conclusion that abstinence-only-until-marriage programs withhold "potentially life-saving information" about birth control and ignore the health needs of lesbian, gay, bisexual, and transgender (LGBT) youth. The letter focused on the large body of evidence showing that abstinence-only-until-marriage programs are ineffective in getting young people to delay sexual initiation, noting that, "Recent reports in professional publications by the authors of this letter have highlighted multiple deficiencies in federal abstinence-only programs."

America's youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.



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**Statement of Sexuality Information and Education Council of the United States (SIECUS)
on the Public Health and Ethical Concerns regarding Abstinence-Only-Until-Marriage
Programs and the Need for Comprehensive Sexuality Education**

**Committee on Oversight and Government Reform
Submitted for the Record
April 23, 2008**

SIECUS, the Sexuality Information and Education Council of the United States, has served as a strong national voice for sexuality education, sexual health, and sexual rights for over 40 years. SIECUS affirms that sexuality is a fundamental part of being human, one that is worthy of dignity and respect. We advocate for the right of all people to accurate information, comprehensive education about sexuality, and sexual health services. SIECUS works to create a world that ensures social justice and sexual rights.

As an organization concerned about the health and education of our nation's young people, we wish to inform you of our public health and ethical concerns regarding abstinence-only-until-marriage programs and urge you to provide the necessary oversight so as to bring an end to federal funding for these ineffective programs. SIECUS is pleased with the Committee's decision to hold this critically important hearing. Abstinence-only-until-marriage programs have been sold as public health and social welfare programs; however, these programs have used billions of federal taxpayer dollars to push a narrow, conservative agenda above all else—above public health, medical opinion, scientific evidence, and basic human rights. This policy has been promoted above what the evidence tells us is the most effective way to help people make healthy life decisions in the long term and ensure that they live full and productive lives. There is a true need for evidence-based comprehensive sexuality education that meets the needs of all youth and fully informs them about abstinence and contraception, among a variety of other topics. We are committed to sound science and the health and welfare of our nation's youth and we wish to express our profound concern with the continuation of any funding for abstinence-only-until-marriage programs.

Scientific evidence does not support abstinence-only-until-marriage programs. These programs have been funded by the federal government for over 25 years and yet, no study in a professional peer-reviewed journal has found them to be broadly effective. Most recently, a federally funded study of abstinence-only-until-marriage programs was conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services. Released in April 2007, the study found no evidence that abstinence-only-until-marriage programs have achieved their goal of increasing rates of sexual abstinence—the entire supposed purpose of the programs. Students in the abstinence-only-until-marriage programs had a similar age of first sex and similar numbers of sexual partners as their peers who were not in the programs. In addition, the average age of sexual debut was the same for the abstinence-only-until-marriage participants and those in the control groups (14 years, 9 months).¹

This report followed on the findings from 13 states that have evaluated their own Title V abstinence-only-until-marriage programs with results ranging from finding the programs ineffective to finding them harmful. For example, the 2004 evaluation completed in President Bush's home-state of Texas included five self-selected "abstinence education" contractors who participated in a study conducted by researchers at Texas A&M University. Analysis found that there were "*no significant changes*" in the percentages of students who "pledg[ed] not to have sex until marriage."² In addition, the analysis revealed that the percentage of students reporting having ever engaged in sexual intercourse increased for nearly all ages between 13 and 17. One of the study's investigators said, "we didn't see any strong indications these programs were having an impact in the direction desired. . . these programs seem to be much more concerned about politics than kids, and we need to get over that."³

Furthermore, in early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007*, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, discussing what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report looked at both abstinence-only-until-marriage programs and comprehensive sexuality education and found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior while finding that comprehensive sexuality education programs were effective.⁴

- The study found that no evidence to support the continued investment of public funds.

"In sum, studies of abstinence programs have not produced sufficient evidence to justify their widespread dissemination. . . Only when strong evidence demonstrates that particular programs are effective should they be disseminated more widely."

- The study also found that, to date, no abstinence-only-until-marriage program that is of the type eligible for funding by the federal government has been found in methodologically rigorous study to positively impact teen sexual behavior.

"At present, there does not exist any strong evidence that any abstinence program delays the initiation of sex, hastens the return to abstinence, or reduces the number of sexual partners. In addition, there is strong evidence from multiple randomized trials demonstrating that some abstinence programs chosen for evaluation because they were believed to be promising actually had no impact on teen sexual behavior."

- In contrast, the study found that a substantial majority of the comprehensive sexuality education programs are effective. The positive effects found include delaying the initiation of sex, reducing the frequency of sex, reducing the number of sexual partners and increasing condom or contraceptive use.

"Two-thirds of the 48 comprehensive programs that supported both abstinence and the use of condoms and contraceptives for sexually active teens had positive behavioral effects."

- In addition, comprehensive sexuality education programs were found to be well suited for widespread replication and dissemination.

"When three [comprehensive] programs were replicated with fidelity in different locations throughout the United States, but in the same type of setting, the original

positive effects were confirmed. This is very encouraging and suggests that effective programs can remain effective when they are implemented with fidelity by other people in other communities with similar groups of young people.”

The study also found that, contrary to the statements of many advocates for abstinence-only-until-marriage programs, comprehensive sexuality education does not increase sexual activity nor does it provide a confusing or “mixed message” to adolescents.⁵ In addition, Dr. Kirby found that the benefits of sexuality education extend to several areas of decision-making skills for adolescents:⁶

“Virtually all of the comprehensive programs also had a positive impact on one or more factors affecting behavior. In particular, they improved factors such as knowledge about risks and consequences of pregnancy and STD; values and attitudes about having sex and using condoms or contraception; perception of peer norms about sex and contraception; confidence in the ability to say ‘no’ to unwanted sex, to insist on using condoms or contraception, or to actually use condoms or contraception; intention to avoid sex or use contraception; and communication with parents or other adults about these topics. In part by improving these factors, the programs changed behavior in desired directions.”

A report released by the non-partisan Government Accountability Office (GAO) in November 2006 confirms that there are few mechanisms in place to measure the effectiveness of abstinence-only-until-marriage programs and questions the oversight of these programs. The report documents the actions of the U.S. Department of Health and Human Services (HHS) and finds, in part, that:

- The Administration for Children and Families (ACF), the division of HHS responsible for the vast majority of the programs, including Community-Based Abstinence Education grantees, does not review its grantees’ materials for scientific accuracy and does not require grantees to review their own materials for scientific accuracy.
- ACF has a total lack of appropriate and customary measurements to determine if funded programs are actually working. ACF took over the administration of these programs in 2001 and promptly gutted evidence-based measures such as determining whether programs reduced teen pregnancy rates. In their place, ACF now only requires grantees to provide non-health based measures, such as how many young people were in the program and the number of hours the program operated.

Furthermore, these programs are not supported by any of the leading public health and medical organization in this country or abroad. Every major medical and public health organization supports a comprehensive approach to sexuality education. These include the American Academy of Pediatrics, the American Medical Association, the American Nurses Association, the American Public Health Association, the Institute of Medicine, the National Institutes of Health, and the Society for Adolescent Medicine, among others. Several, including the American Public Health Association, the Institute of Medicine, and the Society for Adolescent Medicine, have gone so far as to call for the repeal of current abstinence-only-until-marriage programs and funding.

In addition, on November 21, 2007, ten public-health researchers sent a letter to House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid urging Congress to reduce or eliminate federal support for abstinence-only-until-marriage programs, in part because the programs have “multiple scientific and ethical errors.” We strongly support the researchers’ conclusion that abstinence-only-until-marriage programs withhold “potentially life-saving information” about birth control and

ignore the health needs of lesbian, gay, bisexual, and transgender (LGBT) youth. The letter focused on the large body of evidence showing that abstinence-only-until-marriage programs are ineffective in getting young people to delay sexual initiation, noting that, “Recent reports in professional publications by the authors of this letter have highlighted multiple deficiencies in federal abstinence-only programs.” The researchers noted at the time that, “. . . we are surprised and dismayed that the Congress is proposing to extend and even increase funding for these programs.” They continued by concluding that “We strongly urge the U.S. Congress to reconsider federal support for abstinence-only education programs and policies.”

It is noteworthy that 17 states have declined participation in the federal Title V abstinence-only-until-marriage program. Acting on principle and in the best interest of their youth, many of these governors have rebuffed a source of much needed revenue because they concluded that these unduly restrictive and ideologically driven programs were, at a minimum, ineffective and, at worst, harmful. In states such as California, Maine, and New Jersey, it is essentially illegal to teach these programs in publicly funded schools. Of Arizona’s decision to no longer participate in the program, Governor Janet Napolitano said that the state should not fund “and educational system that doesn’t educate.” John Auerbach, Massachusetts’s state commissioner of public health, stated, “We don’t believe that the science of public health is pointing in the direction of very specific and narrowly defined behavioral approaches like the one that is mandated by this funding.” Ned Calonge, Chief Medical Officer of the Colorado Department of Public Health and Environment, asked, “Why would we spend tax dollars on something that doesn’t work? That doesn’t make sense to me. Philosophically, I am opposed to spending government dollars on something that’s ineffective. That’s just irresponsible.” And, upon turning back his state’s Title V abstinence-only-until-marriage funding, Virginia’s Governor Tim Kaine noted, “Studies have shown that . . . comprehensive sex education programs have been successful in delaying initiation of sex and preventing teen pregnancy.” This chorus from the states is sending the message to policymakers in Washington to end the extremism of abstinence-only-until-marriage programs and help states fund real solutions to helping young people.

We also have several ethical concerns with abstinence-only-until-marriage programs. Federally funded abstinence-only-until-marriage programs must adhere to a strict eight-point definition⁷ and even stricter federal guidelines. Many aspects of the definition and guidelines are in direct opposition to the goals and tenets of a public health framework, which seeks to help young people navigate adolescence and become healthy adults. Though they are often presented to communities and school boards as programs designed to prevent pregnancy or sexually transmitted diseases (STDs), including HIV/AIDS, abstinence-only-until-marriage programs consistently ignore many youth who are most in need of information, education, and skills training and censor information vital to the health of all young people.

Abstinence-only-until-marriage-programs do a serious disservice to young people as they provide medically inaccurate information and consistently disparage contraception, particularly condoms. This only serves to leave youth woefully unprepared when they do become sexually active and to set back the public health gains the United States has made thus far. In December of 2004, now-Chairman of the Oversight and Government Reform Committee, Representative Henry Waxman released a report documenting serious problems with abstinence-only-until-marriage curricula used in Community-Based Abstinence Education-funded programs. The report reveals an utter disregard for basic public health data that resulted in gross medical inaccuracies being taught to youth. For example, several curricula repeatedly reference a discredited study on condom effectiveness that said

condoms fail approximately 30% of the time. Others told young people that HIV could be transmitted through tears and sweat.

As it has been interpreted by Congress, the federal definition of “abstinence education” prohibits federally funded programs from discussing the effectiveness of condoms and contraception in preventing unintended pregnancy and disease transmission. Because the first element requires that federally funded abstinence-only-until-marriage programs have as their “exclusive purpose” promoting abstinence outside of marriage, programs may not in any way advocate contraceptive use or discuss contraceptive methods except to emphasize their failure rates. Some programs actually discourage the use of contraception, especially condoms, and many programs give teens medically inaccurate information about and exaggerated failure rates.⁸

For example, *Why kNOW*, one curriculum widely used in federally funded programs, provides distorted information about condoms and their effectiveness. One of the lesson plans in the curriculum instructs teachers to construct an eighteen-foot long Speedy the Sperm© out of what essentially amounts to a pillow and a piece of rope. Speedy is designed to be exactly 450 times the size of a penny, because “the HIV virus is 450 times smaller than a human sperm.” (*Why kNOW*, 8th grade and high school, p. 96) The teacher is told to stretch Speedy© out to his full length, then hold up a penny and ask the students: “If the condom has a failure rate of 14% in preventing Speedy© from getting through to create a new life, what happens if this guy (the penny) gets through? You have a death: your own.” (*Why kNOW*, 8th grade and high school, p. 96) While the curriculum does not actually state that condoms may have holes large enough for the HIV virus to travel through, this is clearly the implication behind this activity. The suggestion that condoms have large holes is a myth that continues to be used in abstinence-only-until-marriage programs to discourage their use.

WAIT (Why Am I Tempted) Training, another of the most widely used curricula in federally funded programs states:

“[Students] need to know that, when used every time, condoms at best only provide a 50% reduction in the transmission rates of syphilis, gonorrhea and Chlamydia. They should be told that condoms do not appear to provide any protection from HPV, (which causes 99% of all cervical cancer).” (*WAIT Training*, p. 21)

“While in ‘theory’ teen use of contraception every time sounds good, it isn’t realistic to expect. Thus, a condom is actually setting a teen up for failure when we realize, as adults, that condoms won’t be used ‘consistently and correctly’ every single time.” (*WAIT Training*, p. 36)

In reality, according to the Centers for Disease Control and Prevention (CDC), latex condoms, when used consistently and correctly, are highly effective in preventing the transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other STDs, including gonorrhea, Chlamydia, trichomoniasis, genital herpes, syphilis, chancroid, and HPV.⁹ *WAIT Training* seems to suggest that it is acceptable to mischaracterize data on condom efficacy because teens are unable to use condoms consistently and correctly. The author seems to assume that if adolescents believe that condoms and other contraceptive methods are ineffective, they will abstain from sexual activity. These anecdotes from *Why kNOW*© and *WAIT Training* are just a couple of the many egregious examples of federal funding being used to disparage condoms, discourage condom use when teens do become sexually active, and provide medically inaccurate information.

Abstinence is certainly a good choice for young people and is *the* most effective way to prevent pregnancy and the transmission of STDs, including HIV/AIDS. However, it is unconscionable to deny young people information, provide misinformation, and deliberately emphasize the failure rates of condoms and contraception.

Abstinence-only-until-marriage programs are also discriminatory at their very core and further stigmatize many groups of young people who may already be in vulnerable positions, in particular lesbian, gay, bisexual, and transgender (LGBT) young people, the children of LGBT parents, youth who are growing up in “non-traditional” families, sexually abused youth, and HIV-positive young people.

Through the continued funding of abstinence-only-until-marriage programs, the government’s message is clear—heterosexual marriage is the only appropriate adult relationship. The federal definition requires programs to teach that “a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity.” In order to comply with the federal definition, abstinence-only-until-marriage programs must present one family structure as morally correct and beneficial to society. Programs go beyond prescribing marriage and suggest that only married people have happy, successful lives and raise happy, successful children. By declaring a two-parent, heterosexual marriage to be the singularly appropriate manner of raising children, the guidelines may alienate young people who have single, divorced, widowed, or gay and lesbian parents.

Still, federally funded abstinence-only-until-marriage programs are required to promote heterosexual marriage—to teach young people that all unmarried individuals (both adults and youth) should, and actually do, remain celibate. This is unrealistic and dangerous in a time when the median age of first marriage is 27.1 for men and 25.3 for women¹⁰ and when there are more than 100 million American adults who are classified as single because they have either delayed marriage, decided to remain single, divorced, or entered into gay or lesbian partnerships.¹¹ It is not reasonable to expect these adults to adhere to this “standard,” nor is it accurate to teach young people that this is reality.

While it is true that unprotected sexual activity can lead to unintended pregnancies and STDs/HIV, and that some intimate relationships can be harmful for a variety of reasons, this is a possibility regardless of marital status. The reality, however, is that the majority of people have had sexual relationships outside of marriage and negative repercussions are far from inevitable. Today, most young people have sex for the first time at about age 17, but do not marry until their middle or late 20s. This means that young adults are at risk of unintended pregnancy and STDs for nearly a decade, yet, abstinence-only-until-marriage programs refuse to provide them with the information they need to protect themselves.

Moreover, by their very nature, abstinence-only-until-marriage programs exclude gay and lesbian youth who can not legally marry in this country.¹² These programs depend upon and enforce an intensely intolerant and destructive conception of sexual orientation. The overt biases they include, the assumptions they make, and the discussions they refuse to allow all send powerful and disturbing messages to young people of all sexual orientations. By promoting marriage, assuming heterosexuality, disparaging non-traditional families, and spreading fear, shame, and inaccurate information about sexual orientation, abstinence-only-until-marriage programs, assert that LGBT individuals and relationships are unhealthy and morally inferior.

Abstinence-only-until-marriage programs also do a disservice to those who are survivors of rape, sexual assault, or sexual abuse. Unfortunately, abstinence-only-until-marriage programs fail to provide this vulnerable group of teens with information or skills that could help them cope with the issues of sexual abuse. Instead, students are simply told that all sexual activity outside of marriage is wrong and that individuals who engage in sexual activity before marriage face dire consequences such as the inability to bond emotionally with a partner. Such messages are likely to cause further feelings of hurt, shame, anger, and embarrassment in these already victimized young people.

Abstinence-only-until-marriage programs often contain similarly damaging messages about individuals who are HIV positive implying that they are at fault and that HIV is an automatic death sentence. These are not messages that any young person who is HIV positive, or who has an HIV-positive parent, should hear as they sit in class. Half of all new HIV infections in the U.S. occur among young people yet abstinence-only-until-marriage programs leave this population vulnerable to a heightened risk of stigmatization. Moreover, by denying critical information these programs fail to meet the needs of HIV-positive young people who, thanks to advances in treatment, will one day go on to live long and full lives that include entering into intimate relationships and forming families.

Organizations that support abstinence-only-until-marriage programs portray sexuality education as a controversial issue. They go so far as to completely misrepresent polling data about American sentiment on this issue. For example, a 2007 message testing poll conducted by the respected Zogby polling firm has been consistently passed off as an actual opinion poll of the American public. In fact, the survey was commissioned by the abstinence-only-until-marriage industry's lobbying arm, the National Abstinence Education Association (NAEA), and the survey instrument was designed to test the outrageous positions of this organization. NAEA has used this survey to argue, among other things, that it shows parents support "abstinence education" over a more comprehensive approach by 2 to 1. After the continued misrepresentation of the poll by NAEA and other organizations with similar agendas, advocates questioned Zogby about the poll. Fritz Wenzel, Director of Communications for Zogby, wrote that the "survey was a message testing survey commissioned by an interested party, not a benign issue poll to determine public sentiment on the topic. We emphasize the fact that these surveys have limited or no value for the purpose of news reports because they contain questions with pre-set premises that do not necessarily match reality or the mindset of the general public or the voting public in America today." Moreover, Mr. Wenzel indicated that the NAEA had been repeatedly informed of the real nature of the survey but that they and others continue to misrepresent the findings.

In fact, it is abundantly clear that comprehensive sexuality education is a mainstream American value. A vast majority of Americans support comprehensive sexuality education and believe young people should be given information about how to protect themselves from unintended pregnancies and sexually transmitted diseases (STDs).¹⁵ And, the American public stands strongly in favor of an end to abstinence-only-until-marriage program funding. The overwhelming majority of Americans, including parents, want the federal government to fund programs that are medically accurate, age appropriate, educate youth about both abstinence and contraception, and are based on evidence, not ideology. Abstinence-only-until-marriage programs simply do not fit the bill.

Recent polling confirms that a majority of adults, especially parents, support a comprehensive approach to sexuality education—one that provides students with information about abstinence *and*

contraception, including birth control and condoms. Seventy-eight percent of those polled favor allowing public schools to provide students with birth control information, and nearly as many (76%) believe schools should teach teenagers to abstain from sex until marriage.¹⁴ Clearly, the general public does not see conflict in pursuing comprehensive sexuality education that addresses both abstinence *and* contraception.

Broad support for comprehensive sexuality education also cuts across ideological and religious lines. A majority of voters in nearly every demographic category, including Democrats, Republicans, and independents, as well as Catholics and evangelical Christians, support comprehensive sex education.¹⁵ Thirteen denominations have issued statements supporting comprehensive sexuality education in schools, including the Union for Reform Judaism, the United Church of Christ, the United Methodist Church, and the Church of the Brethren. In addition, more than 15 faith-based organizations are members of the National Coalition to Support Sexuality Education, including the American Jewish Congress, the Office of Family Ministries and Human Sexuality of the National Council of Churches of Christ, the Unitarian Universalist Association, and the Young Women's Christian Association of the USA. Finally, almost nine in ten self-described Evangelical or born-again Christians support sexuality education being taught in schools.¹⁶

The vast majority of America's parents, educators, and religious leaders agree that youth deserve real solutions that will help delay the onset of sexual activity and prevent unintended pregnancies and sexually transmitted diseases, including HIV/AIDS. Abstinence-only-until-marriage programs are not the answer. We ask Congress to end abstinence-only-until-marriage programs and to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.

In the Fiscal Year 2003 *Budget Message of the President*, President Bush said, "Where government programs are succeeding, their efforts should be reinforced...and when objective measures reveal that government programs are not succeeding, those programs should be reinvented, redirected, or retired." We could not agree more with this sentiment. This means ending funding for abstinence-only-until-marriage programs now before any more resources are wasted or before any additional young people are left poorly prepared or even harmed by ill-conceived policies that are failing our country.

¹ Christopher Trenholm, et. al., "Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report," (Trenton, NJ: Mathematica Policy Research, Inc., April 2007), accessed 6 September 2007, <www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf>.

² Patricia Goodson, et al., *Abstinence Education Evaluation Phase 5: Technical Report* (College Station, TX: Department of Health & Kinesiology-Texas A&M University, 2004), 170-172. Emphasis included in original document.

³ "Texas Teens Increased Sex After Abstinence Program," *Reuters*, 2 February 2005, accessed 17 February 2005, <http://news.yahoo.com/news?tmpl=story&u=/nm/20050131/hl_nm/health_abstinence_texas_dc>.

⁴ Douglas Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, (Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy, 2007), p. 15, accessed 5 February 2007, <http://www.thenationalcampaign.org/EA2007/EA2007_full.pdf>.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ **Section 510(b) of Title V of the Social Security Act, P.L. 104-193**

For the purposes of this section, the term "abstinence education" means an educational or motivational program which:

- A. has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- B. teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;

-
- C. teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
 - D. teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity;
 - E. teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
 - F. teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
 - G. teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances, and
 - H. teaches the importance of attaining self-sufficiency before engaging in sexual activity.

⁸ *The Content of Federally Funded Abstinence-Only Education Program* (U.S. House of Representatives Committee on Government Reform, December 1, 2004).

⁹ *Latex Condoms and Sexually Transmitted Diseases-Prevention Messages*, U.S. Centers for Disease Control and Prevention (CDC), (Atlanta, GA: CDC, 2001), p. 2; Rachel L. Winer, et al., "Condom Use and the Risk of Genital Human Papillomavirus Infection in Young Women," *New England Journal of Medicine*, 354.25 (June 22, 2006): 2645-2654.

¹⁰ *Estimated Median Age at First Marriage, by Sex: 1890 to the Present* (Washington, DC: U.S. Census Bureau, released on the internet, 21 September 2006), accessed 21 April 2008, < <http://www.census.gov/population/socdemo/hh-fam/ms2.pdf>>.

¹¹ American Community Survey for 2006 (Washington, DC: U.S. Census Bureau), accessed 21 April 2008, <www.census.gov/acs/>.

¹² Today Massachusetts is the only state that recognizes legal marriage between individuals of the same sex.

¹³ *Sex Education in America: General Public/Parents Survey* (Washington, DC: National Public Radio, Kaiser Family Foundation, Kennedy School of Government, 2004), 5.

¹⁴ *Abortion and Rights of Terror Suspects Top Court Issues*, (Washington, DC: Pew Research Center for the People & the Press/Pew Forum on Religion and Public Life, 3 August 2005), accessed 30 August 2005, <<http://pewforum.org/publications/surveys/social-issues-05.pdf>>.

¹⁵ Peter D. Hart Research Associates, Inc., "Memorandum: Application of Research Findings," (Washington, DC: Planned Parenthood Federation of America and National Women's Law Center, 12 July 2007), accessed 2 October 2007, <<http://www.nwlc.org/pdf/7-12-07/interestedpartiesmemo.pdf>>.

¹⁶ Sex Education in America, Table 3.



Committee on Oversight and Government Reform

Statement of The Woodhull Freedom Federation Assessing Domestic Abstinence-Only Programs April 23, 2008

In Support of Comprehensive Sexuality Education

Very few Congressional hearings are as important to the health of our children as this hearing. The question presented here is nothing less than whether young Americans will live or die. We live in an era in which sexuality can be practiced in a way that is safe or unsafe. Unsafe sex practices pose a very real threat of contracting a disease that is, for the majority of those infected, still fatal. Even under the best of circumstances, a young American who engages in sex without an adequate understanding, both of the risks and of the steps that can be taken to reduce those risks, may face an entire lifetime of difficult measures necessary to manage an ever-present life-threatening illness.

We are pleased that the Committee on Oversight and Government Reform of the U.S. House of Representatives continues to analyze the failure of the abstinence-only until marriage educational fiasco. It is well-known that these programs are of little value to sexually active teens that they discriminate against lesbian, gay, bisexual, and transgender youth. These initiatives also discriminate against all youth in such programs who are in nontraditional families, including single-parent households or those whose parents are lesbian, gay, bisexual or transgender.

This Committee will almost certainly hear wise advice that government – at the federal, state and local levels – has a responsibility to provide effective comprehensive sexuality education that leads to healthy, positive sexual beings in our nation. You may also hear the same hysterical falsehoods that have allowed the government to continue to fund a program that has been proven to be ineffective. You may be told by some that providing comprehensive sexuality information will encourage young people to engage in sex where otherwise they would not do so. You know, each of you, that is wrong. Your own experiences in your own neighborhoods, confirmed by all reputable studies, shows that peer pressures, hormonal development and the general culture in which we live – not the



availability of comprehensive sexuality education – is what motivates young people to become sexually active. In short, whether you or we like it or not, a high percentage of teenagers are today sexually active. They are vulnerable to disease and ultimately death if they are not educated as to the risks and as to the measures they can take to protect themselves.

You may also hear from witnesses that comprehensive sexuality education is entirely the responsibility of parents, not schools. To accept that argument ignores the reality that the best way to educate our youth is through a partnership between the homes and schools, providing and reinforcing information and resources. It also ignores the reality that while some parents are conscientious about sexuality education, many are not. Many parents either decline, or are too uncomfortable, to talk to their children honestly about sex and sexuality. Many are themselves misinformed or ignorant of basic sexual facts and in denial that their child needs such information. Thus, despite even the best of intentions, many parents are unprepared to do sex education with their children beyond an important but insufficient sharing of their values and expectations.

Comprehensive sexuality education in schools has the potential to teach and provide access to vital, life-saving information in a peer environment where students may be more comfortable asking questions and seeking relevant answers to those questions. It is an easier, more reliable way to provide age and developmentally appropriate comprehensive access to information to children and teens. It prepares them for situations they may likely face, instructs them how to make safe, informed decisions, and can help in understanding differing forms of sexual expression, gender identity and sexuality.

You will also, we fear, hear testimony that it is “bad policy” or even “immoral” to teach comprehensive sexuality education, a program that, by its very definition, censors important sources of sexuality information – making it more likely that young people will take risks, increasing chances of pregnancy and sexually transmitted diseases, and contribution to the emotional harm to many adolescents. You will probably hear that people of a certain religious view will rise up and cast you out of office if you authorize or condone comprehensive, scientific sexuality education. It is a sad fact that this puritanical – and, for young people, deadly – ideology has struck fear into the hearts of legislators in many parts of this country. We encourage you to stand resolute in the face of those who would suppress vital information, recognizing that the suppression of information about our bodies and our sexuality and, indeed, our health and lives, is not the way to protect future generations of Americans – our children!



Summary

The Woodhull Freedom Federation is devoted to advocating the proposition that sexual freedom is a fundamental human right. For adults, this means the freedom to engage in the consensual sexual activity and sexual expression of their choice. For children, it means that government – and society as a whole – must provide the tools to develop the understanding that is necessary to make responsible sexual decisions – understanding of the risks of sexuality as well as the joys; understanding of the responsibilities to ones' partner as well as the rights to engage in consensual practices; and understanding of the ways to protect yourself and your partner from disease and harm.

Comprehensive, realistic sexuality education and access to information is essential to enable young people to make decisions and protect themselves. Sexuality education courses should have universally consistent, accurate curricula. Courses should be mandatory, and comprehensive, inclusive sexuality education (including abstinence information) should be taught. Sexuality education should begin early and be taught continuously throughout a child's education.

Access to any and all information regarding sexual health, sexuality, and sex is a fundamental right of young people. Sexuality education should also include diversity and acceptance. Regardless of differences in gender identity, sexual expression or orientation, sexuality education must convey thorough, accurate and unbiased sexual-health information.

People – all people - have a right to access any and all sexual health information, as well as services and materials needed to express their sexuality in an affirmative way. Sexuality education needs to be an integral method of access to accurate and honest sexual information.

Respectfully submitted,

Ricci Joy Levy
Executive Director, the Woodhull Freedom Federation
1325 Massachusetts Avenue, NW
Suite 700
Washington, DC 20005
Phone: 202-628-3333

Dear Chairman Waxman,

My name is Christopher Whitfield. I previously attended Cleveland High School in Portland Oregon. Health class was never an imperative for me. I took my sexual education into my own hands out of a need to understand certain things faster than mandatory education would allow. This letter is a reflection on those who have not had the same opportunity.

I view sex education as a gateway. Not only will competent education secure students with the knowledge to preserve life, it provides the mindset (required) to live life in the most comfortable, productive, and healthy way possible.

My influence comes primarily from the LGBTQ communities. What I witness, however, is not community. I feel there is a certain level of generalizing as a means of survival. Queer youth categorize themselves then close up. They close up not only to straight populations, but to others queer identified that do not share their self image. This is dangerous. This is dangerous not only because it can be used as a tool for those willing to marginalize, stereotype and oppress us, but it is dangerous because thousands and thousands of questioning teens are left resourceless and ostracized by a community embittered and fated by previous generations.

I really believe that adequate sex education has the power to change this. The problem is a cycle of stigma (arguably subliminal, but still present), engendered by the curriculum.

At the school I attended, a focal point of our education was The STD Slide Show. A twenty minute tirade of graphic imagery. For weeks before and after, a cloud of repulsion and antagonism would descend upon the school. And this was funny, until that attitude was inevitably transferred to sex. Students would close up. Students would not retain any adequate knowledge. Students would remain ignorant. Unable to properly self diagnose, shunned by a nurse who was supposedly there to help, and left growing ever more disgruntled fighting for a credit that left students confused and uninformed.

This is no environment to begin the process of discovering oneself. In a time where sexual issues dominate political forums, schools should not be fostering segregation, ambivalence and closed mindedness.

Good luck with your work,
Thanks.

Dear Chairman Waxman,

My name is Kassie, I'm 18 and a Senior at Cleveland High School in Portland Oregon. I am in full support of comprehensive sexual education. Growing up with a well-rounded sexual education strengthened my confidence in myself and helped me grow into an open-minded woman. I know that it has been through my sex education in elementary school, F.L.A.S.H., that a lot of my own stigma around sex was abolished. Learning about health and sex in that environment made me much more comfortable with the word sex.

Even though I had a good comprehensive sex education for my age in elementary school by high school I was once again very ignorant of many sexual topics because my middle school had not done a good job in informing me. I chose to take Health online and because of this, I missed out on a lot of important sexual information such as how to protect myself and understanding concepts that my friends and I had a lot of stigma around. My sophomore year my boyfriend and I participated in many sexual acts without protection. I was very lucky that I did not receive any sexual diseases from him. After that year I joined Teen2Teen, a HIV/AIDS advocate group through Cascade AIDS Project. It was through Teen2Teen

that I received a very thorough comprehensive sexual education. Not only did this teach me the importance of protecting myself but it also gave me a much stronger understanding of myself. Through my work with Teen2Teen I saw that most of my friends were in the same position I had been in. My friends were participating in many sexual acts without protecting themselves because they had not received a good sexual education. Because of my participation with Teen2Teen I was able to spread my new knowledge to them so that I could try and help my community stay safe. I believe that a comprehensive sexual education is essential to fighting HIV, lowering pregnancy rates as well as STD rates. Through my experiences I know that abstinence only education does not work to stop teens from having sex. It is a part of our nature to want to have sex and abstinence only education does not stop those hormones. However, comprehensive sexual education does work ~~because~~ to lower pregnancy rates because teens learn the real consequences and see the advantages of using protection. Please vouch for comprehensive sexual education, it is very important that teens across the nation and globe can receive the same education as I have so they can stay safe and healthy.

Thank you,

Kassie Simmons-Yager

Dear Chairman Waxman,

April 22, 2008

I am 16 and in high school in downtown Portland, Oregon. I attend a small alternative school with very open-minded, non-biased, practices and traditions. The school is a Kindergarten through 12th grade school, and I came in 6th grade.

6th grade is the first year that my school introduces sexual education into the curriculum. It was an awkward time in my life in which I was the least comfortable talking about my sexuality as I could have possibly been. I had previously been (mainly by peers + classmates) bombarded with the stigma that surrounded my identity, and my "private parts", and every other aspect of my sexuality.

One thing about my sixth grade sexual education that I won't forget is how my teachers really brought the concepts down to my level. The information was perfect for my ^(own) maturity level (mentioning every option, not favoring one, such as abstinence, over the other) and the way the information was presented was comprehensible, and no longer intimidating.

I am grateful to have comprehensive, all encompassing sexual education all my life, and to have access to any information and supplies I may ever need. I believe that this has greatly helped me in making better and more informed decisions for myself.

SINCERELY,

KIRA MOYER-SIMB

Dear Chairman Waxman,

My name is Rachel Carpenito. I am a senior in high school, and I currently volunteer as a youth advocate for safer sexuality and the prevention of HIV/AIDS.

I am writing to you hoping you may see another side to the story" in sense. I highly disapprove of the "Abstinence Only" sex education in our country. I have been to 3 different middle schools and 3 different high school. I have never had any "sex" education. This has forced me to learn on my own by joining groups like Teen 2 Teen, a youth advocacy/education group, or from my personal experience, or learning from adults around me (who aren't all that educated themselves.) Since many of my teachers are scared of losing their jobs if they taught comprehensive sex-ed, or anything similar, when I asked a question they always looked the other way. This is not how I want my children's education to be, **but** I am only one voice of many. Thank you for your time.

Sincerely,
Rachel Carpenito
Age 17

Dear Chairman Waxman,

In 4th and 5th grade I got fabulous sex-ed through a program called FLASH (Family Life and Sexual Health). Through FLASH we learned real and useful information about sexual intercourse and puberty. Although at the time many of us laughed awkwardly when forced to talk about sex - the curriculum was actually incredibly empowering. I came away more comfortable discussing sexuality and more informed about my own body. FLASH was also the only sex-ed program I've ever had that actually explained how sexual intercourse takes place. This is mind-boggling to me - how can any sex-ed be effective if it totally skirts around the subject of sex itself?

All of the sex-ed ~~and~~ classes I've had since elementary school have been abstinence based or extremely watered down. We learned skills such as: "how to say NO" (a great skill to have but there's more to sexuality than saying "No"), ~~and another~~ but we barely touched on methods of contraception.

I have never once seen a condom or other method of contraception in a class. Never were we taught how to use a condom or birth control — and to a teenage girl this is incredibly frustrating. How can I be prepared for a safe healthy life if I don't know how to protect myself?

Thankfully through the Teen2Teen program at the Cascade AIDS Project I've learned all about contraception, STDs, sexual health, stigma, and masturbation, & other fascinating subjects. ~~or that have to do with the teenage experience and~~ ~~sexual~~ Learning about these things has not increased my desire to have sex — rather it has made me confident that when I do choose to have sex — I will do so safely, and I have watched friends make dangerous decisions about their sexual health because they never got a thorough honest sex education. I firmly believe that if you want to help America's youth to lead healthy sex lives, you need to give them

the ~~knowledge~~ tools to ~~be~~ help themselves.
Teach us about contraceptives, teach us
that masturbation is safe and normal,
teach us about STDs in a way that
doesn't foster fear and dangerous stigma.
~~Abstinence~~ Abstinence only education
simply isn't complete - ~~we deserve~~
and youth deserve and need ~~a~~ much
more comprehensive ~~education~~ sex
education!

sincerely,

Malina Keutel

Dear Chairman Waxman,

As a queer youth, my sexual orientation and potential sexual experiences were not even acknowledged in the sex education I received in the Beaverton Public School District. Every diagram in every book, worksheet, and assignment depicted heterosexual couples. As a result, students regarded their LGBTQ peers as aberrations or freaks. It wasn't until the sex-positive atmosphere of a private college that I felt comfortable coming out as queer.

I was involved with my high school's Gay Straight Alliance because I felt that my high school's sex education did not address specifically LGBTQ issues. While my school's sex education ignored LGBTQ identities, at least it didn't actively discriminate against ~~sexual~~ LGBTQ students — it didn't teach that homosexuality was wrong, it simply pretended it didn't exist. Silence is a passive form of discrimination, I believe that sexual orientation and gender identity that differs from heteronormative conceptions of masculinity and femininity should be included in sex education curriculum as healthy and normal.

LGBTQ students should be represented, acknowledged, and respected in sex education literature.

There's a reason LGBTQ students are much more likely to attempt suicide or face depression. By treating non-heterosexuality as just another variation of normal, LGBTQ students will be able to feel supported and accepted by their peers and by adults.

I want to see homosexuality, bisexuality, transsexuality, and everything in between represented respectfully and fairly in public schools' sex education curriculum.

Sincerely,

Maisha Foster-O'Neal

Dear Chairman Waxman,

I am a youth who has been fortunate to grow up with a loving, open family. From day one, part of my parents way of making this happen has been being open about sexuality. Sexuality is something that can be talked about in my family anytime anyplace, and I am thankful for that. Because of that outlook, I am not afraid to ask questions and identify as a sexual being. Their openness has kept me healthy because I am not afraid to speak up when I think something's wrong.

This openness that I feel has contributed to my well being is echoed in comprehensive sex ed. I have gotten great sex ed, and in those lessons, sexuality is complex and something everyone has. ~~It's~~ It's something that is talked about, something you can ask questions about.

Knowing that many kids don't have a family who is open about sexuality and an education that isn't open about it really upsets me. The narrow view offered by abstinence only education creates fear and shame surrounding sexuality. That fear and shame leads to kids not protecting themselves and not asking

questions and not seeking help - like
medical help - when they should.
Abstinence-only sexuality education
literally impedes the well being
of the students. That is not education's
job - it should be helping us make
healthy decisions instead of ignoring
possibilities and causing fear and
shame.

I hope one day all my peers will
not be afraid to ask questions and
get help when they need it.

Thank you. I need this to make
a difference.

♡♡ Angela Carkner
18

SPREAD THE WORD: SPREAD THE LOVE ♡
STOP HIV. &

Dear chairman Waxman

I look around and see so many examples of where sexuality education has failed us, the youth of America. It's presents on the faces of the sexual minorities who were harassed in school hallways, the 16 year old girl who's pregnant because she wasn't aware of basic health care available to her, and to every high schooler with an STD that might have been prevented with the correct application of a condom. I had the opportunity to take my high school health class online through Portland State University. Prior to taking this course I felt extremely uneducated on issues surrounding stigmas of LGBTQ community as well as safe sex practices and healthy sexuality practices. Thanks to the health class I took I now feel informed and empowered. I have the ability to make choices for myself that are healthy and suite my needs. If only every youth in America had this opportunity.

Sincerely,

Kaitery Gramberg, 17

Dear Chairman Waxman,

I am such a supporter of holistic Sexuality Education in schools. The study that came out recently about abstinence only until marriage has proven it was ineffective. This shows that you need more brighter information on how to protect yourself and tells others what you want. The content in these programs are not changing the attitudes of those going to or having sex. Also that tells me that I need to teach in a more holistic and friendly way to teach our bodies. I find that it negatively puts views of our bodies in such a bad way. That is not a good way to show how our bodies work and feel. I feel that we need to show how to properly protect ourself and those that we are with. I personally have not been sexually activity ~~but~~ nor been affected by this abstinence only program. I choose for personal reasons. The government needs to know that ~~teets~~ need lots of choices about how to live their lives.

Nathan Lee

Dear Chairman Waxman,

I am currently a peer educator because I strongly believe that abstinence only programs are not effective. From my past experience with sex education, there hasn't been much emphasis on how a person could protect themselves. I know there are the typical birth control methods such as condom use that may prevent STD's but most of the sex education I've received doesn't go beyond that. Educators say abstinence is the best way to go, but in reality those who learn more ways to protect themselves seem to be less prone to ~~obtaining~~ obtaining an STD. While those who try to be abstinence become curious and participate in a sexual act without ~~knowing~~ much knowledge of how to protect themselves from STD's. In my eyes the peer education program that I'm part of has taught me way more than I've ever learned in school and if only it were possible to continue the education out of this program without having to only teach abstinence, but emphasize more on ~~protecting~~ protection against STD's and Safer Sex Habits.

Sincerely,
Emilee Nguyen, 18

Dear Chairman Waxman,

I attend high school in a conservative suburb of Portland, OR. Moments in my sexual education have been wonderful, comprehensive, and educational. But there have also been moments where I have wanted to stomp, yell, scream and say "no! that's not true". But I believe there should be those moments of frustration, or the education I am receiving is not comprehensive at all. I am not concerned with the education people at my school are receiving that includes both sides of sexual education. My concerns are for the students that don't receive any. A girl at my school, very responsible but conservative, had her parents sign a form that opted for her to receive no sexual education because of her faith. She only heard what her parents believe, wait till marriage. After this girl was engaged, she thought that was close enough. She is now the single mother of a 10-month old. She is full of regret and while she loves her child, wishes she had known the other options, not just one side. She wishes she had a choice. Please keep comprehensive sexual education funded and supported.

- Meryl H. (18, Portland OR)

Statement of Representative Dan Burton
House Committee on Oversight and Government Reform Hearing
Domestic Abstinence-Only Programs: Assessing the Evidence
April 23, 2008

I would like to thank Chairman Waxman and Ranking Member Davis for holding this hearing today to examine the benefits and short comings of Federally-funded programs to teach abstinence-centered sex education in our schools. Let me say from the outset that I have long supported abstinence-education programs and I will oppose any effort by the Democrat-majority in the House to de-fund abstinence education programs.

The Democrat Majority has essentially stacked today's panel with experts who will assert that abstinence-centered programs are largely ineffective. The Majority and their witnesses will also assert that science says that so-called comprehensive sex education is the best form of sex education. Unfortunately for the Majority, the facts suggest that neither of their assertions is true.

For example, Dr. Stanley Weed, a highly respected researcher and Director of the Institute for Research and Evaluation is expected to testify that, "emerging evidence supports the notion that abstinence-centered strategies, if well-designed and implemented, can significantly and substantially reduce teen sexual initiation for periods of 1 to 2 years and thereby may positively impact the health of American adolescents." Dr. Weed is also expected to testify that, "When measured using comparable criteria, comprehensive sexuality education strategies (risk reduction) show little evidence for success at achieving the crucial outcomes of consistent condom use, reduced pregnancy, and STD rates."

The truth is that genuine abstinence-centered education works and it can have a positive physical, psychological and emotional impact on our kids. An abstinent teen has a zero percent chance of becoming pregnant or acquiring a sexually transmitted disease. In addition, abstinence-centered programs can help teens develop a positive self-image; teach them how to develop healthy relationships, how to avoid or get out of dangerous, unhealthy, or abusive relationships, the skills to make good decisions and how to set goals for the future – and how to take realistic steps to achieve those goals.

Contrary to the assertions of the Democrat Majority, the effectiveness of abstinence-centered education is not merely anecdotal or wishful thinking but backed up by science. The non-partisan Heritage Foundation recently reviewed 21 studies of abstinence education programs, of which 15 were abstinence-centered. Of those 15 studies, 11 reported positive findings.

My friends on the Democrat side of the aisle will either suggest that these studies are scientifically flawed and therefore meaningless or that 15 studies are not sufficient to prove the case in favor of abstinence-centered education. In response, I would say to my friends that the real-life experience of 40+ years of the "progressive" sexual agenda – which has led us to the proliferation of more than 25 sexually transmitted diseases and an

out-of-wedlock birth rate of 33 percent compared with three STDs and only 5 percent of babies being born out-of-wedlock in 1960 – proves the case that comprehensive sex education hasn't worked; and that we have nothing to lose and everything to gain by changing the message we teach kids from "anything goes" to "just say no."

In my opinion, if abstinence-centered education fails, it fails not because of the message, but because our society does not give abstinent teens adequate support for their decision to be abstinent. Today's teens face strong peer and societal pressure to engage in risky behavior. Media and popular culture condone and even glorify violence, and casual sex. In fact, the latest so-called trend among teenaged daters to send X-rated photos of themselves to one another via their cell phones. And they see nothing wrong with this. And the Federal government implicitly supports these messages and actions by spending over \$1 billion annual to promote contraception and so-called safe-sex education.

Eighty-percent of parents want schools to teach young kids to abstain from sexual activity until they are in a committed adult romantic relationship nearing marriage. I believe that it's high time we started listening to them.

April 23, 2008
Committee on Oversight and Government Reform
Full Committee Hearing
“Domestic Abstinence-Only Program: Assessing the Evidence”

STATEMENT OF REP. LYNN A. WESTMORELAND

Mr. Chairman,

Since you scheduled this hearing, my phones have been ringing with calls from parents and students who support abstinence education. I want to thank you for holding this hearing to showcase a public health message that is favored in my district by an overwhelming majority. My only regret is that you would have included more witnesses on this panel to speak to the good things abstinence education is doing for teens in America. I have read Dr. Stanley Weed's testimony and find the research in support of abstinence education hopeful and encouraging. But I have heard many personal stories from young people in Georgia about how programs like Students Teaching Abstinence Responsibility and Self-respect (STARS) are doing more than just providing teens with facts about STDs and condoms. STARS, funded in part by Community Based Abstinence Education (CBAE) grants, provide teens a community of like-minded peers who encourage each other to set goals, maintain strong character and resist the temptations of alcohol, drugs, and sex.

In Georgia, where all students are taught abstinence education, the teen pregnancy rate has dropped for 11 straight years. The decline began in 1995 when the Georgia Department of Education created a policy requiring all public schools to teach abstinence education. Compare Georgia to your home State of California where federal funds to support abstinence education are consistently rejected. California reports the highest rates of STDs among any state in this country.

Mr. Chairman, we may disagree about ways in which children should be taught, but we cannot disagree with this fact: Abstaining from sex is the only way for teens to completely avoid pregnancy and STDs. To prevent our youth from hearing this clear, truthful message is to obstruct the interest of public health.

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COMMITTEE ON EDUCATION
AND LABOR
COMMITTEE ON AGRICULTURE
COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM

Congresswoman Virginia Foxx
Extension of Remarks
April 23, 2008 hearing on abstinence education

Mr. Chairman,

The topic of this hearing was supposed to be centered around the argument that abstinence education advocacy is ideologically motivated and not grounded in science. Ironically, after making repeated references to scientific results of abstinence education, five witnesses made it perfectly clear that their opposition to abstinence education was in fact based on ideology, not science. When I asked "If provided evidence [that] abstinence education programs are as or more effective than comprehensive sex education, would you support optional federal funding for such programs?", five of the Democrats' witnesses answered that they, in fact, would still oppose federal funding for abstinence education. Their answer to that question completely compromises any claim each of those witnesses may have to science-based objectivity. The question and their respective answers speak for themselves. Anyone who might seek their advice on the subject should question any "expert" advice offered by these witnesses, outside of their own "expert" ideological preference.

The truth is that abstinence is the only 100% effective way of avoiding pregnancy and sexually transmitted diseases.

It is important to know that states have the choice of whether to receive federal abstinence education funding with 33 states having made that choice. For a party that espouses providing choice regarding issues such as abortion, I find it strange that members of the Democrat Party would want to deny all states the choice of receiving funding for this purpose.

Before you called this hearing, I was unaware of the true nature of what teens are taught in abstinence education programs. The mainstream media rarely reports on the studies, like the one in Virginia that showed students who receive abstinence education are 50-percent less likely to initiate sexual activity. Dr. Stan Weed, who conducted the study, testified about the merits of abstinence programs and about the effectiveness of programs around the country that Community Based Abstinence Education grants help support.

By name, abstinence education sounds like a very simple message to teens, but after hearing Dr. Weed's testimony and learning more about this approach, it is clear that students in abstinence education programs learn about condoms and the possible effects of engaging in sexual activity. Indeed, they learn about all types of contraception, they learn about HIV/AIDS and other sexually transmitted diseases. They learn about the emotional risks of casual sex, something teens rarely see portrayed in movies, music or any other medium where they often receive the message that sexual activity is all glamour and no consequence. In the ten years that abstinence programs have received federal funding, a broad study of research has concluded that abstinence education delays the onset of sexual behavior in teens, and often reverses risky behavior in teens who are already sexually active. It has been credited with playing a significant role in the decline in teen pregnancy.

There is no doubt that ideas will differ on the best approach for teens, but after participating in this hearing, my question is not whether abstinence education works. It's why are we not reviewing ALL sex-ed programs, especially those to which this government gives substantially more funding than abstinence education.

**Additional Statement of Congressman Souder on
“Domestic Abstinence-Only Programs: Assessing the Evidence”**

Mr. Chairman,

During the Oversight and Government Reform Committee’s April 23rd hearing on abstinence education, one of the witnesses, Ms. Shelby Knox, asserted that the “word-count” method used in the Department of Health and Human Services’ *2007 Review of Comprehensive Sex Education Curricula* did not accurately convey the real content of so-called “comprehensive” sex education curricula. I would like to submit for the record a full copy of this report, which in fact makes a very convincing case that any claims of balance between abstinence and contraceptive education in such curricula are completely unmerited. At best, the report found, abstinence “is at times a non-trivial component” of comprehensive sex education—putting a lie to the oft-repeated claim by witnesses and Committee members alike that abstinence is the “core” of such curricula.

In particular, I would like to highlight a quote found on page 6 of the report:

“[Comprehensive sex education] curricula often do not spend as much time discussing abstinence as they do discussing contraception and the ways to lessen risks of sexual activity. Of the curricula reviewed, the curriculum with the most balanced discussion of abstinence and safer-sex still discussed condoms and contraception nearly seven times more than abstinence.” [emphasis added]

Mr. Chairman, thank you for this opportunity to clarify the record.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Response to additional questions for the record by the
Committee on Oversight and Government Reform

Dr. Margaret J. Blythe
Chair, Committee on Adolescence
American Academy of Pediatrics

1. Yes or No-If research was presented conclusively showing that comprehensive sex education was not as successful as abstinence education, would you still support federal funding for it?

The American Academy of Pediatrics supports federal funding for effective sexuality education programs that provide age-appropriate, medically accurate discussion and information for the prevention of sexually transmitted infections and unintended pregnancies. Abstinence-only education programs have not been shown to change adolescent sexual behaviors.

2. You said during the hearing that abstinence should be the "core" of the sex education message. How do you define "core"?

Comprehensive sexuality and reproductive health education that emphasizes abstinence is the best option for adolescents. Children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behavior as adults, but also to avoid early, exploitative or risky sexual activity that may lead to health and social problems.

3. Do you believe that comprehensive sex education texts should be examined and held to a standard of accuracy?

Medical accuracy is always important for any health-related curricula, including sexuality education.

4. What should be done with content in comprehensive sex education curricula that encourages behaviors that provide a health risk to students?

As stated above, all sexuality curricula should be effective and science-based, including being medically accurate and age appropriate.

5. Why do you oppose abstinence education, even if research shows its effectiveness?

As stated above, abstinence-only education programs have not been shown to change adolescent sexual behaviors. In fact, abstinence-only programs may cause harm by providing inadequate and inaccurate information.

6. Do you agree with the testimony of Dr. Weed that consistent condom use should be an outcome measure to determine the effectiveness of comprehensive or contraceptive-based sex education?

It is the policy of the American Academy of Pediatrics that pediatricians should:

- Encourage adolescents to abstain from intercourse as the surest way to prevent STDs, including HIV infection, and pregnancy.
- Counsel adolescents who have been sexually active previously regarding the benefits of postponing future sexual relationships.
- Actively support and encourage the correct and consistent use of reliable contraception and condoms by adolescents who are sexually active or contemplating sexual activity.
- Support research that identifies methods to increase correct and consistent condom use by sexually active adolescents and to evaluate effectiveness of strategies to promote condom use, including condom education and availability.

7. In your professional opinion, is sexual experimentation necessary for healthy sexual development?

As pediatricians, we are aware that "healthy sexual development" does not begin with adolescence or adulthood but with early childhood often expressed as curiosity and interest in one's own body. Early adolescence is marked by the initiation of puberty, when that curiosity and interest intensifies not only in one's own body but in that of peers; these interests and romantic feelings often result in a variety of questions about how to handle those sexual feelings and concerns.

It is the policy of the American Academy of Pediatrics that pediatricians should:

- Put sexuality education into a lifelong perspective. Actively encourage parents to:
 - Discuss sexuality and contraception consistent with the family's attitudes, values, beliefs, and circumstances beginning early in the child's life.
 - Encourage parents to offer sexuality education and discuss sex-related issues that are appropriate for the child's or adolescent's developmental level.
 - Provide guidance about abstinence and responsible sexual behavior to their children. Encourage reciprocal and honest dialogue between parents and children.
 - Be aware of circumstances that are associated with earlier sexual activity, including early dating, excessive unsupervised time, truancy, and alcohol use.
- Should not impose values on the family. Be aware of the diversity of family circumstances.
- Obtain a comprehensive sexual history from all adolescents, including knowledge about sexuality, sexual practices, partners and relationships, sexual feelings and

identity, and contraceptive practices and plans. In discussing reasons to delay sexual activity or use contraception, frame the suggestions in terms of the individual's development, language, motivation, and history.

- Address knowledge, questions, worries, or misunderstandings of children and adolescents regarding anatomy, masturbation, menstruation, erections, nocturnal emissions ("wet dreams"), sexual fantasies, sexual orientation, and orgasms.
- When appropriate, acknowledge that sexual activity may be pleasurable but also must be engaged in responsibly. During these discussions, also be open and nonjudgmental.
- Acknowledge the influence of media imagery on sexuality as it is portrayed in music and music videos, movies, television, print, and Internet content.
- Be sensitive to cultural and family norms, values, beliefs, and attitudes, and integrate these factors into health promotion or behavior change counseling. Also be aware of the potential for, and ask about, abuse or coercion in relationships or sexual activity.
- Ensure that adolescents have opportunities to practice social skills, assertiveness, control, and rejection of unwanted sexual advances.

8. Do you believe behavior theory-based cessation programs can work for previously sexually active youth (e.g. similar to the Stages of Change/Transtheoretical model)?

As indicated in the previous question and answer, the development of healthy sexuality should be approached as a lifelong goal. Healthy sexuality education and interventions to promote healthy sexuality should not be focused solely on negative outcomes but allow discussion of knowledge about sexuality, sexual practices, partners and relationships, sexual feelings and identity, and contraceptive practices.

In discussing reasons to delay sexual activity or use contraception, pediatricians should frame the suggestions in terms appropriate to the individual's development, language, motivation, and history while including the benefits of postponing future sexual relationships.

Responses by Dr. Harvey V. Fineberg, to written questions posed by Mr. Souder after the hearing (questions shown in **bold**, followed by answers):

1. Yes or No-If research was presented conclusively showing that comprehensive sex education was not as successful as abstinence education, would you still support federal funding for it?

If abstinence-only sex education were more successful than comprehensive sex education in reducing pregnancy and preventing sexually transmitted diseases, I would favor support for abstinence-only education.

2. You said during the hearing that abstinence should be the "core" of the sex education message. How do you define "core"?

Abstaining from sex is a healthy and appropriate behavior for young adolescents and is an important component of sex education.

3. Do you believe that comprehensive sex education texts should be examined and held to a standard of accuracy?

I believe all sex education materials should be scientifically accurate.

4. What should be done with content in comprehensive sex education curricula that encourages behaviors that provide a health risk to students?

Comprehensive or abstinence-only sex education curricula should be structured with the aim of reducing health risks to students.

5. Do you agree with the testimony of Dr. Weed that consistent condom use should be an outcome measure to determine the effectiveness of comprehensive or contraceptive-based sex education?

Consistent condom use is one appropriate measure of effectiveness of comprehensive sex education. Other important behavioral measures include increased frequency of condom use, decreased frequency of unprotected sex, decreased frequency of sex, increases in the age at time of sexual initiation, and reduction in the number of sexual partners. Relevant biological outcome measures include reduced rates of HIV infection, of other sexually transmitted infections, and of pregnancy.

6. Can you tell us how many of the 39 abstinence-plus (comprehensive sex education) programs included in the Underhill Cochrane review increased the number of teens who practice consistent condom use?

Twenty-six of the 39 trials reported a measure of condom use. A significantly protective effect was found in 14 trials, but the Underhill Cochrane review does not specify the exact measure of condom use in each study.

7. Can you tell us how many of the 39 comprehensive sex education programs included in the Underhill/Cochrane review decreased STD rates?

Three trials assessed self-reported diagnosis or treatment of sexually transmitted infection. None found significant protective effects.

8. Can you tell us how many of the 39 comprehensive sex education programs included in the Underhill/Cochrane review decreased rates of teen pregnancy?

Seven of 39 trials measured the impact of programs on self-reports of becoming pregnant (females) or getting someone pregnant (males). One unpublished study found a significantly protective effect of the program on female participants. Three studies suggested a positive outcome, but the studies had methodological flaws (e.g., limited statistical analyses or high rate of participant attrition) that limit their utility. [This response is extracted from my written testimony.]

9. Given that none of the 39 comprehensive sex education programs included in the Underhill/Cochrane review increased adolescents' consistent condom use or decreased their rate of STDs, and the 2 programs that reduced teen pregnancy were not school-based comprehensive sex education programs, why should they be considered effective?

For three reasons: first, as mentioned in response to Question 5, consistent condom use is only one of several measures of results with respect to condoms, and on these other measures, such as increased frequency of condom use, a number of comprehensive sex education programs showed improvement in comparison to control groups who did not receive the same education. Second, on other measures of relevant behavior, some comprehensive programs report success; for example, four of 13 studies found a significant reduction in the number of sex partners, and five of 21 studies found a reduced incidence of vaginal sex. Third, I do not discount successful, comprehensive sex education programs that reduce teen pregnancy because they are not school based, in contrast to what is implied in the question.

10. Would you concur with Dr. Weed's statement at the hearing that, to date, 115 peer-reviewed studies of comprehensive sex education programs show that they have not decreased ST1 rates in the country? Do you believe this to be an accurate outcome measurement on the effectiveness of sex education programs?

As a general matter, one would seek to measure the success of educational programs (115 or any other number) in terms of improvements each achieved compared to a similar control group who did not receive the same education. One might extrapolate program results to estimate what would be the impact on STI rates in the entire nation if all children received the same education and experienced the same degree of benefit as in the study populations. However, the effectiveness of discrete programs should not be gauged by overall national trends. By analogy, if a medical practice achieved a 90% abstinence rate among heavy smokers for five years, it would be hailed as a great success even if 115 such programs had no measurable effect on the secular trend in smoking in the nation as a whole.



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Kathleen M. Sullivan, Chairman & CEO
Rosalinda Villaseñor, Director

April 30, 2008

Chairman Waxman and Committee Members
U. S. House Committee on Oversight
and Government Reform
U. S. House of Representatives
2157 Rayburn House Office Building
Washington, D. C. 20515
Sent via email: earley.green@mail.house.gov

Subject: April 23, 2008 hearing, "Domestic Abstinence-Only Programs:
Assessing the Evidence"

Dear Chairman and Committee Members:

Project Reality wishes to enter into the Official Congressional Record of the Committee hearing of April 23, 2008 on abstinence-only programs, the outstanding positive results of our current abstinence education pilot study of the *Game Plan* and *Navigator* curricula in areas of Florida, New Mexico and Washington D.C. funded through a CBAE grant.

The members of the Committee on Oversight and Government Reform need to be aware of these remarkable responses from students who have participated in an authentic abstinence program (as provided by Project Reality's *Game Plan* and *Navigator*) as we were not represented at the April 23rd hearing.

Please see the attached evaluation statistics. Thank you for entering this information into the official record of the hearing and for assuring that all committee members see it.

Very truly yours,

A handwritten signature in black ink that reads "Kathleen M. Sullivan".

Kathleen M. Sullivan, Chairman & CEO
Project Reality

Attachments

PROJECT REALITY

Leader in Abstinence Education Since 1985

Results of *Game Plan* Abstinence Program

These preliminary results were compiled during the 2006-07 school year using data from a sample of schools participating in Project Reality's Community Based Abstinence Education grant program pilot study in Florida, New Mexico and the Washington, D.C. area funded by the U. S. Department of Health and Human Services. **Game Plan** is an eight-unit sports-themed abstinence curriculum for grades 7 through 9 developed in conjunction with NBA "Ironman" A.C. Green and published and distributed by Project Reality. **Game Plan** uses a student workbook, teacher's manual, CD Rom, videos and posters to reinforce the message of abstinence until marriage. **Game Plan** presents the abstinence message emphasizing long- and short-term goal setting, character and relationship skills, marriage and secondary virginity. Dr. John S. Lyons, Ph.D., Professor and Director of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine of Northwestern University will further analyze the results after year 3 of the grant is completed. The Northwestern study will be available by contacting Project Reality at 847.729.3298 or online at www.projectreality.org

Choosing to be sexually active can have negative physical, emotional, mental and social consequences.

	Pre-Test	Post-Test
Agree/Strongly Agree	67%	81%
Disagree/Strongly Disagree	8%	7%
Not Sure	24%	12%

Abstinence is voluntarily choosing not to engage in sexual activity until marriage.

	Pre-Test	Post-Test
Agree/Strongly Agree	66%	85%
Disagree/Strongly Disagree	10%	4%
Not Sure	24%	11%

Sexual activity refers to any type of genital contact or sexual stimulation including, but not limited to, sexual intercourse.

	Pre-Test	Post-Test
Agree/Strongly Agree	52%	66%
Disagree/Strongly Disagree	12%	7%
Not Sure	36%	27%

Abstinence is the only 100% effective protection from the possible physical, emotional, mental and social consequences of sex before marriage.

	Pre-Test	Post-Test
Agree/Strongly Agree	44%	72%
Disagree/Strongly Disagree	19%	10%
Not Sure	37%	18%

Practicing abstinence is healthy.

	Pre-Test	Post-Test
Agree/Strongly Agree	56%	79%
Disagree/Strongly Disagree	11%	6%
Not Sure	32%	15%

A person who has been sexually active is able to choose abstinence for the future.

	Pre-Test	Post-Test
Agree/Strongly Agree	43%	70%
Disagree/Strongly Disagree	19%	13%
Not Sure	38%	17%

Choosing to avoid the use of drugs and alcohol can help me to save sex for marriage.

	Pre-Test	Post-Test
Agree/Strongly Agree	55%	72%
Disagree/Strongly Disagree	20%	12%
Not Sure	25%	16%

Abstinence from sexual activity until marriage will help me to accomplish my goals in life.

	Pre-Test	Post-Test
Agree/Strongly Agree	63%	80%
Disagree/Strongly Disagree	13%	6%
Not Sure	24%	14%

PROJECT REALITY

Leader in Abstinence Education Since 1985

Results of *Navigator* Abstinence Program

These preliminary results were compiled during the 2006-07 school year using data from a sample of schools participating in Project Reality's Community Based Abstinence Education grant program pilot study in Florida, New Mexico and the Washington, D.C. area funded by the U. S. Department of Health and Human Services. *Navigator* is an 8-unit abstinence curriculum for grades 9 through 12 developed, published and distributed by Project Reality. *Navigator* uses a student workbook, teacher's manual, CD Rom and video to reinforce the message of abstinence until marriage. *Navigator* presents the abstinence message emphasizing long- and short-term goal setting, character and relationship skills, marriage and secondary virginity. Dr. John S. Lyons, Ph.D., Professor and Director of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine of Northwestern University, will further analyze the results after year 3 of the grant is completed. The Northwestern study will be available by contacting Project Reality at 847.729.3298 or online at www.projectreality.org

Choosing to be sexually active can have negative physical, emotional, mental and social consequences.

	<u>Pre-Test</u>	<u>Post-Test</u>
*Agree/Strongly Agree	69%	82%
Disagree/Strongly Disagree	12%	7%
Not Sure	19%	11%

Abstinence is voluntarily choosing not to engage in sexual activity until marriage.

	<u>Pre-Test</u>	<u>Post-Test</u>
Agree/Strongly Agree	73%	86%
Disagree/Strongly Disagree	7%	5%
Not Sure	20%	8%

Sexual activity refers to any type of genital contact or sexual stimulation including, but not limited to, sexual intercourse.

	<u>Pre-Test</u>	<u>Post-Test</u>
Agree/Strongly Agree	64%	69%
Disagree/Strongly Disagree	10%	10%
Not Sure	26%	21%

All types of sexual activity can spread sexually transmitted diseases.

	<u>Pre-Test</u>	<u>Post-Test</u>
Agree/Strongly Agree	67%	79%
Disagree/Strongly Disagree	14%	8%
Not Sure	20%	13%

Abstinence is the only 100% effective protection from the possible physical, emotional, mental and social consequences of sex before marriage.

	<u>Pre-Test</u>	<u>Post-Test</u>
*Agree/Strongly Agree	54%	78%
Disagree/Strongly Disagree	15%	8%
Not Sure	31%	15%

Practicing abstinence is healthy.

	<u>Pre-Test</u>	<u>Post-Test</u>
*Agree/Strongly Agree	55%	75%
Disagree/Strongly Disagree	10%	7%
Not Sure	36%	18%

A person who has been sexually active is able to choose abstinence for the future.

	<u>Pre-Test</u>	<u>Post-Test</u>
*Agree/Strongly Agree	45%	67%
Disagree/Strongly Disagree	20%	13%
Not Sure	35%	20%

Choosing to avoid the use of drugs and alcohol can help me to save sex for marriage.

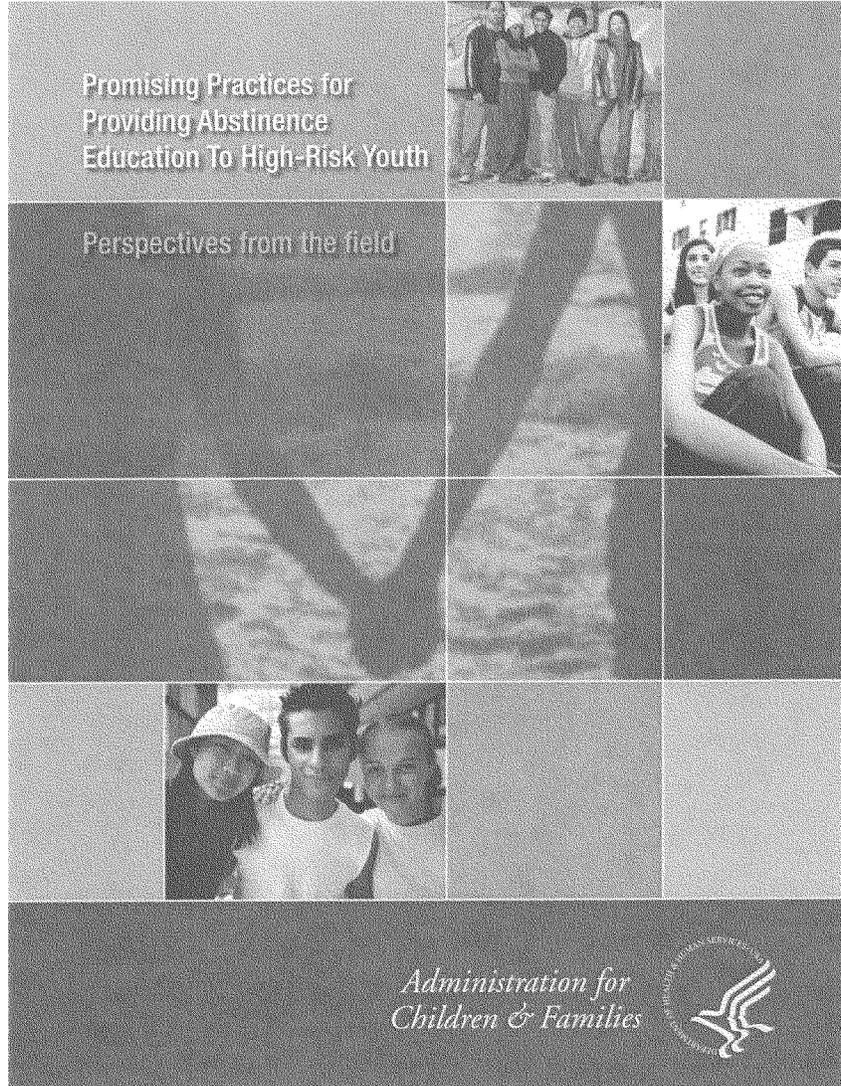
	<u>Pre-Test</u>	<u>Post-Test</u>
Agree/Strongly Agree	61%	76%
Disagree/Strongly Disagree	19%	11%
Not Sure	20%	13%

Abstinence is the only sure way to prevent pregnancy.

	<u>Pre-Test</u>	<u>Post-Test</u>
*Agree/Strongly Agree	59%	79%
Disagree/Strongly Disagree	16%	8%
Not Sure	25%	13%

Abstinence from sexual activity until marriage will help me to accomplish my goals in life.

	<u>Pre-Test</u>	<u>Post-Test</u>
Agree/Strongly Agree	63%	75%
Disagree/Strongly Disagree	14%	9%
Not Sure	24%	16%





High-Risk Abstinence Education Site Visits	1
Letter to the Educator	5
Promising Practice 1 Engage community leaders, parents or guardians, and school staff and administrators to support your program	1
Promising Practice 2 Promote your program to schools and other youth-serving organizations for integration of abstinence education into existing classes and activities	2
Promising Practice 3 Recruit and support staff that are passionate about working with young people and can relate to the issues and challenges faced by the youth they are serving	3
Promising Practice 4 Establish trust before teaching abstinence, and continue to cultivate relationships with the youth you are serving	4
Promising Practice 5 Adjust and frame the lessons and activities of your curriculum to make them appropriate to the situation, culture, and language of your students	5
Promising Practice 6 Use participatory and dynamic learning activities	6
Promising Practice 7 Make youth aware of media messages that misrepresent and distort sexual activity	7
Promising Practice 8 Present information and statistics on STDs in a way that youth can understand and communicate	8
Promising Practice 9 Emphasize the economic and social impact of having a child	9
Promising Practice 10 Frame abstinence messages positively in the context of the youths' future by helping students set short- and long-term goals	10
Promising Practice 11 Invest in transportation and other participant support costs to improve participation levels	11
Promising Practice 12 Create and encourage peer support for abstinence inside and outside the classroom setting	12
Promising Practice 13 Incorporate efforts at the beginning of the grant to ensure continuity of services beyond the end of the grant	13

Perspectives from the field

This publication is for people interested in teaching abstinence education. In this publication you will find 13 promising practices for reaching high-risk youth with the message of abstinence. These practices, not presented in any priority order, were gathered from interviews with senior administrators, program staff, partners and stakeholders, program participants, and parents from seven abstinence education programs across the Nation (see table below). Each of the practices is explained in detail, often with one or more activities and examples of how to replicate the practice in your own abstinence education program.

The Family and Youth Services Bureau within the Administration for Children and Families, U.S. Department of Health and Human Services, would like to thank the staff from these programs for sharing their knowledge and experiences.

High-Risk Abstinence Education Site Visits

Program, Organization, Location of site visit	Description of Program and High-Risk Youth Population(s) Served
Resolve, Jewish Child Care Association (JCCA), Bronx, Brooklyn and Pleasantville, New York	JCCA, founded in the early 1800s, is a full-service foster care placement agency serving foster children and abused youth in the New York metropolitan area who have been physically, sexually, and mentally abused . The mission of JCCA is based on the universal mandate within Jewish tradition of <i>tikkun olam</i> —repair the world—the responsibility of every person to “repair the world.” Their programs serving youth in the foster care system include 300 residential treatment beds in Westchester County, and more than 500 youth in regular therapeutic boarding homes, group homes, and residential facilities. JCCA also has a large array of mental health programs, day care, after school, tutoring, adoption, and programs for youth with special needs. JCCA serves more than 12,000 children and family members per year, with a staff of 500.
Aiming for Abstinence, Booneville School District, Booneville, Mississippi	The Booneville School District Aiming for Abstinence program serves a five-county area in Northern Mississippi that includes rural poor with 70 percent of the teens who give birth being unmarried. The vision of the program is to give youth and their families the tools necessary to combat the myriad of problems associated with teen pregnancy, sexually transmitted diseases (STDs), drugs and alcohol, violence, and other high-risk behaviors through the dissemination of information and training to promote abstinence from all these high-risk behaviors. The Aiming for Abstinence program works with parents, students, and communities and has more than 64 collaborating partners.
Native Challenge Abstinence Project (NCAP) Riverside-San Bernardino County Indian Health, San Bernardino, California	NCAP operates abstinence education in 13 schools targeting Native American youth from among 10 different tribes located in Riverside and San Bernardino counties. The program served approximately 2,200 youth with their in-school abstinence programming, and has had more than 6,000 youth, community members, and tribal elders in signed attendance at either the monthly family fun nights or the annual Youth Leadership Conference.
It's a Better Life, Pennsylvania Association of Latino Organizations (PALO), Harrisburg, Reading, and Bethlehem, Pennsylvania	PALO was incorporated in 1998 to serve as a statewide Latino intermediary dedicated to the strengthening of Latino Community-Based Organizations (CBOs) through economic development, capacity building, education, and creation of effective bilingual/bicultural community services across Pennsylvania. For the abstinence project, the mission is to teach the abstinence message to Hispanic/Latino youth through 10 affiliated CBOs across the state implementing abstinence education programs, and for each project site to actively collaborate with the youth to create additional curricula.
Choices, Christ Community Health Services (CCHS), Memphis, Tennessee	CCHS has four healthcare settings in Shelby County, Tennessee. CCHS is the fiscal agent for the Choices abstinence program, which provides abstinence education to primarily African-American, urban youth in Memphis. Initially, the grant provided allocated funds to serve 145 youth. However, the program has steadily increased and now serves a total population of 421 students—many through in-school, classroom presentations.
Authentic Answers Abstinence Alliance (4-A), Celebrate Kids, Inc., Killeen, Texas	The children of Army personnel attend school in the local Killeen Independent School District with the children of the civilians that live in Killeen. These youth face a number of challenges, including family separation due to re-deployment of one or both parents. Celebrate Kids, Inc. has served high-risk youth for more than 15 years and is based in Fort Worth, Texas. They have incorporated their abstinence education program within their broader youth education framework. The mission of the program is to help teens avoid high-risk behaviors by identifying and meeting their care needs in healthy ways.
Positive Choices, St. Vincent Mercy Medical Center, Toledo, Ohio	The Positive Choices program, founded in 1986 by a pediatrician, provides abstinence education services to a wide variety of high-risk populations, primarily African-American , including homeless and foster care youth in households with substance abuse and domestic violence . All of the programs (including a privately funded program for parochial schools) offer eight sessions built around the Choosing the Best and Game Plan curricula in schools. In addition to the classroom education, the program offers approximately 20 different outreach opportunities.

Note: This study was not conducted as a comparative analysis of programs serving high-risk populations and those serving other (i.e., low-risk) populations. All of the sites visited served high-risk populations. In most cases the promising practices are not necessarily specific to high-risk populations and are applicable to abstinence education in general. However, throughout this publication each practice is discussed in light of the particular high-risk category(ies) where the practice was observed, thus providing the proper context. For some of the promising practices, reference will be provided as to why it is of particular significance for serving high-risk youth.

Dear Abstinence Educator



In November 2006, Macro International Inc., partnering with the National Abstinence Clearinghouse, was awarded a contract from the U.S. Department of Health and Human Services' Administration on Children and Families (ACF) to study and produce a publication on promising practices for reaching youth at high-risk of engaging in sexual activity with the message of abstinence education.

Abstinence education programs from the entire Nation were invited to submit a brief description of their program in order to be considered for study, and out of the approximately 130 entries that were submitted, 7 were selected for a site visit. Those we studied served a substantial number of troubled youth, had been delivering abstinence education programs for at least 2 years, and could demonstrate that the programs were effective. Each site was visited by a team of two researchers who conducted a 1- to 2-day visit and met with senior administrators, program staff, partners and stakeholders, program participants, and parents. Researchers completed detailed reports about each site visit, met to discuss their experiences, and developed a list of 13 promising practices, which are presented in this report.

These practices are presented with specific examples observed during the site visits. They are considered effective strategies and approaches for reaching one or more high-risk populations with the abstinence-until-marriage message. They are not a prescription on how to conduct a program, but ideas you may use to enhance your program.

Whether you are developing a new abstinence program or are working on one that has been around for a while, the examples in this publication should be helpful. Those working on new programs may find it helpful to determine how they can incorporate each of these practices into program operations. Those working on existing programs may want to determine which practices they are currently implementing effectively, those that need improvement, and those that are not part of their program but could be incorporated.

There is not a one-size-fits-all approach that will work for all abstinence programs. The goal in developing this publication is to share the knowledge and insights provided by these seven programs, and hopefully plant the seeds so that a dialogue on promising practices can grow. Over time, other practices may be added to this list through consensus. When that happens, this effort will be a major success. For more information, please call the Division of Abstinence Education at ACF at (202) 401-9205.

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Engage community leaders, parents or guardians, and school staff and administrators to support your program.



The adage that “it takes a village to raise a child” is particularly true for high-risk youth, many of whom come from broken families. Abstinence educators serving these populations need to identify and connect with other organizations serving these youth, the most important being the school system, to gain the access needed to communicate the abstinence message. The examples that follow reflect different approaches taken by some of the programs visited.

Identify people and organizations in your community that may be interested in promoting the abstinence message.

- Contact community leaders and “gatekeepers” within the school system to discuss your program and ask for their support and/or access to youth (i.e., via class/program time).

Example: Shortly after receiving funding, the Choices program, operated by Christ Community Health Services in Memphis, hosted a luncheon for school principals at an exclusive country club (the space was donated by a board member). During this time, the Choices team presented their program and objectives to the principals in hopes of being offered class time to present the program in the schools. The event was very successful in providing Choices with access to the schools, to the point that now there are seven schools on the waiting list to have them come to their school.

- Identify and nurture a school staff person that can champion your program from the inside.

Example: Personnel in many schools are often overworked and operate within very rigid structures. Also, not everyone is convinced, at least initially, that abstinence education is effective. The abstinence educators from the Pennsylvania Association of Latino Organizations (PALO) were successful by investing a lot of “face time” with school personnel, and eventually won over one educator who became their champion in the school. The identification of a champion has been their way of gaining access to the four middle schools and one high school where they operate.

Involve parents and guardians both as key promoters as well as participants in your program.

Example: Before any child attends an after school program for the Positive Choices program, a staff member visits the child’s home to meet with the parent or primary caregiver. During home visits, staff members introduce him/herself and the program to the parent. The staff and the parent begin a relationship where the educator is given the opportunity to reinforce and expand upon the abstinence message hopefully being delivered at home, and the parent learns more about promoting abstinence until marriage outside of the home. In addition to the home visits, the staff members call all of the homes of the students each week to remind the parents about the program and to ask if transportation is needed.

Keep community leaders and other partners/stakeholders informed of, and engaged with, your program.

“in terms of community leaders, when we start a program we say what is needed in the community and then get their buy-in to the need. Then, it’s all about implementing the message, and having them come along with us and own the message as much as we do.”

[Brighton Ncuba, Native Challenge Abstinence Program, Riverside-San Bernardino County Indian Health]

High-risk youth are often served by more than one organization, each addressing other high-risk behaviors (e.g., violence, substance abuse) that stem from the same causes as risky sexual behavior. These organizations often invite guest speakers and presenters as part of their programs. Be creative in finding these audiences to gain new and different platforms for communicating the abstinence message.

Be flexible with your curricula to fit within whatever timeframe you are given.

Example: The Booneville School District's Aiming for Abstinence Program keeps its curriculum flexible to adapt to the time provided them by their community partners to communicate the abstinence message. Many times, groups such as the Boys and Girls Club have weekly meeting times and have time slots to fill with various activities. The Booneville program helps these programs by taking charge of that time slot and providing the kids with engaging lessons and activities that teach abstinence and character-building. Because the program is so flexible and dependable, many groups invite them back, knowing the presentation and activities will be both educational and entertaining.

Be open to opportunities to present the abstinence message through other youth-serving organizations.

Example: Celebrate Kids is periodically asked to do a "1 Shot" to an outside group such as a church youth group or other after school program. Before doing these 1 Shots, they ask the organization what is the most important need to address. They assist the group leader in getting to the bottom of the problem because "symptoms are not always the problem." These 1 Shots vary in length from 30 minutes to 2 hours, but can be an important booster to the abstinence education lessons the youth already receive in school.

Be attuned to where and how your abstinence program supports key themes that the school or other youth-serving partner organization is trying to communicate to youth.

Example: The Celebrate Kids program philosophy—"Caring about all children as individuals at the foundational level and wanting to help them to make positive choices to have a better life"—fit perfectly within the high school curriculum for Haynes Alternative High School in Killeen, Texas. This is why the principal chose this organization above the others that proposed coming into the school.

Focus on providing a quality product.

Example: A guidance counselor for one of the schools PALO works through mentioned that the head of the English Language Acquisition (ELA) program loves the abstinence classes and the teachers have nothing but positive things to say. The youth look forward to the sessions and seem to have a good relationship with the abstinence educator. They don't show this same kind of interest for other classes. One way the teachers know the students enjoy the abstinence education program is because they hear the students keep talking about what they have learned in the program and ask when the abstinence educators are coming back to the classroom.

Promote your program to schools and other youth-serving organizations for integration of abstinence education into existing classes and activities.



"With regard to incentives, the greatest incentive we have is worthwhile content. This is the greatest thing we have to give."

(Kathy Koch, president, Celebrate Kids)

Recruit and support staff that are passionate about working with young people and can relate to the issues and challenges faced by the youth they are serving.



High-risk youth are seeking positive role models, which makes the selection of abstinence educators that much more important. Sometimes this means hiring staff that were themselves un-wed teen parents, while other times it simply means someone the kids consider “cool.” For certain cultural groups, staff that share the same race/ethnicity or gender are important. These educators need to be empowered to do what they need to in order to connect and relate with these youth, while also receiving the needed professional development support and training.

Choose instructors that serve as role models for the youth they are working with.

“The women who run the program are phenomenal. They have a great ability to engage youth. Because they have adopted abstinence and are cool, the youth believe that if they also adopt this they can look cool. They also know they will have staff support.”

(Elizabeth Schnur, Resolve project director, JCCA)

Use instructors that are culturally/socially matched with the youth.

Example: For PALO’s It’s A Better Life project, the fact that the abstinence educators were Latinos was positively highlighted by the school teachers, as the students saw them as people from the community. One of the teachers described the abstinence educators as very charismatic, and as having a great rapport with the students and a knack for teaching.

Employ male instructors to talk to male youths.

Example: The Choices project, operated by Christ Community Health Services, uses male educators to teach the boys. Many of the youth don’t have a male role model in their lives. The entire staff is young and lives in the same community—and has character that the youth can relate to.

Empower staff as your program ambassadors.

Example: The staff for St. Vincent’s Positive Choices project is given flexible schedules, where they can work as they need to get the job done. This system works well since the staff must make the home visits, present in the classrooms, and work in the evenings for the after school programs. Each educator is responsible for recruiting and booking their own classroom presentations and filling their after school groups. This system has created motivated educators who constantly promote the program and are routinely out in the community among the parents, grandparents, and caregivers of their students.

Support your staff with training and other professional development resources.

Example: The staff for Celebrate Kids’ Authentic Answers Abstinence Alliance project learns about abstinence education from a variety of sources. From the e-mail update service offered from a national abstinence organization to Google News searches and magazines such as People and Family Circle, and journals such as Educational Leadership, the staff is well-read. More evidence of the commitment to reading is that the program budgets \$1,000 annually for books and publications. The staff also attends various professional development conferences relating to abstinence education and outreach to at-risk youth.

“What I learned from the hiring process was that there is no substitute for being passionate and motivated about the work you do. Our staff members are self-starters, collaborators, and dedicated to the project. What I do is simply help to steer and direct them and help them with resources and ideas because they already know where they want to take the project.”

(Brighton Ncube, Native Challenge Abstinence Program, Riverside-San Bernardino County Indian Health)

As explained by Kathy Okuley, project director for the Positive Choices program at St. Vincent's Mercy Medical Center, "Studies of the culture of poverty point to the number one most important element of successful programs/interventions as relationships. The value of a relationship is equal to the working class of currency or acquisition. It takes time and many interactions to build trust and develop relationships."

Establish trust before teaching abstinence, and continue to cultivate relationships with the youth who are serving.

Create an open atmosphere where students feel comfortable.

Example: For St. Vincent's Positive Choices program, a dialogue night was designed to help build an understanding between teen boys and girls, but has been expanded to include teens and parents and teens and kinship caregivers. Boys sit in a line on one side of the room and girls stand in a line on the other. Girls take turns airing their grievances against boys/males in general. Some of the grievances have been: "I don't like it when you make a baby and abandon it"; "I don't like it when you hit my mother." Boys stand and repeat the girl's statements after saying, "I heard that you don't like it when..." Next, boys air their grievances and the girls repeat. In the final steps, communication is opened up, because both the boys and girls (parents and teens) have a better understanding of what the problems are and solutions can be found."



"I open my class by saying, 'I'm the only adult in here, and this is the first time you can say anything you want with respect.'"

[Abstinence educator for Christ Community Health Services]

Effective abstinence educators make themselves available to youth outside of the classroom.

Example: For Christ Community Health Service's Choices project, the program staff does not feel this is just a job for them; it's a lifestyle, and they work various hours of the day, communicating with the kids and following up on their activities. The staff is well versed and knows how to connect with kids and show them the values they may not be seeing at home. The administrative team was very careful to hire only people who are passionate and who can connect with the kids. The educators also know how to be diverse and flexible—that is, how to come up with a teaching technique that will fit the various situations presented by different kids at different places in their lives. About 55 percent of the time is spent with the students in the classroom, 25 percent outside of class, and 20 percent at staff meetings, parent events, and weekend activities.

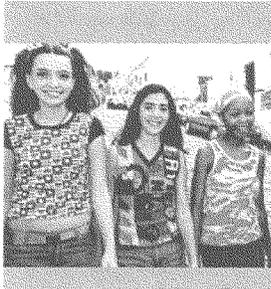
"We run into these kids all over town. If we catch them acting out, we get in their face and straighten them out."

[Abstinence educator for PALO]

"The educators give to kids from the heart. Our kids, as low-income kids, don't have much. But what you give, they receive and then they give back. You can't quantify this. We are, to a degree, surrogate parents to kids and also to the parents. We help the parents to fill gaps that are missing to them. We offer love, understanding, and a nonjudgmental relationship. It's the love that makes the difference. Without the love, then it probably won't work. We get to bond with the kids. They really know that we care about them. We always tell them to come to us with any questions or problems outside of class. We open that door to them. They are allowed to keep that relation with us."

[Margaret Barajas, director for the It's A Better Life project, PALO]

Adjust and frame the lessons and activities of your curriculum to make them appropriate to the situation, culture, and language of your students.



In multicultural, urban settings youth culture changes rapidly. A curriculum that is developed one year may appear outdated the next, which only serves to confirm that adults are “out-of-touch.” If high-risk youth, who are already highly distrustful, believe the adult abstinence educators don’t understand them, they will be deaf to whatever message is being delivered.

Ensure that the curriculum materials you are using are both current and relevant.

Example: To keep their abstinence education curriculum current, PALO’s *It’s A Better Life* project designed a unique student-centered, consumer-driven delivery system to ensure continued curriculum relevance. Their curriculum can be modified by each site by submitting requests for additions or changes to PALO and their external evaluator, who ensures that any implemented curricula pieces are medically accurate and meet the A-H standards.

Provide your staff and students a broader framework within which to deliver the abstinence message and ensure consistency in program delivery.

Example: Celebrate Kids’ Authentic Answers Abstinence Alliance program relies heavily on an education model developed by the program’s founder more than 20 years ago. The model is designed to help the target high-risk youth identify their core needs in a way that is appropriate to their situation, culture, and language. The components of the model are as follows:

- **Security:** Who can I trust? I need to trust people who have earned my trust—they tell me the truth and don’t want to hurt me. Also, I need to make wise choices so I can respect and trust myself.
- **Identity:** Who am I? I need to know my strengths to use them and my weaknesses to improve them. Change is possible! When I respect myself, I’ll work to develop more of my talents and I won’t believe lies about me.
- **Belonging:** Who wants me? I should meet this need with people who are good for me. When I respect myself and others, I’ll work to become someone others want to be with for the right reasons.
- **Purpose:** Why am I alive? I need to positively influence other people. The good things I can do, I should do! When I respect myself, I’ll believe I can help others and I will!
- **Competence:** What do I do well? I can do many things well. When I respect myself and others, I won’t base my feelings of competence on how others do.

All lessons provided by the program revolve around these five core needs. The lessons build upon one another so that each of the five core needs is addressed during a 10-session curriculum.

Institute continuous quality improvement processes in your evaluation to adjust curriculum content as needed.

Example: PALO gives each of its 12 abstinence education sites the latitude to adopt any supplemental curricular or activities that make the program relevant to the particular Latino youth sub-culture (e.g., Puerto Rican, Mexican) they are trying to reach. The success of the project has been in using a core curriculum as a jumping off point relevant to each project’s community. To manage the program, PALO instituted process evaluations to ensure program fidelity to the following standards: 1) all students that complete the program have attended lessons based on at least 80 percent of the curriculum learning objectives; 2) all CBAE facilitators (i.e., abstinence educators) have sufficient rapport with students so to ensure the influence of a “caring adult” for their CBAE students; and 3) all facilitators exhibit flexibility, creativity, and ability working within a consumer-determined pedagogical model that requires facilitators to respond quickly to changes in youth culture in order to deliver the 16 learning objectives effectively.

High-risk youth are particularly in need of innovative educational approaches that: 1) attract and keep their attention; and 2) help them view their risky behaviors in a new context, so they can apply alternative models for behavior and decisionmaking. Below are some examples of hands-on activities from the programs we studied.

Pottery Wheel

Who: Aiming for Abstinence (Booneville School District, MS)

How: The educator takes a lump of clay and begins making a bowl with it. She or he makes a mistake with the clay and has to start over. At the end the educator show the students a beautiful bowl.

Why: Helps students realize that even though a mistake was made and it had to be re-worked, she or he can still start over. The message of "secondary virginity" can be introduced to the class.

Budget Activity

Who: Aiming for Abstinence (Booneville School District, MS)

How: Students are asked what they think a monthly or bi-weekly salary would be for a person making the minimum wage. Based on those figures, students would develop a monthly budget for a family of four.

Why: Helps the students understand the cost of living and maintaining a family on a minimum wage salary.

Collage

Who: Positive Choices (St. Vincent Mercy Medical Center, OH)

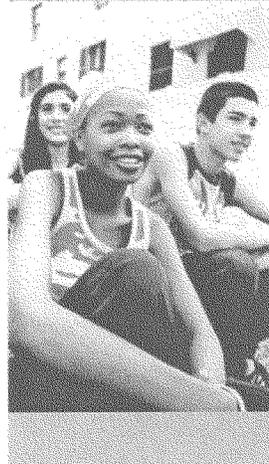
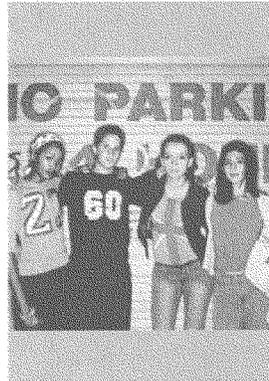
How: Have students cut out pictures from magazines to describe their future (e.g., wedding, career).

Why: Helps students visualize and realize their dreams.

"The best marketing we have is the word-of-mouth between the kids that have taken the class telling their friends to sign up for the class. We work hard to make the classes as participatory, hands-on, and interactive as possible, and the kids are really responding to the message."

[Brighton Ncube, Native Challenge Abstinence Program,
Riverside-San Bernardino County Indian Health]

Use participatory
and dynamic
learning activities.



Make youth aware of media messages that misrepresent and distort sexual activity.



High-risk youth, many from broken homes, are especially vulnerable to the influence of media messages, because there is often no one at home to act as a role model or otherwise contradict messages promoting sexual activity.

Make students aware of the effect of advertising and "sexualized" media messages.

Example: For JCCA's Resolve program, the focus of one particular lesson was the impact of mass media through the use of sexual innuendo. The educator quickly showed them the cover of a magazine with a scantily clad girl on the cover. He then asked them if they remembered the name of the magazine. Most agreed their eyes were on the girl and not the name of the magazine. He repeated this with two other ads. He also asked them if they know how movies have changed. He indicated that since 1980 there is more violence and sex. He also pointed out that 75 percent of all movies have violence or sexual innuendo. The overall message he relayed is that seeing more sex and violence at a younger age will result in the person having more sex and violence in their lives.

Example: St. Vincent's Positive Choices project used a series of beautiful gift bags and a series of ugly gift bags to make a point about media messages. Inside the beautiful bags, they placed items such as a Baby Ruth, a Laffy Taffy, and other candies that can be associated with negative connotations (e.g., you're having a baby, everybody is laughing at you). They then filled the ugly bags with ring pops, Hundred Grand Bars, and other items associated with positive connotations (e.g., marriage, successful jobs). The abstinence educator then had the students select their favorite bag and remove the candy. They used this activity to show how Hollywood sends the message that sex before marriage is good, but inside this message are negative consequences. The abstinence educator described how Hollywood often makes marriage and abstinence look bad, when actually good results came from these lifestyle decisions.

Develop a social marketing campaign to counteract media influences and reinforce the abstinence message.

Example: Celebrate Kids' Authentic Answers Abstinence Alliance conducted a social marketing campaign using a branded look that flows through all aspects of the program. The colors of the program are bold, primary colors: red, blue, purple, green, and yellow/orange. These colors and the look of the campaign were proposed, along with others, to the teens of the focus group, who chose their favorites. Colors and messages were coordinated with all the billboards, movie theater ads, t-shirts, and student folders and posters that developed a form of "branding" students could quickly identify. The staff spoke of how important they felt branding was to the success of the program. When the students, parents, and professionals see the advertisements, flyers, posters, and notices, they immediately associate them with the program. This reminds them of the lessons they received in the program and reinforces the messages.

Because of the lack of "moral" role models and/or examples of abstinence until marriage within their homes and communities, high-risk youth especially need to see and understand, among other things, the health consequences of their risky behaviors as part of the effort to change their decisionmaking processes.

Get the latest facts about sexually transmitted disease (STD) rates in your area and the types of treatments available.

Example: Up-to-date information on public health statistics for your county or city is available via the Internet. Sample sources: www.cdc.gov, www.naphis.org, http://phpartners.org/health_stats.html, or your State Department of Health Website.

Students from a number of the programs we visited were usually surprised by the STD statistics and typically remembered, at a minimum, the public health aspect of the abstinence message. One student realized he could easily be a part of those statistics if he did not choose abstinence.

Present the information in clear and creative ways that the youth can understand.

Example: Students interviewed at one of the programs indicated that using large numbers to illustrate the prevalence of STDs is not effective. For example, telling students that 40,000 people in the U.S. become infected with HIV each year does not register with students because they may not have a point of reference for that number. They may not know the current population of the country and how the infection rate poses an actual risk to them. Rather, students understand illustrations, such as "one in five people are currently infected, or will be infected in their lifetime, with the Herpes A virus."

Example: JCCA's Resolve program plays a popular hip-hop song while showing a slide show of STD facts and statistics. The song is glamorizing sexual activity, while the slides are showing the risky results of that type of behavior.

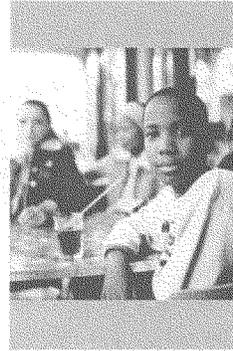
Use creative, interactive activities to convey how STDs can spread.

Example: As part of Christ Community Health Service's Choices program, the abstinence educator puts a bedspread on the floor in front of the classroom. They then hand a card with a first name written on it to each student as they enter the classroom, and tell a story about a couple who is considering getting married. The night before their wedding, they are each reflecting on their past sexual partners. As the abstinence educator names each partner (and the partner's partners), they have the student with that name on their card come up and sit on the blanket. The object is to illustrate that when you have sex with a person, you are exposed to everything their past partners (and their partners) might have been exposed to. The blanket rapidly gets crowded and the students clearly see how quickly "a few partners" can expose you to hundreds of STDs.

Work with other stakeholders who influence youth, especially in the healthcare community (e.g., pediatricians), to reinforce the fact that abstinence is the surest way to avoid STDs.

Example: St. Vincent's Positive Choices program was founded in 1986 by a pediatrician, Dr. Alean Zeiler. When she began the program, the medical professionals with whom she worked believed that teens had to be given "protection" from STDs and pregnancy. This doctor likened this "safer" sex message to telling a teen that it is okay to drink and smoke because we have medical treatments for lung cancer and liver disease. It is not okay to have sex just because we can cure or treat STDs. This is the message that she and other physicians share with their patients and their patients' parents during the checkups. They refer adolescent patients to the abstinence program and talk to them about the other, non-medical consequences of sexual activity.

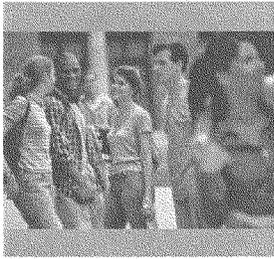
Present information and statistics on STDs in a way that youth can understand and communicate.



Emphasize the economic and social impact of having a child.

"Many of the students may not have been exposed to good examples of married couples in their community. The message that seems to reach the students most effectively is to help them explore the economic consequences of becoming a parent while still a teenager."

[Margaret Barajas, director for the It's A Better Life project, PALO]



Frame the abstinence message as an economic development issue.

Example: The program staff for PALO views abstinence education and teen pregnancy as an economic development issue for the Latino population served by their affiliates. Teen pregnancy tends to result in youth not completing high school or college and thus placing them and their children at a disadvantage economically. The message that seems to reach the students most effectively is to help them explore the economic consequences of becoming a parent while still a teenager. The message to abstain from sex until you finish college and are economically and emotionally ready to marry and start a family resonates very deeply with the students.

Present activities where students can realize how expensive having a child is.

Example: At one of PALO's sites, students were engaged in activities that educate kids as to the economic costs of parenthood. For instance, "No Time, No Money for a Baby" is an activity in which they make a family budget. In another activity, called "The Price is Right," students compete to correctly guess the costs of things such as groceries, electric bills, and rent.

Example: For Booneville School District's 'Aiming for Abstinence' program, abstinence educators had students ask their parents or guardians for past house bills such as rent, phone, utilities, or a car payment. They were also asked to research the prices for diapers, baby food, daycare, and other baby needs. The abstinence educator then helped the students develop a budget for a month, based on a couple earning the minimum wage. When students from this program were asked which activities affected them the most, these students agreed that developing a family budget was an eye-opener. "You would not think it was that much," said one of the students. "You cannot afford having a baby making (earning) the minimum (wage)."

Develop activities that help students recognize how their lives would change if a child arrived.

Example: As part of Booneville's program, the abstinence educator played a tape of a baby crying during class time and asked the students to continue to concentrate on their work. The noise gives the students a glimpse of the frustration that can accompany caring for a crying baby.

Example: For the Positive Choices program, students were asked to make a list of the things and ideals they value (e.g., love, education, money). They then asked them to identify which values would be improved by having sex outside of marriage. None of the things they value are improved by unmarried sex when the consequences are genuinely considered.

"Kids are impressionable and focus primarily on 'what's in it for me?' In all our programs, prevention education is taught. This means that the kids are seeing and understanding that if they don't do this, this is what they can become. Instead of giving throats, we give them benefits and get a positive message across. It is essential to balance the benefits with the consequences."

[Brighton Ncube, Native Challenge Abstinence Program, Riverside-San Bernardino County Indian Health]

One common characteristic of high-risk youth is the absence of life and career goals. Without goals, why should they be abstinent? Therefore, encouraging and establishing goals in the lives of these youths is essential in order to frame the abstinence message in the context of their future plans, and how becoming a mother/father too soon can be a barrier to achieving those goals.

Take an active role in promoting college as part of the future of the youths.

Example: To help their teen leaders understand the importance of college, St. Vincent's Positive Choices program took them on a long campus tour. These campus tours included overnight stops at several colleges in the region. The program stressed the importance of abstinence in order to do well in school and go to college. At least one of the teen leaders already has a full scholarship waiting on the condition that the teen graduates high school with a 3.2 or better GPA.

Example: PALO conducts an annual 1-day abstinence conference at a local college for about 140 youth. The state's Higher Education Assistance agency funds part of the conference because of the strong connection the program makes between pregnancy and the lack of access to college.

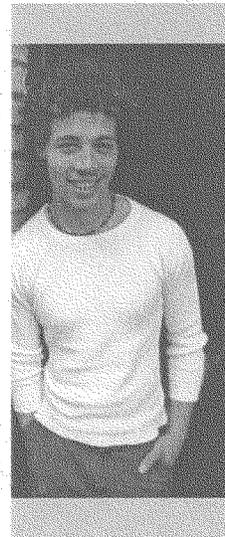
Support youth that are not tracked for college in developing a trade or profession.

Example: JCCA's Resolve program has a career-focused initiative, where youth learn about setting higher goals, career objectives, and the level of school and/or technical training needed for the job they want. The focus is on healthy and constructive outcomes, which create a positive influence in their lives. The goal of the director of this program is that the students become able to perform this without adult supervision.

Recognize and try to compensate for youths where marriage is not modeled in the community.

Example: Many of the girls in St. Vincent's Positive Choices program have never attended a wedding and may not have even seen a marriage. One of the activities for the girls, is to plan their wedding, covering everything from menus, invitations, gowns, number of bridesmaids, to music. This is an activity that helps normalize the process of marriage.

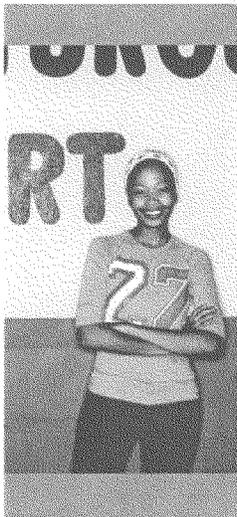
Frame abstinence messages positively in the context of the youths' future by helping students set short- and long-term goals.



"In all of our activities with the kids, we are always looking for ways to get their input and strengthen our relationship with them. One day, during one of our after school programs, one of the kids said, 'Look we get the message about what we should not be doing. Tell us what we should be doing instead.' So as we continued talking about it, both with the kids and the other program staff, we [came] up with the idea of making the next conference like a career fair, so the kids could start thinking about what kind of future they wanted to have."

[Brighton Noubu, Native Challenge Abstinence Program, Riverside-San Bernardino County Indian Health]

Invest in transportation and other participant support costs to improve participation levels.



One of the keys to engaging high-risk youth is furnishing the means by which they can get to your program (i.e., transportation). The other essential element is to provide a reward for remaining in, and completing, the program. Lastly, you can only expect to involve high-risk youth by providing a quality product (i.e., an engaging program).

Make it easier for students to participate in the program by providing transportation.

- Include transportation in your annual budget. If applying for Federal grants, request funding for transportation (e.g., hired drivers, school or rental buses);
- Provide bus passes for students (when appropriate, such as in urban areas);
- Hold events during school hours (if possible) and provide bus transportation to and from event locale.

Example: St. Vincent's Positive Choices program offers free transportation to all students for all the after school and special programming. The ability to offer free transportation is a huge advantage to the program and its ability to attract and retain students. The program hired four part-time drivers, and has a substitute driver available. These drivers, like the rest of the staff, genuinely care about the students and support abstinence until marriage.

Although transportation is offered for the fieldtrips, the offerings are limited to force the parents to bring the youth to the program. The hope is that since parents are dropping their child off anyway, parents will take the time to attend the trip with the child. For other events, such as the Mother's Day Banquet, transportation is offered to assist families in attending.

Motivate students from the beginning of the program by providing participant support costs that encourage program completion/graduation.

Example: Students graduating the Positive Choices after school abstinence program were invited to attend a secular purity ball. Each student brought a sponsor to the ball (parent, guardian, or other responsible adult). The event was semiformal and included dinner. Each student was given a ring and took a pledge to wear it and remain abstinent.

Example: Christ Community Health Service's Choices program held a banquet at the end of the school year to reward youth for completing the program. The banquet was held during school hours and buses provided transportation to the event from the participating schools. A pledge ceremony took place and 125 youth signed pledge cards. Watches engraved with the program's slogan "My Time, My Choice" were given to students as a gift.

Provide food and other items as incentives whenever possible.

Example: The Choices program provided food and incentives. Many kids haven't had a good meal recently. They also provide reward days during the summer such as a college tour, a visit to an aquarium, or an amusement park. In order for kids to attend the reward days, they must have good attendance and take part in community service projects. Whenever there is down time from school, the program provides fun and healthy activities for the kids.*

*Food was paid for with non-CBAE, discretionary funds.

Peer influence and support, both for good and bad, is a powerful motivation for high-risk youths who often have little or no guidance and direction from parents or guardians.

Create and encourage peer support for abstinence inside and outside the classroom setting.

Include peer mentoring training programs.

Example: Booneville School District's Aiming for Abstinence program sponsors a mentoring program, modeled after a national program that offers training and materials in abstinence education. The program matches high school kids to middle school kids. The mentoring program came and trained 100 youth last year on how to be mentors to younger kids. Mentors must commit to be abstinent, and pledge to abstain from drugs and alcohol. Mentors are supervised and supported by an adult facilitator who works at the school and who gives them encouragement and advice; the adult facilitator also ensures that the mentoring relationships are positive for both the mentor and the mentee. The mentors show these younger kids that not everyone is drinking and having sex. Both the mentors and mentees are accountable to each other and closely monitored by program leaders.

Introduce and encourage belonging for those participating in abstinence training.

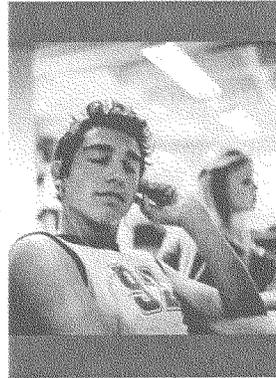
Example: The Booneville program also sponsors the U-DREAM Drama Team, which meets during school hours and produces plays and short presentations regarding abstinence and healthy choice to younger students in schools and churches. Because it is supported by the school district, they are allowed to practice during school hours and are also often invited to perform for other classes in the younger grades. Many from the drama team become mentors.

One of the participants said they enjoyed the drama team because they could act how they wanted—they sort of “became someone else.” They enjoyed presenting to others and not feeling like they were judging them. They felt the program introduced them to very nice people that gave them a lot of support. It helped improve their self-esteem; many of the other kids in the group had the same religious values and morals. They felt a sense of belonging. They learned a lot about how to express themselves with refusal skills and tools. The program taught them a lot about who they were and about their beliefs.

Conferences and other events are also instrumental for strengthening peer support.

Example: Six years ago, a state Commission on Minority Health awarded St. Vincent's Positive Choices program a \$2,000 grant to host a Youth Empowerment Service Conference (YES Conference). The 1-day conference was an astounding success. The workshops pertained to abstinence, alcohol and drugs, and life skills. The teens loved the conference and demanded more.

During the conferences, students were given the opportunity to meet other abstinent teens, speak their minds about abstinence, and learn to better communicate their choices. Teens were inspired to do more for their cities, and they are encouraged to remain abstinent. Three years ago, the YES Conference spanned a whole weekend and included youth from across the state. Next summer it will be four days long.



Incorporate efforts at the beginning of the grant to ensure continuity of services beyond the end of the grant.



Abstinence educators serving high-risk youth should avoid being a part of these youths' experience of transience, common for many of their relationships with parents and other organizations, by planning for sustaining the program beyond their CBAE or other Federal funding. Why should the students believe in a program that only lasts as long as the grant?

Example: The staff for the Aiming for Abstinence program feels that the program will continue regardless of continued Federal funding. They were providing abstinence education for three years before receiving Federal funding and, if necessary, would probably continue on a volunteer basis. An important contribution toward sustainability under this grant has been that program staff have trained and mentored a number of regular classroom teachers in the specific abstinence education curricula. This has built up the technical capacity of the schools involved to the point that many schools would be able to fold the curriculum into their regular classes and absorb most of the teaching costs if the grant monies were to run out.

The networks and stakeholders developed for implementing your program can also be the key to sustaining your program.

Example: In addition to caring about the people, the St. Vincent Mercy Medical Center hospital is also invested in the sustainability of the Positive Choices program. While the program is currently funded mainly through Federal grants, the hospital has made efforts to fund or aid the program. The hospital employees have a fund (like an organizational United Way) and have chosen this program as a recipient of a grant. Additionally, the development department of the hospital has been building program recognition among their donors for several years in preparation for fundraising when the Federal funding ends.

Identify how your abstinence program ties into other initiatives serving at-risk youth.

Example: Staff from one of the sites for PALO's It's a Better Life program mentioned that they are in the process of integrating aspects of the abstinence program into an anti-gang initiative funded by the city, which targets the same kids. They are also looking at the possibility of establishing some video production through some interested individuals. If this works, they will produce DVDs for use in abstinence training and market them to other programs working with Latino youth.

Conducting rigorous evaluations of your program is critical to sustainability.

Both public and private foundation granting efforts are increasingly interested in organizations that can demonstrate results as criteria for funding. Incorporating concrete measures of activities and, more importantly, outcomes and impact associated with your program will not only improve your performance and effectiveness, it will also make you a stronger candidate for continued funding and support.

