Do As I Say ...

Should We Teach Only Abstinence In Sex Education?

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monograph series
occasional paper #4
September 1997

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This monograph was funded by the NIMH Grant No. MH42459
(Center for AIDS Prevention Studies).

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I am indebted to several colleagues who reviewed and made suggestions on previous drafts of this monograph: Tom Coates, Daniel Daley, Susan Kegeles, Jeff Stryker, Jay Unick, and Andrew Walters. And thanks to Susan Lausten for the design and layout of this piece.

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Executive Summary

Politics rather than scientific evidence is driving the debate over abstinence-only vs. comprehensive sexuality education programs. It is an approach to making policy that may satisfy the needs of some adults, but does nothing to address the crucial needs of young people.

In health promotion, as in medical care, the informed practitioner usually chooses a proven-effective strategy over one for which there is no indication of effectiveness. Anything else is malpractice. If policy makers were physicians, they would prescribe what the current sexuality education research indicates actually works: tested comprehensive sexuality education programs. They would not be willing to take a chance on an unproven therapy (i.e., abstinence-only sexuality education), outside of limited studies designed specifically to test the intervention's effectiveness.

The U.S. Congress recently approved one quarter billion dollars in new sexuality education funding. But the money comes with strict restrictions on program content. The mandated "abstinence-only" approach dictated by Congress has not been proven effective in scientific studies, runs counter to the sexuality education approaches of most states, and is based on assumptions inconsistent with the behavior of the majority of the youth in this country.

The costs of unprotected adolescent sex are clear. American teens have the highest rates of unplanned pregnancies and sexually transmitted diseases in the industrialized world. One in four sexually active adolescents acquires a sexually transmitted disease (STD) in any given year. This adds up to three million adolescent STD cases annually. Every 30 minutes another person under 20 becomes newly infected with HIV. Nearly one in ten high school seniors reports becoming pregnant or getting someone else pregnant. About 406,000 teens have abortions annually, 134,000 miscarry, and 313,000 unmarried teens give birth to a child.

In order to address these problems more effectively, it is not necessary to settle any of the political debates that whirl around the issue of sexuality education. What is needed is a commitment to results. Elected officials, teachers, school boards and parents need to choose: is the function of sexuality education in public schools primarily to prevent disease and unplanned pregnancy or to promote traditional ideology?

We need to use the information currently available to set responsible sexuality education policy focused on improved outcomes for youth. Quality research on program effectiveness, along with a close analysis of the needs of young people at especially high risk, provides important guidance.

Comprehensive sexuality education programs discourage teens from having sex before they are ready, and encourage condom and contraceptive use for teens who choose to have sex. The substantial body of current behavioral research indicates that some of these programs have been effective at delaying the onset of sexual intercourse, decreasing the number of sexual partners, and increasing condom and contraceptive use among young people. To date, no published, peer-reviewed research has been able to demonstrate positive outcomes for abstinence-only sexuality education programs like those recently funded by Congress.

It makes scientific sense that the more comprehensive programs would demonstrate promising results. Even the most effective behavioral interventions succeed with only a portion of their intended audience. And given that two thirds of high school seniors report having had intercourse, it is fanciful to expect that abstinence-only programs will be able to bring an absolute end to adolescent sexual activity.

Given that a large percentage of young people are destined to be sexually active, it follows that they will need to know how to protect themselves in sexual situations, and have access to condoms and other contraceptives. Abstinence-only programs fail to deliver these protections. They ignore the complexity of risk factors relating to youth STD and pregnancy rates. And abstinence-only programs are typically silent or condemning on subjects that are critical to many of the young people at highest risk, including gay sex, dynamics with older sexual partners, and abortion.

RECOMMENDATIONS:

Focus on outcomes not ideology. Additional behavioral research should help educators refine their understanding of the elements of effective sexuality education. But the critical issue — at the national, state and local levels — is to focus on positive results for young people rather than political agendas. Everyone can agree that lower rates of disease and unintended pregnancy should be a primary goal of sexuality education.

Require quality research. To take political agendas out of sexuality education, there is a need for more comparative, objective, trustworthy research on all kinds of programs. But as of today, the burden to demonstrate program effectiveness rests clearly with abstinence-only advocates. States and school districts that choose to use federal and other monies for abstinence-only programs should commit to funding research on these programs.

Improve state guidance and regulation. States hold ultimate responsibility for ensuring young people receive adequate education, including the health and sexuality education mandated by state law. Yet it is difficult to determine how many states are providing adequate guidance to local school boards, administrators and teachers with decision-making around health and sexuality education curriculum.

Require adequate teacher training in sexuality education. Most teachers believe their students need sexuality education instruction that will help them protect themselves. But many teachers do not have the skills to deliver this vital education. A 1995 survey of 169 colleges and universities which offer teacher training classes found that none of the schools requires future health education teachers to take a course on HIV/AIDS.

Encourage health care professionals to provide prevention services to youth. Health care workers are a great, largely untapped, prevention resource for young people. In one recent survey, only 39% of adolescents reported discussions with physicians about how to avoid getting HIV/ AIDS from sex.

Make condoms available in high schools. The availability of condoms in high schools does not hasten the initiation of sexual activity or the number of sexual partners among adolescents, and can increase condom use among young people who do have sex. It makes sense to provide young people who will be sexually active with one of the primary tools of prevention.

I. INTRODUCTION

In many classrooms in Virginia next year, when a student asks her sexuality education teacher about birth control she will be told to "ask someone else." In Maryland, a half million dollars in new sexuality education funding will not be used to counsel young people on sexual self-protection, decision-making, or condom use. Those funds will instead be dedicated to programs that keep young people busy after school on playgrounds and in art studios, rather than alone with each other.[1]

These are examples of the lengths to which states across the country are willing to go in an attempt to make use of new federal dollars for sexuality education programs. A quarter billion dollars in sexuality education funding was allocated by Congress as part of the 1996 welfare reform bill, and it comes with strict requirements. Programs receiving these funds cannot provide information on condoms and contraception, and cannot contradict such Congressionally mandated axioms as, "A mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity."

Disturbing rates of unplanned pregnancy and STDs among American teens – the highest rates in the industrialized world – are cause to reassess our country's approach to sexuality education. But to do that we need to be clear on the goal. The danger of policies such as the new federal abstinence-only funding is not that Congress will unilaterally remake sexuality education programming overnight. The real threat of legislation like the welfare bill abstinence-only provisions is that they set educational curricula and public health policy based on political agendas, without demanding solid outcomes for young people.

States may be able to think of creative and benign ways to spend the new abstinence-only funding. But legislation like that in the welfare bill, which prohibits use of federal funds for researching program effectiveness, does nothing to help educators and parents understand what really works best for young people. It fails to acknowledge the need for tested and successful sexuality education programs, or to honestly address the multiple issues involved in the epidemics of teen pregnancy and sexually transmitted diseases (STDs). And because the welfare bill initiative requires a match of three state dollars for every four federal dollars, the legislation also threatens to siphon off funding for more comprehensive (and likely more effective) sexuality education.

The role of public schools to deliver widely accepted social values is inescapable. But it is not enough to agree on what adults would *like* young people to hear. It is also the responsibility of educators to determine the effects of specific educational approaches, and adapt curricula accordingly. The current sexuality education debate is posing the wrong question. It should not be whose world view will win out, but what programs actually work to achieve commonly accepted goals.

Abstinence-only sexuality education approaches include discussions of values, character building and, in some cases, refusal skills. Abstinence-only programs typically avoid specific discussions of contraception, sexually transmitted diseases, abortion or homosexuality.

Comprehensive sexuality education or abstinence-plus programs explore the context for and meanings involved in sex. They acknowledge that many teenagers will choose to become sexually experienced. Programs include discussion of contraceptives, condom use, abortion, and homosexuality. Many comprehensive sexuality education programs encourage abstinence from sex, and contraceptive and condom use if the young person chooses to be sexually active.

The causes of the teen STD epidemic and unplanned teen pregnancy are multiple and complex. So too are the avenues to address these problems. Today's political discussion has focused narrowly on sexuality education curriculum in public schools. Yet there are many ways in which adults are failing to help young people deal with the potential negative outcomes of sex: health care workers often do not deliver prevention messages; parents have difficulty talking about sex with their children; school curricula are not sufficiently evaluated for effectiveness; teachers are not adequately trained in human sexuality issues; states provide limited oversight of schools' compliance with state sex education statutes; a barrage of media images glorify sex; and condoms and contraceptives are not readily available to many young people.

Sexuality education curriculum is just a piece of this social puzzle. And as sexuality education gravitates to the center of political agendas, it also becomes the primary focus of public hopes to combat teen disease and pregnancy rates. A more responsible discussion would be far more encompassing. Crucial issues are being shouted down in the public sex education debate: the obligation to research unproven programming, the needs of youth at greatest risk, the existence of public consensus on key issues, multiple opportunities to influence young people outside school, and the value of public policy driven by science rather than social agendas.

If the long-term goal is to engage more fully the multiple causes of high rates of teen pregnancy and STDs, the short-term agenda is to use the information currently available to set responsible sexuality education policy focused on improved outcomes for youth. There are two avenues to assess programs more objectively for their ability to address common priorities like prevention of STDs and unintended pregnancy. One is quality research on program effectiveness. Another is an understanding of the risk factors, interrelated causes, and epidemiology of unplanned pregnancies and STDs. This monograph provides some context and history on sexuality education policy and then looks closely at that debate through the lenses of behavioral research and risk factors for pregnancy and STDs.

II. The Status of Sexuality Education

There is little new about the controversy surrounding sexuality education. Early in this century, Maurice Bigelow, a major figure in the sexuality education debate, argued that the aim of this instruction was the "total abolition on sexual vice – the prevention of immorality rather than healing its ravages."[2] The stated objective of curing souls rather than disease has survived the decades. At the other end of the century, in 1996, Congress provided new funding for programs that teach that, "Sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects."[3]

Until the 1996 abstinence-only law was passed, the federal government generally avoided dictating sexuality education curricula to the states. Under the Elementary and Secondary Education Act, states may use some federal funds for comprehensive sexuality education in classrooms, but those are state decisions. Other federal funds that might be used for sexuality education are restricted to programming, such as training state level professionals, rather than delivering education directly to students.

Conservative political forces are usually known for championing states' rights and arguing against concentrated federal power. Yet the welfare bill sexuality education provisions, advanced by advocates on the political right, represent a significant new intrusion into state autonomy. That legislation provides $250 million in federal dollars over five years to states. The new funding replaces the traditional "hands off" role of the federal government in sexuality education. (Another program, the Adolescent Family Life Act, provides approximately $9 million annually in additional funding for abstinence-only education.)

Even with the new federal requirements, states have found it difficult to refuse federal education assistance. All 50 states have applied for a piece of the welfare bill sexuality education funding.[4] Some states are using the funds for purposes other than classroom instruction, as noted above in the case of Maryland. This approach avoids forcing teachers to become purveyors of traditional values without acknowledging other perspectives. Virginia plans to evaluate carefully the abstinence-only curricula funded under the welfare bill against more comprehensive sexuality education. The 1998 federal budget agreement allows the Department of Health and Human Services to use up to $6 million in "welfare-to-work" evaluation funds for evaluation of federal abstinence-only education.

Federal Funding for Abstinence-Only Curriculum

Two federal programs now provide approximately $59 million annually for abstinence-only programs.

1996 Welfare Reform Legislation

As part of the 1996 Welfare Reform Act, Congress allocated $50 million annually for five years to states for the provision of abstinence-only programs. To qualify for the funding, states must match every four federal dollars with three state (or other public or private) dollars. The legislation specifically requires funded programs to teach—among other items —that:

- Abstinence from sexual activity outside marriage as the expected standard for all school-aged children
- A mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity
- Sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.

Adolescent Family Life Act

In fiscal year 1997, $9 million is provided through the Office of Population Affairs to deliver abstinence-only curriculum.

That the new federal abstinence-only funding runs counter to established state sexuality education policy is clear from a recent government survey of young people. In 1995, nine out of ten 18 and 19 year olds said they had received formal instruction in "safe sex to prevent HIV," in addition to, "how to say no to sex." Eighty-seven percent in this age group said they had received instruction in "birth control methods."[5] According to the National Abortion Rights Action League (NARAL), 37 states and the District of Columbia require schools to provide STD/HIV or AIDS education.[6] School-linked health centers also reach hundreds of middle and high schools with information about pregnancy and disease prevention, and access to contraceptives and condoms. A small minority of high schools make condoms available to their students.[7]

WHAT SEXUALITY EDUCATION ARE YOUNG PEOPLE GETTING NOW?

The vast majority of young people appear to be receiving at least basic sexuality education information, though questions remain about the quality of this instruction, as well as coverage of important topics such as condom use.

Percentage of 18 and 19 year olds (in 1995) who said they received formal instruction in particular sexuality education topics before they were 18:[8]

- Any formal instruction 96%
- Birth control methods 87%
- STDs 93%
- Safe sex to prevent HIV 91%
- How to say no to sex 90%

State sexuality education requirements:[9]

- 12 states require that sexuality education teach abstinence but do not require the inclusion of contraceptive information
- 11 states require that sexuality education teach both abstinence and contraception
- 13 states do not require schools to provide STD/HIV and/or AIDS education

Percentage of health education teachers in health education classes who teach specific HIV education topics:[10]

- Basic facts about HIV/AIDS 87%
- Reasons for choosing sexual abstinence 78%
- Information on HIV testing and counseling 56%
- Correct use of condoms 37%

THE SOCIAL CONTEXT

For all the acrimony between them, both sides in the sexuality education debate ostensibly share some similar goals, principally the reduction of STDs and unplanned pregnancy among young people. But advocates of abstinence-only and comprehensive sexuality education bring competing world views to the question of how to achieve these goals. The rhetorical strains in today's sexuality education debate often have more to do with social agendas than with the content of what occurs for a few weeks in the classroom. To abstinence-only advocates, the other side is advancing "technocratic"[11] approaches and "highly mechanical and bureaucratic solution [s]"[12] and their, "mission is to defend and extend the freedoms of the sexual revolution."[13] Promoters of comprehensive sex ed have warned of "religious and political extremists ... implementing inaccurate, fear based abstinence-only programs."[14]

Proponents of abstinence-only curricula often emphasize values — the importance of instilling traditional social values in young people. Many leading organizations working for abstinence-only curricula are founded in traditional religious beliefs, and their perspective originates from a deep concern that sex outside the context of marriage is immoral. They decry the "secular humanist" beliefs being foisted on their children, and feel that if anyone is to teach values that run counter to traditional Christian beliefs, it should be parents. On the other side, comprehensive sexuality education advocates emphasize values as well, but also to tend to introduce data – for example, government surveys showing that over two thirds of high school seniors have had intercourse. If sex is a reality for most young people, the argument goes, it is irresponsible not to provide youth with information about contraception and STD prevention.

The sexuality education debate would perhaps be less complicated if advocates, parents and school boards could simply agree that schools should provide basic information about sex free of values, judgments, or advice. But that approach would serve no one's interests. Advocates on the political right worry about young people being exposed to open discussion of premarital sex and topics such as abortion and homosexuality.

Proponents of comprehensive sexuality education argue that these sensitive topics need to be discussed so that all young people can understand how to protect themselves. Simply excluding all controversial material from sexuality education classes is a strategy that ignores the barrage of information, concerns and temptations that confront young people. A third group, behavioral researchers, point out that effective sexuality education is directive about particular values, such as abstinence and consistent condom use.[15] There is no evidence that providing young people with a value-free list of options will help them protect themselves from the unplanned outcomes of sexual activity.

The weight of public opinion has largely been relegated to the sidelines in federal policy making. Approximately nine out of ten parents want their children to have sexuality education in school.[16] A 1996 Kaiser Family Foundation survey of Americans found overwhelming support for school-based AIDS education — 69% of a national sample felt AIDS education should begin by the time a child is 12.[17] In 1995, the North Carolina State Legislature enacted a law requiring public schools in the state to restrict classroom discussion of sex to "abstinence-only." This, despite a poll of North Carolina residents which found that 65% of voters in this conservative state believed schools should educate students about condoms as a way to prevent STDs.[18]

Social and Personal Costs

Where both abstinence-only and comprehensive sexuality education advocates agree is on the urgent need to address the enormous social and physical costs of unprotected teen sexual activity. One in four sexually active adolescents acquires an STD in any given year.[19] This adds up to three million adolescent STD cases annually, one-quarter of annually reported STDs in the country. Serious consequences of STD infection include threats to the reproductive capability of women, who may acquire pelvic inflammatory disease, and adverse affects on newborns.[20] AIDS is steadily becoming a disease of the young, with one quarter of new HIV infections occurring in people under the age of 22, and half of new infections in those under 25.[21] Every 30 minutes another person under 20 becomes newly infected with HIV.[22]

Pregnancy is a frequent unintended consequence of teen sexual activity. Nearly one in ten high school seniors report having become pregnant or having gotten someone pregnant.[23] About 406,000 teens have abortions annually, 134,000 miscarry, and 313,000 unmarried teens give birth to a child.[24] And there are often negative consequences when teens themselves become parents. According to researcher Douglas Kirby, "when compared to children born to women aged 20 and older, babies born to mothers aged 15-17 have less supportive and stimulating home environments, poorer health, lower cognitive development, [and] worse educational outcomes..."[25] It is estimated that $6.9 billion in lost tax revenues and increased public assistance, health care, foster care and criminal justice costs result from births to women aged 15 to 17.[26]

This daunting list of physical, social and economic costs justifies a close reexamination of our approach to STD and pregnancy prevention for youth. But the intensity of the demands for significant alterations in sexuality education curriculum would be more understandable if these outcomes were steadily climbing in severity each year. In fact, numerous measures of teen sexual activity report improving outcomes for the majority of youth. In May 1997, data from the National

Survey of Family Growth found a decline in the percentage of 15 to 19 year old females who had ever had intercourse.[27] The self-reported condom usage rate among high school age youth increased 18% between 1990 and 1995.[28] The National Center for Health Statistics has reported that 54% of women who had sex for the first time during the 1990s used condoms, compared with 18% in the 1970s.[29]

The positive results of increased condom use are reflected in decreased pregnancy and disease rates. In October 1996, the Department of Health and Human Services reported an 8% drop in the teen birth rate from 1991 to 1995.[30] And the Alan Guttmacher Institute reported that pregnancy rates among sexually experienced teenagers aged 15 to 19 years old have been falling over the last two decades.[31] Gonorrhea rates overall have declined 24% from their peak in 1992, and syphilis rates are also falling.[32]

There is little reason to conclude that widespread safer sexuality education (which became more common in the late 1980s and 1990s) is leading young people towards increased negative outcomes. Partly as a result of the AIDS epidemic, school-based instruction in sexual self-protection is today the standard. Today, 87% of 18- and 19-year-old women report having had formal instruction in birth control methods, 91% in safe sex to prevent HIV.[33] Although the personal and social costs of unprotected teenage sexual activity remain staggering, many indicators of risk are on the decline.

These encouraging statistics are emerging even as most teens continue to choose to have sex. Half of females ages 15 to 19 have had intercourse[34] and two thirds (66%) of adolescents report having had intercourse by 12th grade.[35] Most informed young people are no less able to protect themselves than their elders. The Guttmacher Institute reports that “never married teens are slightly more successful than never married women aged 20 to 24 in prevention of pregnancy in the first 12 months of pill or condom use.”[36]

III. What The Research Can Tell Us About Effectiveness

There is no avoiding the fact that some social scientists bring their own beliefs, agendas, and concerns to their work. Many researchers, on both sides of the sexuality education debate, hope to establish the efficacy or limits of programs they are studying. But that personal investment in research does not mean it is impossible to be objective about what curricula is most likely to work for young people. No one study can irrefutably establish the efficacy of a particular sexuality education program. But a combination of high research standards, outside peer review of data and findings, and a comprehensive survey of multiple studies can provide clear guidance to educators and policy makers who are looking for quality, effective programming. More of this quality, objective research on sexuality education is needed. But the totality of research in the area of sexuality education to date provides some unmistakable guidance.

The most comprehensive review of literature on programs designed to reduce teen pregnancy is appropriately titled *No Easy Answers*. Commissioned by The National Campaign to Prevent Teen Pregnancy, the March 1997 report looks at a range of peer-reviewed research on teen pregnancy and STDs, adolescent sexual activity and its consequences, the antecedents of risk-taking, and programs designed to reduce risky behavior among youth. The report's author, Dr. Douglas Kirby, is perhaps the most widely cited and published author and researcher in the area of sexuality education for youth. In the early 1980s Kirby's analysis alerted health educators that curricula based solely on delivering information to young people was not having a major impact on reducing negative outcomes of teen sexual activity.[37]

The title for Kirby's new report rings true: *No Easy Answers* reveals the complex web of factors related to negative outcomes from unprotected adolescent sexual activity. What is "not easy" is figuring out how a course in school can address many of the antecedents of teen pregnancy and STDs, such as social disadvantage, testosterone level, and pubertal timing.

Yet Kirby's comprehensive review leaves little ambiguity about the general lessons of research on educational programs to reduce teen pregnancy and STD rates. Based on the six peer-reviewed, published studies of abstinence-only programs, Kirby reports that, "None of these studies found consistent and significant program effects on delaying the onset of intercourse, and at least one study provided strong evidence that the program did not delay the onset of intercourse. Thus, the weight of the evidence indicates that these abstinence programs do not delay the onset of intercourse."[38] The report cautions that this "evidence is not conclusive," due to methodological limitations in the program evaluations. Further research is needed to determine whether or not other abstinence-only programs may show positive effects.

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Kirby found that research was far more conclusive — and favorable — on the broad category of programs that address both abstinence and contraception. In his literature review, Kirby considered research on programs with different primary foci, including sexuality education, AIDS and STDs programs taught in school, after school classes, and programs in homeless shelters and detention centers. He concluded that,

> "Evaluations of these programs strongly support the conclusion that sexuality and HIV education curricula do not increase sexual intercourse, either by hastening the onset of intercourse, increasing the frequency of intercourse, or

> increasing the number of sexual partners...Further, these studies indicate that some, but not all of these programs reduced sexual behavior, either by delaying the onset of intercourse, reducing the frequency of intercourse, or reducing the number of sexual partners...some, but not all, of the programs increased condom use or contraceptive use..."[39]

Kirby's findings are consistent with numerous other broad reviews of the sexuality education literature.[40] Table 1 provides a summary of findings from major literature reviews of sexuality education curricula.

TABLE 1
Literature Reviews of Sexuality Education Curricula

Sponsoring Organization/ Publication/Title/(Date)	Any Abstinence-only Programs Found Effective	Abstinence + or Comprehensive Sex Ed Increases # of Partners or Hastens Onset of Intercourse	Some Abstinence + or Comprehensive Programs Found Effective
National Campaign Task Force on Effective Programs and Research (1997)	NO	NO	YES
Centers for Disease Control and Prevention (1997)	NO	NO	YES
Office of Technology Assessment (1995)	NO	NO	YES
Public Health Reports School-Based Programs to Reduce Sexual Risk Behaviors (May/June 1994)	—	NO	YES
World Health Organization (two reviews, 1993)	—	NO	YES
AIDS, Prevention of HIV Infection (1994)	—	NO	YES
Family Planning Perspectives, Understanding the Impact (Sept/Oct 1995)	—	NO	YES
National Institutes of Health Consensus Development Conference: Interventions to Prevent HIV Risk Behaviors (1997)	—	—	YES

A Look at Specific Programs

Several abstinence-plus and abstinence-only programs have received extensive attention and published evaluations of these programs are instructive. For example, Dr. John Jemmott and colleagues evaluated an AIDS risk-reduction intervention designed to increase AIDS-related knowledge and reduce problematic attitudes toward risky sexual behavior among African American adolescents. The intervention included a role playing exercise that enacted the potential problems in trying to use safer sex practices, including abstinence. Students were shown the correct use of condoms.

The researchers found that three months after the intervention, those young people who had received the intervention reported "fewer coital partners, greater use of condoms, and lower incidence of heterosexual anal intercourse" than those in the control condition.[41] This intervention is one more example of a comprehensive program satisfying the ostensible goals of both the abstinence-only and abstinence-plus advocates — delayed onset of sex and more protected activity among those young people who choose to have sex.

It is far more difficult to find abstinence-only success stories in the published peer-reviewed scientific literature. A widely used program which was field tested by the US Office of Adolescent Pregnancy Programs[42] is *Sex Respect*, a curriculum that focuses on adolescent sexuality and abstinence. It includes 11 lessons that are supported by a workbook with the same number of chapters. A published article on the program measured changes in young people's attitudes, not changes in their behavior. Joseph Olsen and colleagues surveyed junior high and high school students about their reactions to *Sex Respect* and were able to establish that the younger and less sexually experienced students had more favorable opinions of the program.[43] They did not report whether the program affected STD or pregnancy rates.

The Family Research Council (FRC), a conservative think tank in Washington, D.C., promotes abstinence-only sex ed programs and distributes a fact sheet listing seven programs it says demonstrate the promising results of abstinence-only programs.[44] Yet only one of the programs, *Postponing Sexual Involvement*, cites positive behavioral changes published in a peer-reviewed journal. And the Family Research Council fact sheet fails to note that *Postponing Sexual Involvement* incorporates information about reproduction, family planning, contraceptives, and STDs[45] [46] together with its abstinence message, and is therefore not a classic abstinence-only program. (Research published in May 1997 suggests that the *Postponing Sexual Involvement* program "may be too modest in length and scope" to have an affect on young people's attitudes or behavior.)[47]

What We Tell (and don't tell) Young People

Young people do not exist in a vacuum, but live in a world where images of and allusions to sex are abundant – in entertainment, advertisements, the news, and in their personal and family lives. These sources provide varying information and perspectives on sex. If we admit that sexual messages surround young people in the modern world, it becomes difficult to argue that several sessions of comprehensive sexuality education in school will plant new, tantalizing ideas in the innocent minds of young media consumers. What good sexuality education may be able to do is correct misinformation and provide necessary detail about sex, self-protection, and decision-making around sexuality. Sexuality education classes are perhaps the

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only place where there is an attempt to accurately integrate the multiple sexually oriented messages in the environment.

New qualitative research by Michaels Opinion Research documents extensive misinformation and unanswered questions young people have about sex and sexual protection.[48] And it is clear that if this information is going to be effective, it needs to be delivered early. Programs that target younger adolescents, who have not yet initiated sex, generally show more success.[49] Once young people begin having sex, it becomes more difficult to reduce their sexual risk-taking behavior.[50]

Lack of information is a crucial part of the cycle of STD infection in adolescents. Young people who get STDs need to seek treatment quickly — both to treat the disease, and to reduce the chances they will spread the STD to others. Research by J. Dennis Fortenberry indicates that, "reductions of barriers to care, improved patient recognition of sexually transmitted disease-related symptoms, [and] reduction of stigma...could contribute to reduction in durations of infectiousness among adolescents..."[51]

Yet accurate and complete information is too often absent from abstinence-only curriculum. The Family Research Counsel advises that sensitive issues should be left to talks between parents and their children. School based sexuality education should withhold delicate information, and avoid "danger points," such as affective decision-making and abortion[52] —two issues that are important to sexually active young people. One review of the *Sex Respect* curriculum found that "Basic information on growth and development, anatomy, physiology, masturbation, childbirth, sexual response, sexual orientation, contraception, abortion, and sexual abuse are not among *Sex Respect's* objectives."[53] The Medical Institute for Sexual Health (MISH), a conservative organization that has published guidelines for sex education, calls for instruction on "condom failure rates," without guidance on how condoms can be used effectively to prevent STDs and pregnancy.[54]

Reviewers have questioned the accuracy of information in *Teen-Aid* and other abstinence-only programs.[55] SIECUS has identified several instances of unsubstantiated statements in the MISH guidelines, including the assertion that, adolescents "who do not engage in premature sexual activity have the lowest rate of serious emotional problems."[56]

Abstinence-only Response

Abstinence-only advocates have many arguments in response to the research and critiques outlined above. One is that public schools are simply not the right place to address sensitive sexual topics. Abstinence-only advocates would leave the job of discussing these issues to parents. Unfortunately, many parents are no more comfortable with the issue of teen sexuality than are legislators. In many homes, that conversation is not happening.

For example, a 1995 survey by the American Social Health Association found that only 11% of teenagers get most of their information about STD prevention from their parents or other family members.[57] A 1996 poll of mothers and their adolescent children found that 82% of the mothers believed their daughters were virgins, but only 70% of the daughters actually were; 70% of the mothers believed their sons were virgins, but only 44% of sons actually were.[58] A national survey published in 1997 found that mothers of children aged 11 and older rated themselves "unsatisfactory" at talking with their children on several topics: 40% said they were unsatisfactory at talking about preventing HIV/AIDS; 47% on sexual orientation; and 73% on how to use a condom.[59]

Abstinence-only advocates are quick to point to surveys which find that teenage girls say they want more help saying "no" to sex,[60] and that many youth who have had sex wish they had not initiated sex so early in their lives.[61] But knowing how to say "no" to someone is different from choosing not to have sex at all. Wishing sexual initiation had happened later is not necessarily equivalent to swearing celibacy until marriage, especially given that the average age of marriage is now 25. And in addition to learning sexual refusal skills, many young people say they need more information about sexual self protection. In a 1996 Kaiser survey of 1510 youth ages 12 to 18, 57% said adults give them information on sex when it was "too late," and 47% said they want more information on how to prevent HIV and other STDs.[62]

Some abstinence-only advocates have attempted to skew the terms of the sexuality education debate. In her 1994 *Atlantic Monthly* article, Barbara Dafoe Whitehead focused her discussion of the sexuality education battle on political philosophy rather than outcomes, arguing that "the unifying core of comprehensive sexuality education is not intellectual but ideological."[63] Whitehead used an atypical sex ed program in New Jersey as the foundation of her argument.[64]

If comprehensive sexuality educators are guilty of being driven by "ideology," they are not alone. The Medical Institute for Sexual Health (MISH) has produced a series of publications promoting abstinence-only sexuality education curricula. MISH counsels that sexuality education must "avoid a moral vacuum," and convey somewhat amorphous "core ethical values," which are never made explicit. Couching their arguments carefully, the Family Research Council has warned of "some parental objections to many current sexuality education curricula," and include "promot[ing] homosexuality"[65] in their list.

Another strategy of abstinence-only advocates is to shift the discussion from disease and pregnancy to emotional outcomes. In testimony before the Senate Appropriations Committee, Kathleen Sullivan, Director of Project Reality, argued that "condoms don't protect the heart,"[66] and MISH advises that, "condoms don't make sex emotionally safe."[67] Yet no evidence links abstinence-only curricula with greater mental health. The abstinence-only section in the welfare bill insists young people learn that, "Sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects." But no evidence substantiates this claim.

The question is not whether young people are looking for clear guidance or help refusing sex —most of them are.[68] But many of them are also choosing to have sex, and are looking for accurate information about how to protect themselves. The "one size fits all" approach to education does not work in anti-smoking campaigns, product marketing, or any other endeavors to encourage humans to change their behavior. There is little evidence to suggest it will work with sexuality education.

Advisory Board Recommendations

After reviewing the literature, hearing testimony, and studying curricula, an imposing list of groups have gone on record in support of sexuality education that teaches about STDs, condoms, and contraceptives in addition to abstinence. The National Commission on AIDS advised that, "comprehensive HIV prevention should include information, exploration of values and attitudes, skills building, and access to services, including condom availability."[69] A report from The Institute of Medicine argues that adolescents, "should have access to information and instruction regarding STDs…and unintended pregnancy and methods for preventing them."[70] The federal Office of Technology Assessment (now defunded) and the Centers for Disease Control and Prevention have both concluded that the evidence rests with abstinence plus sexuality education programs.

A panel of outside experts convened by the National Institutes of Health in February 1997 produced a consensus statement on behavioral interventions to prevent HIV which found that abstinence-only provisions in the 1996 Welfare Reform Law, "place… policy in direct conflict with science and ignore...overwhelming evidence that other programs would be effective."[71] President Clinton's Office of National AIDS Policy, in the report *Youth and HIV/AIDS: An American Agenda*, advised that, "Sexuality education, when done properly, reflects the needs of the community and acknowledges the value of both abstinence and safer sex as tools to prevent HIV infection."[72]

The abstinence-only provisions in the 1996 Welfare Reform Law, "place…policy in direct conflict with science and ignore...overwhelming evidence that other programs would be effective."

Lessons from Other Countries

If experiences with sexuality education were radically different in other countries, we might be tempted to reassess the domestic research. Yet based on its own research and literature reviews, the World Health Organization has found that, "School programs which promoted both the postponement of sexual intercourse and the use of condoms when sex occurs were more effective than those which promoted abstinence alone."[73]

Many Western European countries have unintended teen pregnancy rates far lower than in the United States even though rates of sexual activity are similar. For example, Sweden's teen pregnancy rate is just over a third of that in the US.[74] Successful control of the STD/HIV epidemics in Sweden has been attributed to, "Comprehensive health and medical care services…an open-minded attitude to matters of sexuality and interpersonal relations…[and] school education on sexuality and interpersonal relations…"[75] American behavioral researcher Anke Ehrhardt has written that, "...the Netherlands has virtually eliminated its pregnancy problem for teens. The lower rates...are related to how and when sexuality education is delivered and to the availability of contraceptives and family planning."[76]

IV. Meeting the Needs of Those at Elevated Risk

Ideology often speaks louder than epidemiology. In the controversy over sexuality education, it has become easy to lose sight of the young people who are most directly affected by the negative outcomes of unprotected sexual activity. We count the numbers of the children they bear and the STDs they acquire, but the young people themselves are often invisible in the debate. But if the goal is disease prevention we need to measure the success of sexuality education in part by its ability to reach those populations of youth where HIV and other STDs and unplanned pregnancy are concentrated. This is relatively simple math. An intervention that is effective with the majority of young people but misses the mark with those groups that have large numbers of negative outcomes will have minimal effect on reducing the overall rates of disease and unplanned pregnancy.

Looking through the prism of epidemiology, two salient points become clear: 1) risk-taking is part of the territory in many adolescent lives, and, 2) the negative outcomes of risky sexual activity are concentrated in particular populations of youth. National concern with adolescent risk-taking has engendered its own bi-annual government study, The Youth Risk Behavior Survey (YRSB). The YRSB tells us that youth is a perilous time for many. Nearly one fourth (24%) of high school students had seriously considered suicide in the year preceding the survey, and that one out of five (20%) of students had carried a gun, knife or club to school.

One way to think of the YRSB is as a report card on society's efforts to moderate dangerous behavior among young people. The good news is that safety campaigns and policy changes in some areas appear to have had an impact — the 1995 numbers for condom use are up, for example. Yet even generally successful interventions have fallen far short of eliminating risk-taking. The 1996 YRSB tells us that after years of public safety messages, 22% of high school students rarely or never use seat belts when riding in a car with someone else. More than a third said that in the last 30 days they had ridden in a car with a driver who had been drinking alcohol (39%).[77]

Intense information programs have clearly had positive effects, but they have worked for only a subset of the population. One incontrovertible lesson from decades of behavioral research is that no intervention will have an impact on every person. Successful interventions make a marginal, not complete, change in the way the population as a whole lives. With this fact in mind, its clear that as we think about what delivering sexuality education, our goal cannot realistically be radical changes in adolescent sexual behavior.

The implication for the sexuality education debate is that even the best sexuality education programs will have only a partial impact. Even if abstinence-only programs were to reduce sexual activity and risk-taking—and there is no evidence that they do—these curricula would fail to reach a substantial share of the two thirds of high school seniors who report having had intercourse.[78] Given that fact, it is hard to argue that adolescents should be denied information about how to protect themselves in sexual situations or how to seek care if they have been exposed to an STD. It can be argued that abstinence-only messages are appropriate for very young children who have not initiated sex. But this argument is not compelling with adolescents, most of whom have intercourse by the time they are seniors in high school.

Abstinence-only advocates would respond that schools and public health officials use an abstinence-only message when discussing behaviors such as driving without seatbelts or drinking and driving. Yet that example actually makes the point for comprehensive sexuality education. Driving or riding in a car, like sex, is a part of many young people's lives. Educators and health officials say "always wear a seatbelt," not, "don't ever ride in a car." They also say, "always wear a condom."

If we cannot make all young people abstinent from risk, its just as true we can't make them all fit into traditional conceptions of teenage sexuality or lifestyles. For many youth at higher risk for pregnancy or STDs, the traditional vision of a heterosexual but abstinent youth, married couples, and stable families represents a world they can't be part of, or wouldn't want to join.

AIDS is one example. Although ad campaigns may encourage the notion of a generic young person at risk for HIV, the truth is that men who have sex with men represent the majority of infections among young men. In the year proceeding July 1996, *three quarters* of AIDS cases among 20–24 year old males occurred in men who have sex with men.[79] Because of the latency period between infection to disease, we can assume these men in their early 20s were infected in their high school years. How effective can an abstinence-only message be with these young men, when that message is at best silent – at worst, condemning – on homosexuality?

Many young women choose to have sex with older male partners, but the power dynamics of these relationships can be highly risky. The National Survey of Family Growth reported that of those young women who had their first intercourse at 16 years of age, one in five (21%) initiated intercourse with a man aged 20 or over. Kim Miller of the CDC has reported that, "for young women who are sexually active…the age of their first sexual partner may influence their risk of transmission [of HIV]. Young women whose first sexual partner was an older man were less likely to use condoms and possibly at higher risk for HIV infection than those young women whose first partner was the same age."[80] In a survey of the literature, Ralph DiClemente has found that having a sexual partner more than five years older was one of several predictors of less condom use among adolescents.[81]

It is adults' responsibility to help young women learn how to protect themselves in sexual situations with partners who may be older, more experienced and perceived as more powerful in the relationship. The only alternative is to assume abstinence-only programs can miraculously put an end to sexual relations between young women and older men. And the answer is not early marriage for these young women. Data from the Department of Health and Human Services indicate that teenage wives face a much higher risk of separation and divorce than women who wait longer to marry?[82]

The sexual experiences of many young women also do not fit the romantic picture of sexual relations painted as the social norm in abstinence-only programs. The 1995 National Survey of Family Growth found that 16% of girls whose first intercourse was before age 16 reported that initiation of intercourse was not voluntary. Of all the women surveyed, aged 15 to 44, 8% said their first experience of intercourse was not voluntary.[83] The option of abstinence may be a welcome message for many of these young women. Yet how welcoming will curricula stigmatizing sexually active youth be for young women who have already had to confront coercive sexual situations? Many or most of these young women will want to hear that they should not have sex until they are ready. Abstinence-plus comprehensive sexuality education will deliver that message, without ostracizing these young women.

Lack of ability to completely control sexual situations is a condition confronted by youth of all ages. Many young people living on the street, perhaps the group at highest risk of HIV infection, resort to selling sex for money or shelter. It can be particularly difficult for them to insist on condom use with their partners. Abstinence-only programs do not respond to the safer sex education needs of high risk youth. For these young people, housing, services, physical protection, self-defense, self-esteem, and sexual self protection are all likely to be more successful than an abstinence-only message.

If all young people had safe and secure lives a simple abstinence-only message might be more effective. But for most young people, risk-taking is part of a constellation of internal and external influences. Douglas Kirby has described the complexity of risk factors facing youth most likely to experience negative outcomes such as unplanned pregnancy. He writes that, "Youths at greatest risk are more likely to live in communities with high residential turnover, low levels of education, high poverty rates, high divorce rates, and high rates of adolescent non-marital births. Their parents are more likely to have low levels of education, to be poor, and to have experienced a divorce or separation or to never have married…"[84] Kirby concludes that, "the complex pattern of proximal (more closely related) and distal (more distantly related) antecedents strongly suggests that it will be very difficult for pregnancy prevention programs to reduce adolescent pregnancy markedly."[85]

The complex socio-economic aspects of teen pregnancy require responses on many levels. The California Wellness Foundation recently purchased ad space in *The New York Times* to deliver the message that in order to combat the high rate of unplanned pregnancy, young women need not just sexuality education, but more positive options in their lives: "Highlight math and science in school. Challenge job barriers. Overcome trivializing media stereotypes. All help give girls positive reasons to set goals and live up to them."[86] In this vision, comprehensive sex education is just part of a multi-pronged strategy.

Some proponents of abstinence-only curricula have offered draconian responses to the challenge of helping young people at particularly high risk. Writing in the *Journal of Pediatric and Adolescent Gynecology*, Dr. Stan Weed has apparently concluded we should pretty much abandon high risk youth and not make contraception available to young people because, "at risk students are the least likely to use contraception."[87]

Can We Rescue Them From Sex?

It is ironic that decades after Freud it is necessary to quote statistics to demonstrate that sex is a natural urge in human beings. Whatever adults think about it, some experience with sex is the norm for young people. And data from the YRSB also indicate that once they start having sexual intercourse, only a minority of young people return to abstinence. For example, almost half of 10th graders report having had sexual intercourse, but less than a third (30%) of these sexually active youth were abstinent in the three months preceding the survey. Many young people who are counted as abstinent in government surveys are actually experimenting with other kinds of sexual behaviors. In a study of high school aged virgins, Mark Schuster found that during the previous year 29% reported having engaged in heterosexual masturbation of partner, and 31% reported they had been masturbated by a partner.[88]

Based on in-depth interviews with over 900 adolescents, Kim Miller suggests that we must understand adolescent sexuality as a continuum of contemplation and activity. Miller identified five patterns of sexual activity among teens: delayers, anticipators, one timers, those with steady partners, and youth who had multiple sexual partners. She writes that abstinence messages may be "ineffectual" with the 36% of youth who fall into the "steadies" and "multiples" categories. Miller concludes that, "Prevention programs should include a range of messages and message delivery approaches appropriate for a range of sexual experiences…"[89]

The promising results from interventions targeted to young people at elevated risk are an additional reason to refine comprehensive or abstinence-plus sexuality education approaches rather than abandon them for abstinence-only curricula. Mary Jane Rotheram-Borus studied an

intervention with homeless and runaway youth that included up to 30 HIV intervention sessions addressing general HIV knowledge, coping skills, access to health care, and individual barriers to safer sex. The program successfully increased consistent condom use for those receiving the intervention.[90] The Jemmott program noted above is another example of an intervention which successfully reduced risk-taking among youth facing multiple challenges. Five rigorously evaluated abstinence-plus pregnancy prevention programs summarized in an article by Jennifer Frost and Jacqueline Darroch Forrest were successful with populations in middle and lower income areas.[91]

The documented successes of school-linked health centers is another example of age appropriate counseling and services helping young people at higher risk avoid the potential hazards of unprotected sex. School linked centers are typically able to reach many high-risk youth who fall through the cracks at schools, including homeless and out-of-school youth. Nine in ten school-linked centers provide HIV counseling and family planning, and about 80% provide birth control pills and condoms to their clients.[92] Studies have found a decrease in pregnancy rates and postponement of sexual involvement for youth with access to school-linked health center services.[93] [94]

A great many of the young people most likely to experience negative outcomes of unprotected sex do not fit into the picture of traditional adolescent life being proffered by abstinence-only advocates. These young people are grappling with the “danger points” the Family Research Council wants teachers to avoid. There is no reason to expect that a ten-hour session in school will radically change their deep desires or complex social situations. At best, it can help them choose whether they want to be sexually active, and, if so, learn to protect themselves and gain access to tools of prevention such as refusal skills, safer sex negotiation, and condoms. Turning away from the multiple challenges these young people face cannot succeed in protecting them from disease or unplanned pregnancy.

V. RECOMMENDATIONS

As the debate over sexuality education becomes mired in political agendas, educators and legislators are in danger of making policy that is responsive to political pressures rather than concrete evidence of results for young people at risk. The new money in sexuality education—one quarter billion federal dollars over five years—is going to abstinence-only programs which have no foundation in peer-reviewed research literature. The costs of unprotected teen sexual behavior are far too great for research-based decision-making to be dismissed as an invasion of the "technocrats." Following is a list of recommendations consistent with the goals of reducing disease and unplanned pregnancy, and public policy informed by research rather than one particular group's ideology.

• Focus on Outcomes not Ideology

Political agendas and discomfort with teen sexuality are obstructing our ability to use credible research to prevent disease. But in order to make responsible health education policy, it is not necessary to settle any of the ideological debates that whirl around the issue of sexuality education. What is needed is a commitment to value results. Behavioral science can tell us which programs are most likely to delay the onset of sexual activity, and reduce disease and unplanned pregnancy. Whether the goal is to encourage the greatest number of young people to delay sex until marriage, or to prevent the maximum number of STDs, research points to quality, abstinence-plus sexuality education programs emphasizing abstinence, and honestly discussing the tools of sexual self protection.

Staffers with the House Ways and Means Committee have written an interpretation of the abstinence-only provisions in the 1996 Welfare Reform bill. In that document, they argued that, "As in the cases of civil rights and smoking, the explicit goal of the abstinence-only education programs is to change both behavior and community standards for the good of the country."[95] But there are some important differences between the civil rights and anti-smoking campaigns and the abstinence-only effort. In the former cases, there was broad consensus on the need for racial justice and reduced smoking rates. In the later, the social consensus does not match the campaign—most Americans want children to receive sexuality education that is effective in preventing disease and unplanned pregnancy. There is no consensus that young people should be denied basic information about self protection in sexual encounters.

Too often, politics has driven health and education policy, and young people have paid the price.[96] Public sector leaders – school board members, administrators on the national, state and local level, and teachers – have a responsibility to use the lessons of behavioral science to promote healthy outcomes for young people, not the ideology of a chosen group.

The fact is, many sexuality educators are way ahead of the polemics of the sexuality education debate. They are already delivering a balanced curriculum that encourages abstinence and teaches young people who do have sex to protect themselves. This is not a "value neutral" approach, but a curriculum that acknowledges diversity of desires and experience and responds with a firm message of self respect and self protection.

• Require Quality Research

To take political agendas out of sex education, there is a need for more comparative, objective, trustworthy research on all kinds of programs. But as of today, the burden to demonstrate program effectiveness rests clearly with abstinence-only advocates. States and school districts that

choose to use federal and other monies for abstinence-only programs should commit to funding research on these programs.

Academic researchers typically study the impacts of one particular program on a population, using a control group that receives an intervention of lower intensity. In order to reach more conclusive answers to questions about effective sexuality education, foundations should consider funding research that measures the outcomes of abstinence-only and abstinence-plus sexuality education curricula head-to-head against each other in several schools.

• Improve State Guidance and Regulation

States hold ultimate responsibility for ensuring young people receive adequate education, including the health and sexuality education mandated by state and federal law. Yet it is difficult to determine how many states are providing adequate assistance to local school boards, administrators and teachers with decision-making around health and sexuality education curriculum. A 1997 report concluded that in California, the state with the largest number of children, the state provides "no substantive content and accuracy review of HIV/AIDS prevention and sexuality education curricula at the state level."[97] The report, titled *Sex, Lies, & Politics*, also concluded that the State education agency has failed to provide school districts with adequate guidance concerning state regulations on sexuality education curricula.

States must provide local school districts with research and guidance on effective sexuality education, HIV/AIDS, and pregnancy prevention curricula. State education agencies should also monitor local districts' compliance with state law regarding delivery of sexuality and health education.

• Require Adequate Teacher Training in Sexuality Education

Most teachers believe their students need sexuality education instruction that will help them protect themselves. Research from 1989 found that the majority of 7th to 12th grade teachers believe topics such as STDs and pregnancy should be covered by the 7th and 8th grades at the latest. But only about four out of five reported that their schools provided such instruction. Pressure from parents, community and school administration and lack of appropriate instructional materials were cited as reasons for the shortfall in sexuality education.[98] Lack of training for teachers is another major impediment. A 1995 survey of 169 colleges and universities which offer teacher training classes found that none of the schools require future health education teachers to take a course on HIV/AIDS, and only 9% of health education certification programs require a sexuality education methodology course.[99] One study has found that fewer than half of high school teachers formally teach about homosexuality. Only one in four teachers ranked themselves as very competent in teaching this issue.[100]

School districts and state education departments should provide teachers with training in effective sexuality education approaches. Teacher education programs must include research-based health education instruction in their required coursework.

• Encourage Health Care Professionals to Provide Prevention Services to Youth

Health care workers are a great, largely untapped, prevention resource for young people. A recent study found that 58% of adolescents surveyed said they would find it "very helpful" to talk with a physician about how to avoid getting HIV or other STDs from sex, and 75% said they would trust a physician to keep secret questions they might have about sex in general. Yet only

39% of adolescents reported discussions with physicians about how to avoid getting HIV/AIDS from sex, and only 15% reported discussing their sex life with a physician.[101]

• Make Condoms Available in High Schools

The availability of condoms in high schools does not hasten the initiation of sexual activity or the number of partners among adolescents, and can increase condom use.[102] [103] It makes sense to provide young people who will be sexually active with one of the primary tools of prevention. One published review of five successful pregnancy prevention programs found that the two programs that significantly reduced the proportion of adolescents who became pregnant were the two that put the greatest emphasis on providing access to contraceptive services.[104]

Many Americans support condom availability in high school. A 1991 national survey found that "65% of the American adult population supports condom availability in schools to prevent the transmission of HIV."[105] A 1996 Kaiser study titled Americans and AIDS/HIV found that 46% of adults agreed that condoms should be provided in high schools.[106]

A recent survey determined that only 2.2% of all public high schools and 0.3% of high school districts made condoms available. Even at these schools, 45% of the students obtained an average of less than one condom per student per year. "Only 5% of the schools made condoms available through baskets or bowls, the most barrier-free and nonrestrictive approach to condom provision," the researchers noted.[107]

High schools should make condoms and birth control information readily available to students.

CONCLUSION

The sexuality education debate is in part the product of political opponents now battling it out on a wide range of social issues. That debate will not be resolved soon. But we can agree to value results over rhetoric. Different communities have different standards of acceptable messages for youth. What is constant among these communities is the need to prevent disease and unplanned pregnancy.

Educators and policy makers can use innovative education, services, and credible evaluation methods to help the young people most profoundly affected by the youth STD and pregnancy epidemics. And we can broaden our efforts on the teen pregnancy and STD epidemics to include a greater emphasis on the roles of parents, health care workers, and the media.

Advocacy efforts for abstinence-only sex ed programming is part of a political—not disease prevention—agenda. It does not respond to the complex situations of youth or the choices they make, the majority of public opinion, the inclination of teachers about what students need, the consensus of public health experts, or the desires of adolescents for more information about how they can protect themselves. And the abstinence-only campaign ignores the broad reach of published scientific research on the subject of sexuality education.

The stakes are too high to base education and health policy on narrow political agendas. Last year 10,000 people under 22 become infected with HIV, three million got an STD, and over 300,000 unmarried teens gave birth. Ultimately, we have to choose whether the role of public schools is to exclusively promote traditional Christian ideology or deliver programs that can prevent unplanned pregnancy and disease. The research to date tells us we cannot have it both ways.

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