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Abstinence-only Sex Education in the United States: How Abstinence Curricula Have Harmed America

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Abstinence-only Sex Education in the United States: How Abstinence Curricula Have
Harmed America

by

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requirements for the degree of

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Abstract: Abstinence-only sex education has been a prominent form of reproductive health information for adolescents in the United States. Abstinence-only sex education programs often provide data that is incorrect or factually misleading, even though they are funded with federal dollars. Because of the dated and biased information presented in abstinence-only classrooms, gender stereotypes are reinforced to base women's worth on their sexuality, traditional marriage is touted as the paramount societal norm, and groups such as LGBTQ are marginalized. Facets of abstinence-only programs such as virginity pledges do not demonstrate success in preventing premarital sexual intercourse, but may lead to adverse outcomes such as avoiding STI testing. In comparison to comprehensive sex education, abstinence-only sex education fails to demonstrate significant effects on reducing rates of sexual activity. Thus, adolescents are inadequately prepared to prevent transmission of STIs and pregnancy. Providing comprehensive sex education to US adolescents will promote healthier behaviors and attitudes than abstinence-only curricula.

Introduction:

All of the high school health class's eyes sit transfixed on a piece of scotch tape their teacher has just cut. She holds it in the air, prepared to make her point.

"Think of this piece of tape as a female. At the moment, she has never had sex. But now she and her boyfriend are going to have sex for the first time," the teacher affixes the tape to a male student's shirt. After removing the tape from the first male, she allows the class to observe the lint it has picked up. "Now, look at what happens when she tries to make a connection with another man," the tape is not adhesive to the next male's shirt. "She is incapable of bonding to him, and by being used in this manner, is no longer able to have strong relationships."

The females in the class express distress as their teacher lets the piece of tape fall in the wastebasket and pulls out a textbook, ready to continue onto the next lesson.

This lesson, as detailed by Jessica Valenti in *The Purity Myth* (Valenti, 2009, p. 33), is one of the many tactics employed in abstinence-only sex education classes to

incite shame and guilt about sexual activity in an attempt to prevent intercourse until marriage. With the proliferation of abstinence-only sex education for adolescents in the United States, are these programs having their intended effects?

Background: Abstinence-Only in the US Classroom

The 1970s and 1980s gave rise to two epidemics in the United States. The first was a significant increase in teenage pregnancies, and the second was HIV/AIDS. Public concern over these matters influenced states to adopt policies to teach about sexuality in classrooms (Boonstra, 2009). In 2009, the CDC reported over 400,000 teen girls gave birth (CDC, 2015). The burden of teenage pregnancy is great; teen moms are less likely to complete high school or attend college, more likely to have large families, and at greater risk to be single, compounding the risk of living in poverty. Children born to teens also are costly to taxpayers, amounting to 9.1 billion US dollars in 2004. In 2002, about seventy-five of every thousand girls aged 15-19 became pregnant (Kirby, 2007). Abstinence-only sex education is meant to reduce both the transmission rates of STIs and teenage pregnancy via promoting no sexual activity between adolescents until marriage.

Abstinence-only sex education has been a prominent fixture of the US educational system. Since 1982, the federal government has spent over a billion dollars on abstinence-only sex education programs. This funding originated with the Adolescent Family Life Act (AFLA) during the Reagan Administration (Kay & Jackson, 2008). AFLA's creation was intended to decrease rates of pregnancy among unmarried teens by promoting chastity and sexual restraint (Blank, 2007). Title V in 1996 outlined stricter funding for abstinence-only education and formed guidelines for abstinence-only material, as specified in Table 1:

Table 1 (Kay & Jackson, 2008, p. 6)

The Federal Definition of Abstinence-Only-Until-Marriage Programs	
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 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 increases vulnerability to sexual advances, and
h.	teaches the importance of attaining self-sufficiency before engaging in sexual activity.
42 U.S.C. § 710 (2000 & Supp. III 2003)	

The last creation of federal funding for abstinence-only education was in 2000, called Community-Based Abstinence Education (CBAE), once also known as Special Projects of Regional and National Significance (SPRANS). The creation of CBAE was of particular controversy because it removed states' autonomy in deciding recipients of program funding (Kay & Jackson, 2008).

Following these federal rules, some states proceeded to also outline the direction of funds for sex education programs. Bills were passed in 1998 requiring that sexuality education programs featured abstinence as the sole or preferable mean to prevent sexually transmitted infections and pregnancy in Virginia, Ohio and Missouri (Kempner, 1998). A study conducted by the Alan Guttmacher Institute found that between 1988 and 1995, abstinence being instructed as the only way to prevent STIs or pregnancy by public

school teachers increased significantly. The increase was from one in fifty to one in four teachers (Dailard, 2001).

Over two thirds of public school districts require sex education. Over eighty percent of these district requirements were enacted during the 1990s. During this time, opinions varied immensely over the content of sex education, and whether contraceptives and prevention of STIs should be included in the material (Dailard, 2001).

Across the United States, harrowing policies regarding sex education in public schools can be found. Sex education for public school students is mandated by twenty-two states and the District of Columbia but only nineteen states require factual accuracy in the material presented to students (National Conference of State Legislatures, 2015). Providing information about contraception is only required by eighteen states and the District of Columbia, and abstinence messages reached eighty-seven percent of public and private high schools in 2006 (Guttmacher Institute, 2012).

The School Health Policies and Programs Study conducted in 2012 by the National Centers for Disease Control found that in U.S. high schools, twenty-eight percent taught information to students about eleven key topics related to prevention of pregnancy, HIV and other STIs as part of a required health education course. Thirty-nine percent of required education classes taught how to correctly use a condom. The same study when conducted in 2006 identified that fifty-eight percent of classes taught about contraception (CDC, 2015).

Abstinence-only sex education draws criticism for its efficacy in preventing teen pregnancy and sexually transmitted infections (STIs) in comparison to comprehensive

programs (Lindberg & Maddow-Zimmet, 2012). The use of contraceptive rates at first sexual intercourse is higher among students who have received a comprehensive sex education course as compared to abstinence-only (Lindberg & Maddow-Zimmet, 2012).

Upon review of the material taught in CBAE-funded programs, a 2003 report by the US House of Representatives Committee on Government Reform concluded over eighty percent of curricula used false, misleading or distorted information about reproductive health. This program content is not reviewed or approved by the government, meaning a swath of US tax dollars have been diverted into ineffectual and unscientific education programs for students.

In abstinence-only classes, tactics to incite feelings of fear, shame, and guilt about sexual activity are deployed using inaccurate information, religious messaging and discussion of contraceptive only as it relates to methods' failure rates to discourage students from having sex. Material also has a bias against females (LeClair, 2006), utilizing gendered stereotypes such as females need financial support of males or are responsible for minding male sexuality (Kay & Jackson, 2008).

Facets of abstinence-only education such as the use of virginity pledges (a promise to remain chaste until marriage) are also of significance in their impact on adolescent health. Though sexual onset is delayed among pledgers, rates of STIs compared to non-pledgers are similar. Testing for STIs is practiced less among pledgers as they frequently avoid seeking reproductive health care to prevent detection as being sexually active, allowing STIs to prevail (Bruckner & Bearman, 2005).

Sex education can be comprehensive; teaching about methods of contraception and means to practice safer sex while also promoting abstinence as an ideal behavior or abstinence-only; which only promotes abstaining from sex and discusses contraceptive only in regards to failure rates.

Groups and organizations that support abstinence-only sex education include conservative and religious think tanks such as Concerned Women for America, the Eagle Forum, the Family Research Council, Focus on the Family, the Heritage Foundation, the Medical Institute for Sexual Health (MISH), the National Coalition for Abstinence Education, and STOP Planned Parenthood International (Collins & Summer, 2002). Those in favor of abstinence-only programs contend that teaching about condoms and other forms of contraception subverts the abstinence-only message and its impact (Hauser, 2004) and other people favor abstinence-only programs because of the belief “that sex before marriage is wrong, whether for religious, health, or other reasons, also believe either that sex should not be discussed in schools at all or that only abstinence should be encouraged. Some people believe that teaching young, unmarried people where to obtain condoms and contraception, and how to use them, encourages immoral or unhealthful sexual behavior and will thereby increase rates of STD and pregnancy” (Kirby, 2007, p. 112). These are arguments that have helped position abstinence-only sex education as the prominent class available to students.

When it comes to sex education in the US, programs should be in place that promote healthy behaviors; ideally maintaining low rates of teen pregnancies and STIs and high utilization of contraceptive and health services. With the historical prominence

of abstinence-only education in US classrooms, a critical review of how well students have been served by these programs is imperative. In comparison to other teaching methods, abstinence-only sex education is not the apex means of teaching it has been made out to be.

Methods:

Literature about abstinence-only sex education was analyzed to compile this literature review. Due to the inception of abstinence-only sex education in the United States in 1982, only articles published from then until 2015 were considered relevant. This review only considered articles pertaining to abstinence-only sex education in the United States due to the focus of the thesis.

Keywords to help identify relevant literature included: *abstinence-only sex education, abstinence-only, abstinence-only sex education efficacy, comprehensive sex education, teen pregnancy, teen sexual activity, virginity pledge, sex education curriculum, sex education, history of abstinence-only, and outcomes of abstinence-only*. Articles were primarily identified from Google Scholar, The Journal of Adolescent Health, and ScienceDirect.

Literature Review:

Components of Abstinence-Only Education: *False and Misleading Program Material*

“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.”- Oregon student who received abstinence-only education (Kay & Jackson, 2008, p.10)

Abstinence-only curricula have become notorious for presenting factually inaccurate material to students. Glaring fallacies include data regarding the efficacy of contraception, risks associated with abortion, conforming scientific facts to religious ideology, and promoting gender stereotypes. Abstinence-only programs receive immense federal funding, but the content of programs is not reviewed for accuracy by the government (US House of Representatives Committee on Government Reform, 2004).

When Title V funding for abstinence-only sex education first reached states' health departments to administer, abstinence-only contractors subsequently became the recipients of the funds. Curricula that were used frequently include *Education Now Babies Later (ENABL)*, *Why Am I Tempted? (WAIT)*, *Family Accountability Communicating Teen Sexuality (FACTS)*, *Choosing the Best Life, Managing Pressures before Marriage*, and *AC Green's Game Plan* (Hauser, 2004).

An astounding eighty percent of programs receiving money through the CBAE initiative contain false or misleading information and abstinence-only programs frequently invoke emotional reasons to promote abstinence, including “romantic notions of marriage, moralizing, fear of STDs, and by spreading scientifically incorrect information” (Stranger-Hall & Hall, 2011, 9). Playing to students’ emotions may not lead to the intended outcome, as Hauser found, “youth expressed frustration... when staff attempted to tell them what was right and wrong. Youth wanted to be respected for their ability to weigh information... in arriving at their own decisions regarding sex” (2004; 17).

Fear as a tactic to prevent sexual activity was found to be so distorted that upon evaluation of Pennsylvania's Title V abstinence-only programs, school children falsely believed sexual involvement could cause death (Hauser, 2004). Arizona students who received abstinence-only education expressed less favorable views towards contraception after the program. A possible explanation for this could be the program's portrayal of contraception in terms of failure rates, and not their accessibility or instructions on use. (Hauser, 2004). Reducing transmission of STIs and HIV with condom use is also grossly misrepresented in program material (US House of Representatives Committee on Government Reform, 2004).

Contrary to the Centers for Disease Control and Prevention's guidelines that condoms are "highly effective" in preventing transmission of HIV, many abstinence-only programs reference a debunked and discredited study from 1993 conducted by Dr. Susan Weller. The study finds condoms only sixty-nine percent effective in preventing HIV transmission. Classes emphasize an uptick in the use of condoms and higher rates of STIs, suggesting a causal relationship between the two trends. This assertion ignores declines in incidence of specific diseases, and condoms' ability to cut transmission rates (US House of Representatives Committee on Government Reform, 2004).

As Kay and Jackson found, students leave abstinence-only classes remembering images "of all the nasty infections and diseases we could acquire by having sex. The program made it seem that those diseases came straight from sex, not unprotected and unsafe sex" (Kay & Jackson, 2008, p. 24). This ambiguity can negate the importance of practicing safe sex.

Condoms also are disparaged as a contraceptive method by abstinence-only programs. The program *Choosing The Best* says “research shows that condoms fail an average of 14 percent of the time in preventing pregnancy. This means if a teen uses condoms for birth control during four years of high school, they will experience a cumulative failure rate of more than 50 percent”(Kay & Jackson, 2008, p.14). The program neglects to specify that the fourteen percent figure is the high side of a user failure rate (a rate affected by user error), and that perfect use rates fail only three percent of the time. The use of a “cumulative failure rate” incorrectly represents the statistics of condom use. Condoms at each use will maintain an average failure rate of up to fourteen percent (Kay & Jackson, 2008, p.14).

Abortion is presented to students as doing irreparable harm to women and their fertility. Programs that receive funding through CBAE are also often closely involved with agendas to restrict abortion access. Programs explain that “five to ten percent of women will never be pregnant again after having a legal abortion”, and if they do, “premature birth, a major cause of mental retardation, is increased following the abortion of the first pregnancy” (US House of Representatives Committee on Government Reform, 2004, p. i). Abortion is also falsely implied as being responsible for subsequent ectopic pregnancies and higher rates of suicide (Kay & Jackson, 2008). These statements are contrary to obstetrics publications that do not link abortion to an increased incidence of infertility or premature birth (US House of Representatives Committee on Government Reform, 2004). Premarital intercourse is rampantly stigmatized by proponents of abstinence-only education and program content. Eric Keroack oversaw funding for reproductive health programs for the Bush Administration and commented comparing

premarital sex to modern germ warfare, a sentiment that echoes the conservative attitude that drafted the Title V guidelines (Valenti, 2009).

Premarital sex also is expressed by abstinence-only programs as undermining the US institution of family (Valenti, 2009), and pregnancy as a product of premarital sex is purported to have negative effects for not only the child, but also the child's parents and society at large (Kay & Jackson, 2008). These lessons may alienate students who come from nontraditional backgrounds, such as single parents or non-married relationships.

Reinforcement of Gender Stereotypes

“People want to marry a virgin, just like they want a virgin toothbrush or stick of gum.” - Texas sex education worksheet (Klein, 2013, par. 1)

Antiquated notions of acceptable roles for men and women are frequently included in abstinence-only curriculum. The use of these stereotypical gender roles also discriminates against females in the classroom by asserting they are responsible for preventing unwanted sexual advances (LeClair, 2006). Because of the traditional norms that are touted by abstinence-only classes, the LGBTQ community is excluded completely from gaining meaningful knowledge about sexual health (Kay & Jackson, 2008).

The program *Facts and Reasons* explains “[i]n deciding to have intercourse, women are more likely than men to be in love, want a mutually satisfying relationship, and are interested in what their partner feels and thinks...men, true to the stereotype, are more likely to engage in sex with a warning to the woman that there will be no

commitment” (Kay & Jackson, 2008, p. 20), suggesting that women are the only party with emotional investment, and that men will partake in what sexual activity is available.

A common quality subscribed to females in abstinence-only curriculum is that they are the “gatekeepers” of male sexuality. The responsibility is put on females to keep men’s behavior in line, explained by saying females are better suited to keep intimacy in perspective since females feel arousal less easily (LeClair, 2006). The lesson of women being gatekeepers to men’s sexuality also takes a more sinister turn, and places the blame on women for men’s indiscretions in lesson excerpts reminding females not to dress like teases (LeClair, 2006) and from Heritage Keepers’, “females need to be careful with what they wear, because males are looking! The girl might be thinking fashion, while the boy is thinking sex. For this reason girls have an added responsibility to wear modest clothing that doesn’t invite lustful thoughts” (Kay & Jackson, 2008, p. 20). These claims appear to negate responsibility on a male’s part for any action done onto a female who dresses “provocatively”.

Upon examination, eleven of thirteen widely-used curricula in federally funded abstinence-only programs treated gender stereotypes as if they were scientifically proven facts (Kay & Jackson, 2008). Current day textbooks have pulled material from advice books published as late as in the forties (Valenti, 2009). Why kNOw’s lessons teach that “women gauge their happiness and judge their success by their relationships” while “men’s happiness and success hinge on their accomplishments” (Kay & Jackson, 2008, p. 20). Other programs detract from the importance of females having academic and professional success (LeClair, 2006).

Remaining a virgin is an important value for females emphasized by abstinence-only classes. The program *HIS* tells females that if they are no longer a virgin, she can no longer be found pure, fresh, or unspoiled (SIECUS). Many classroom lessons have been employed to demonstrate the effects of a female losing her virginity. Beyond the tape exercise described by Jessica Valenti in her book *The Purity Myth*, many analogies exist to show the consequences of a female losing her virginity. There is the lesson “The Rose With No Petals” utilized by the program *Choosing the Best Path*. Here, a beautiful rose is stripped of its petals individually by students to denote that it has lost its worth after these metaphorical “sexual encounters” (SIECUS). Elsewhere, a Texas school district using *Reality Check* curriculum likened having premarital sex to being like a chewed piece of gum (Klein, 2013). These lessons disempower young females and stigmatize individuals.

An abstinence-only program was denied by a Colorado school district after a presentation to the board took a live goldfish from its bowl and left it on a table, suffocating, as a metaphor for sexual activity outside of marriage, leaving the school board members very perturbed (Kempner, 1998). And in Nevada, a radio advertisement was secured by the abstinence-only coordinator of the state to remind females that premarital sex would lead to them losing their boyfriends and feelings of being dirty and cheap (LeClair, 2006).

Abstinence-only curricula have stirred controversy with advocates of victims of sexual assault. Elizabeth Smart, who was kidnapped and sexually abused at age fourteen, attributes part of her decision to stay with her captors due to the sex education she received that made her feel sexually active women were “worthless”. She has voiced

concerns over the impact that these messages have on victims of sex trafficking and abuse (Klein, 2013).

Discussion of consent in sexual relationships is a matter that is glossed over in abstinence-only classes. Kay and Jackson (2008) quote a student on page ten who received abstinence-only sex education in Oregon as saying “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” (Kay and Jackson, 2008, p. 10). This is a frustrating situation as found in evaluation of abstinence-only programs because “sexual violence is real. Many females reported that sexual abstinence was unrealistic in their world. Without prompting, they described episodes of forced sex” (Hauser, 2004, p. 17).

Females suffer from a higher burden of STIs than males due to biological susceptibility (Woebse, 2014). Complications from infection can include pelvic inflammatory disease (which left untreated can lead to infertility), cancer of the reproductive organs, stillbirth, ectopic pregnancy, and increased vulnerability to contracting HIV (Collins & Summer, 2002). Research has demonstrated that females are more likely to partake in unsafe sexual activities if they have not had adequate access to proper sexual health information (Kay & Jackson, 2008). Condoms are more likely to be used during a first sexual encounter by females who have received education about contraceptives than those who have not (Woebse, 2014). Compared to adolescent males, females of the same age typically know less about how to use condoms correctly (Kay & Jackson, 2008). All of these implications for females, as well as childbearing, make it of utmost importance that information is unbiased and available.

Another matter disregarded by abstinence-only sex education is inclusion of the LGBTQ community. Findings from the Kaiser Family Foundation reveal that seventy-six percent of parents surveyed wish to see the subject of homosexuality and sexual orientation in sex education programs (Collins & Summer, 2002). A position paper penned by the Society for Adolescent Medicine on abstinence-only education found that abstinence-only sex education were not adequate in meeting the needs of LGBTQ youth. While as many as one in ten teens may not be comfortable with their gender identity, abstinence-only classes frequently paint homosexuality as deviant and unnatural (Santelli et al., 2006) Abstinence-only educators are given material that includes teaching students that “research shows that homosexuality 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” (Kay & Jackson, 2008, p. 13).

The abstinence-only program *I'm in Charge of the FACTS*, a recipient of federal funds, instructs “Sexual identity is not fully established until the late teens or early twenties... Young persons may sense affection and even infatuation for a member of the same-sex. This is not the same as ‘being’ a homosexual. Any same sex ‘sexual experimentation’ can be confusing to a young person and should be strongly discouraged” (Kay & Jackson, 2008, p. 13). This language connotes a tone of ‘gay conversion therapy’ or otherwise detrimental and damaging language towards LGBTQ individuals.

Educational needs of the LGBTQ community are often not met to give them the adequate health information they need (Santelli et al., 2006). These lessons may normalize discrimination against LGBTQ adolescents, and contribute towards

discrimination against the LGBTQ population at large (Kay & Jackson, 2008).

Behavioral and health outcomes due to homophobia can include substance abuse, suicide, HIV infection, and isolation (Santelli et al., 2006). Sexual violence and issues of consent also greatly affect lesbian, bisexual and gay adolescents. The HIV epidemic has been particularly grave for this group and the Centers for Disease Control advises a sustained prevention effort for all generations of young gay and bisexual men is needed (Collins & Summer, 2002).

Virginity Pledges

“While the effect of virginity pledges is real, virginity pledges are not an immunization which work in every context. Policymakers would be wrong to think that virginity pledges will have a magical effect on kids' behaviors. Pledges work only for those young people who identify with this norm. If you make it mandatory, kids will fight it.” – Michael D. Resnick, Add Health Researcher, Center for Adolescent Health and Development at the University of Minnesota (Dailard, 2001, par. 8)

Virginity pledges are pledges taken by individuals to promise to remain abstinent until marriage. The Southern Baptist Church ignited this movement in 1993 and brought pledges to churches, schools and colleges throughout the United States (Bersamin et al., 2004). While many pledge promises are intrinsically religious, abstinence-only programs have altered these pledges so that they can be used in schools (SIECUS). Across the United States, it is estimated 23% of females and 16% of males who are adolescent have taken a virginity pledge (Bersamin et al., 2004).

Efficacy of virginity pledges has been measured in different ways and proven to various extents. Both findings from Bersamin et al. (2004) and Bruckner and Bearman

(2005) conclude that virginity pledges have a positive effect on delaying sexual onset. Bruckner and Bearman (2005) also find those who have taken a pledge have lower rates of testing for STIs and the use of reproductive health services, likely to avoid detection as sexually active. Another study in 2006 revealed fifty-two percent of pledge takers had sex within a year and those who take a virginity pledge are around 1/3 less likely to use contraceptive the first time they have sex (Blank, 2007).

Bruckner and Bearman (2005) also found that the National Longitudinal Study of Adolescent Health demonstrated similar rates of HPV, trichomoniasis, Chlamydia and gonorrhea infections between those who had and had not taken virginity pledges. The Society for Adolescent Medicine warns in their position paper that virginity pledges' failure rates are particularly high when considering biological outcomes including STIs (Santelli et al., 2006). Janet Rosenbaum's analysis of the National Longitudinal Study of Adolescent Health found that seventy-three percent of people who took a virginity pledge denied doing so upon their second survey interview, leading her to believe the interviewees were not strongly invested in the pledge (Mehren, 2006).

Bersamin et. al (2004) finds that virginity pledges will fail when taken simply due to outside pressures from parents or teachers. This echoes the findings of a study published in the *Journal of Child and Family Studies* that concludes religiosity of the pledger is an important component to remaining abstinent (Kutner, 2014). Utilization of virginity pledges in abstinence-only programs is thus only relevant for people already intrinsically motivated to remain abstinent.

Discussion:***Outcomes of Abstinence-only Sex Education: Rates of Sexual Activity***

“Talking about sex is not going to make a person have sex. In fact, it may quell some of the curiosity and help the individual build a healthy sense of sexuality as well as to understand when, how, and with whom they want to have sex.” - Student who participated in abstinence-only classes in Virginia (Kay & Jackson, 2008, p. 26)

Abstinence-only sex education has not been an effective means to reduce the rate of sexual activity among teens and adolescents. After 1996, federal funds increased significantly for abstinence-only sex education. Although these programs proliferated, evaluation demonstrated that there they were not very effective at delaying onset of sexual intercourse (Santelli et al., 2006).

The United States House of Representatives Committee on Government Reform’s report commissioned by Representative Waxman on abstinence-only sex education found that the net effect was no overall change to sexual behavior and use of contraceptives by implementing abstinence-only sex education. Another congressionally mandated report was published by Mathematica Research in 2007 that concluded students participating in abstinence-only programs were sexually active at the same age and with as many people as their peers who did not take an abstinence-only class (Kay & Jackson, 2008). National Campaign to Prevent Teen and Unplanned Pregnancy also concluded that abstinence-only classes rarely demonstrated positive impacts, especially in comparison to comprehensive classes (Kay & Jackson, 2008).

In 2004, reviewing Minnesota’s program *enabL* found junior high students participating in the program actually increased their participation in sexual activities,

from 5.8% to 12.4% (Kay & Jackson, 2008). In Pennsylvania, evaluation of Title V abstinence-only programs found “positive attitudes towards abstinence declined significantly and there was a concomitant increase in the proportion of young people who experienced sexual intercourse for the first time. Unfortunately, only about half of these sexually active youth used any form of contraception” (Hauser, 2004, p. 4). In Missouri, evaluation confirmed that abstinence-only programs were not impacting adolescents’ sexual behavior (Hauser, 2004).

Alternatively, there have been findings that “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” (Santelli et al., 2006, p. 83). The National Survey of Family Growth from 2006-2008 found that receiving sex education of any type will delay sexual activity as opposed to never receiving sex education (Lindberg & Maddow-Zimmet, 2012).

According to Centers for Disease Control’s 2013 survey of high school students, 46.8% have had sexual intercourse. When asked about the last time they had had intercourse, 40.9% of students had not used a condom. Fifteen percent of respondents have had sex with four or more people (CDC, 2015). With almost half of US adolescents sexually active (CDC, 2015), the intended effect of abstinence-only sex education preventing sexual activity before marriage has been proven unrealistic. These statistics also reflect the dangerous precedent that nearly half of students chose not to use a condom the last time they had intercourse. This behavior is incredibly risky with unintended consequences such as pregnancy and STIs.

STIs/Pregnancy

“It appears that a comprehensive approach provides the most promising prevention of teen pregnancies and STDs.” (Hauser, 2004, p. 12)

By limiting the availability of information about condoms and contraceptives to students, abstinence-only sex education programs are inadequately preparing a population of students that will by and large be sexually active regardless. Among developed nations, teens in the United States have the highest rate of birth and among the highest rates of sexually transmitted infections (Hauser, 2004).

Such was the case for Texas’ Crane Independent School District, an “abstinence-only” school district, which in May 2015 found an outbreak of Chlamydia going on among high school students. One in fifteen of the students were estimated to have the disease. The school district’s sex education program runs for three days yearly and focuses on abstinence (Klein, 2013). The CDC reports that about half of the 19 million new STI cases a year occur in those aged fifteen to twenty-four (CDC, 2015).

When women are not given access to the reproductive health information they need, it will contribute to their involvement in unsafe sexual behaviors (Kay & Jackson, 2008). Compared to those who have received information about condoms, women who have not are less likely to use condoms when they have their first sexual encounter (Woebe, 2014), compounding their risk of contracting a disease.

Comparison between comprehensive and abstinence-only programs found in a study nationwide of 15-19 year olds, teens participating in sex education programs that provide information about contraceptives and talk about the importance of delaying sex were much less likely to report teen pregnancies compared to those who never had a sex

education class and those who had abstinence-only education (Kohler et al., 2008). A comprehensive sex education approach that also includes abstinence as an ideal behavioral option has shown to be positively linked to low teen pregnancy rates across states (Stranger-Hall & Hall, 2011).

Teenage pregnancy can have significant consequences; teen moms are less likely to complete high school or attend college, more likely to have large families, and at greater risk to be single, compounding the risk of living in poverty. Children born to teens also are costly to taxpayers, amounting to 9.1 billion US dollars in 2004. In 2002, about seventy-five of every thousand girls aged 15-19 became pregnant (Kirby, 2007). In 2009, the CDC reported over 400,000 teen girls gave birth (CDC, 2015).

An article authored by Kathrin Stranger-Hall and David Hall (2011) analyzed state policies on sex education as well as teen pregnancy rates by state. States were stratified into four different levels based on the emphasis given to abstinence-only sex education in their policies. A state with a rating of “3” focused exclusively on abstinence-only, while a “1” has comprehensive sex education, and “0” said nothing explicitly in their laws and policies about abstinence (Stranger-Hall & Hall, 2011).

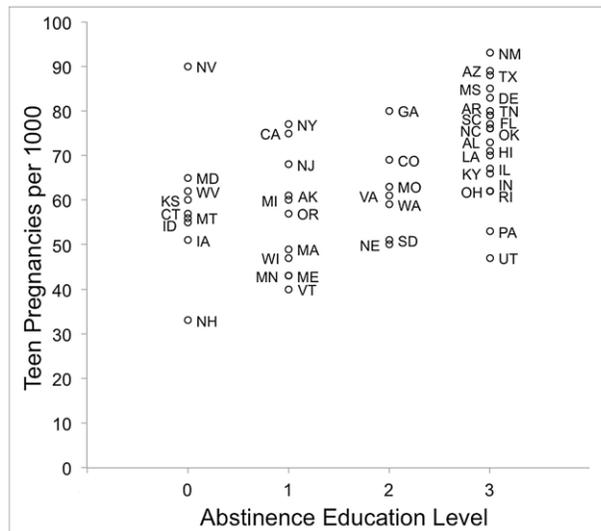


Figure 1 (Stranger-Hall & Hall, 2011, p. 4)

Stranger-Hall and Hall found “that abstinence education in the U.S. does not cause abstinence behavior. To the contrary, teens in states that prescribe more abstinence education are actually more likely to become pregnant” (Stranger-Hall & Hall, 2011, p. 2). As seen in Figure 3, states with higher ratings of abstinence-only education are also experiencing higher rates of teen pregnancy.

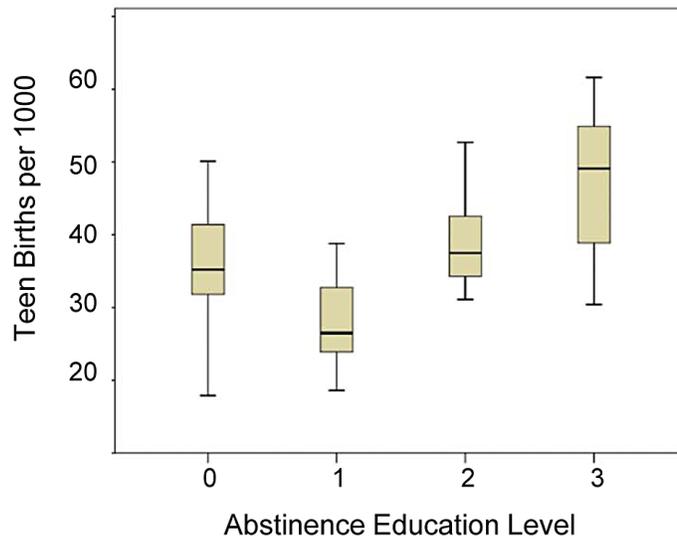


Figure 2 (Stranger-Hall & Hall, 2011, p. 6)

Stranger-Hall and Hall echo the findings of the CDC, Kirby, and Underwood et al.'s analyses and conclude “comprehensive sex or HIV education that includes the discussion of abstinence as a recommended behavior, and also discusses contraception and protection methods, works best in reducing teen pregnancy and sexually transmitted diseases” (Stranger-Hall and Hall, 2011, p. 7).

Conclusion:

The Future of Sex Education

While abstinence-only sex education may be suitable in representing the values and social norms in the communities where it is utilized, there is little other proven benefit to students. Comprehensive sex education classes are better at providing the tools necessary to prevent pregnancy and STIs. One hundred and fifteen sex education programs were reviewed, finding that the programs providing information about using contraceptive correctly can significantly delay the initiation of sex, lower the frequency

of sexual contact, lower the number of sexual partners, and increase the use of condoms or other contraceptives among adolescents (Kirby, 2007).

In Kirby's study, comparison of selected comprehensive and abstinence-only programs found comprehensive programs to have more significant efficacy in the following areas:

Table 2 (*Emerging Answers*, 2007, p. 109)

Outcome Measured	Abstinence Programs N=8	Comprehensive Programs (N=48)
Delay Sex	(N=8)	(N=32)
Delayed Initiation	1	15
No Significant Results	7	17
Hastened Initiation	0	0
Reduce Frequency of Sex	(N=6)	(N=21)
Reduced Frequency	2	6
No Significant Results	4	15
Increased Frequency	0	0
Reduce Number of Partners	(N=5)	(N=24)
Reduced Number	1	11
No Significant Results	4	12
Increased Number	0	1
Increase Condom Use	(N=5)	(N=32)
Increased Use	0	15
No Significant Results	5	17
Reduced Use	0	0
Increase Contraceptive Use	(N=4)	(N=9)
Increased Use	0	4
No Significant Results	4	4
Reduced Use	0	1
Reduce Sexual Risk-Taking	(N=3)	(N=24)
Reduced Risk	0	15
No Significant Results	3	9
Increased Risk	0	0

Though there has been a significant amount of money directed towards abstinence-only curricula in schools historically, President Obama signed an act into law in 2009 that was the first to provide federal funds for comprehensive sex education. The Teen Pregnancy Prevention Initiative of this act provides funding to the sum of 114.5

million dollars towards scientifically sound and age-appropriate programs that reduce teen pregnancy and other risk behaviors (Woebse, 2014).

Currently, seventy-five million US dollars are available annually to states until 2017 through the Personal Responsibility Education Program. Programs with this funding focus on financial literacy, healthy relationships, education and employment skills, and healthy life skills, in addition to preventing pregnancy and STIs. Programs available for selection have been selected by the Department of Health and Human Services for their successful evidence-based models (National Conference of State Legislatures, 2015).

The Society for Adolescent Medicine is in favor of a comprehensive approach to reducing sexual risk, including abstinence and correct and consistent use of condoms among sexually active teens (Santelli et al., 2006) and it is CDC policy to support behaviors that encourage health and reduce the risk of contracting HIV, other STIs, and accidental pregnancy (CDC, 2015). Other organizations in support of comprehensive sex education programs include the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Medical Association, the American Nurses Association, the American Psychological Association, the American Public Health Association, and the Institute of Medicine (SIECUS).

Comprehensive sex education programs can minimize the risk of STIs and pregnancy by promoting the correct and consistent use of contraceptives by those young people who are sexually active in addition to the promotion of condoms. When feasible, programs should promote using condoms and long-term contraception methods (Kirby, 2007).

Kirby's 2007 study found the following curricula to have the most positive effects on delaying sexual activity and improving STI and pregnancy rates, all of which including comprehensive teaching methods:

Table 3 (Based on *Emerging Answers*, 2007, p. 23)

Curriculum-Based Sex and STD/HIV Education Programs

1. Becoming a Responsible Teen: An HIV Risk Reduction Program for Adolescents [1]

2. ¡Cuidate! (Take Care of Yourself) The Latino Youth Health Promotion Program [2]

3. Draw the Line, Respect the Line [3-5] (Implemented with both genders; found effective for boys only)

4. Making Proud Choices: A Safer Sex Approach to HIV/STDs and Teen Pregnancy Prevention [6]

5. Reducing the Risk: Building Skills to Prevent Pregnancy, STD & HIV [7]

6. Safer Choices: Preventing HIV, Other STD and Pregnancy [8-11]

7. SiHLE: Sistas, Informing, Healing, Living, Empowering [12] (Implemented and effective for girls only)

Comprehensive sex education programs can evolve to promote safer behaviors by promoting a reduction in the number of sexual partners, avoiding concurrent sexual partners, testing and treating STIs, increasing the wait time between sexual partners, and vaccinating against HPV (the human papillomavirus) and hepatitis B (Kirby, 2007). Most Americans would like sex education to be taught to students in schools. More than eighty-five percent of Americans are in support of school-based sex education programs providing information about the proper use of contraceptives and seventy-seven percent of Americans are not in support of federal dollars going towards programs that only teach about abstinence (ACLU).

Abstinence-only programs feature medically inaccurate, deceiving and fear-inciting methods to deliver the message students should wait to have sexual intercourse.

The lessons unjustly discriminate against groups such as females and those who are not heterosexual. Utilization of virginity pledges has not been adequately demonstrated to prevent sexual initiation. These parts of abstinence-only sex education are unsound means to promote abstinence until marriage.

When considering the health outcomes of abstinence-only sex education, including reduced STI testing, sexually transmitted infections, teen pregnancy and less utilization of contraceptives, these programs fail to adequately protect America's youth and adolescents. Comprehensive sex education outcomes offer far more positive results and these programs are widely accepted by the US populace. Comprehensive sex education programs should continue to receive support and implementation in US classrooms.

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