THE IMPORTANCE OF APPROPRIATE SEXUALITY EDUCATION

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Public Support for Sexuality Education

School programs about human sexuality have evolved in response to concerns about high rates of teen pregnancy and increasing rates of sexually transmitted infections (STIs), including HIV/AIDS. Compared to teens in other industrialized countries, American teens aged 15-19 have the highest pregnancy rate (Meschke, Bartholomae & Zentall, 2002). Currently in the United States, more than 800,000 females under age twenty become pregnant each year: Eighty percent of those are unintended pregnancies (Henshaw, 2004). Although teens and young adults 15-24 years of age comprise only one quarter of the sexually active population of individuals under 44 (Abma, Chandra, Mosher, Peterson, & Piccinino, 1997; Laumann, Gagnon, Michael & Michaels, 1995; Sonenstein, Ku, Lindberg, Turner & Pleck, 1998), they acquire nearly one half of all new STIs (Weinstock, Berman & Cates, 2004). This translates to about 9.1 million young people in this age group acquiring STIs (Guttmacher Institute, 2006). As a group, adolescents are at greatest risk for many STIs. In fact, more than half of HIV infections acquired after infancy occur during adolescence (Centers for Disease Control, 2004; Meschke et al., 2002).

The majority of parents, health professionals, and the public agree that there should be sexuality education in schools and that girls should delay childbearing until they are self-sufficient. However, there is a major difference between what most parents and professionals agree should be in a curriculum and what is actually offered. In a 2004 poll conducted by the Kaiser Family Foundation, National Public Radio, and the John F. Kennedy School of Government at Harvard, 95% of the parents of junior high students and 93% of the parents of senior high students indicated that birth control and other methods of preventing pregnancy are

appropriate topics for sexuality education in schools. In the sample as a whole, a minority of respondents (15%) favored abstinence-only education in which no information is given about condoms or other contraceptives (Kaiser Family Foundation, 2004). However, a plurality (46%) of respondents favored a more comprehensive approach in which abstinence is taught as the best option, while acknowledging that it is not always observed and that schools should provide information about contraception. Thirty-six percent of respondents indicated that the primary goal in sexuality education is not just abstinence, but teaching youths to make responsible decisions about sex.

Even though only 15% of Americans support abstinence-only education in schools, Federal and State matching funds for abstinence-only education have exceeded $1.5 billion since 1996 (Advocates for Youth, 2007). This takes away resources from the comprehensive sexuality education that a majority of parents want. Thirty percent of the principals of middle and high schools which provide sex education report that their schools use abstinence-only education curricula (Kaiser Family Foundation, 2004).

Abstinence-Only Education

Sexuality education programs that advocate abstinence until marriage are based primarily on religious beliefs that couples should not engage in sexual intercourse outside of marriage. The tenets of this approach to sexuality education are frequently defined in such a way as to imply that any violation of these precepts is immoral.

Origins of Abstinence-Only Education

Federal funding for abstinence-only education programs began in 1981 with the passage of the Adolescent Family Life Act. Early programs were designed to promote abstinence and self-discipline among adolescents; however, there was no clear definition of abstinence. Because

the intent of the program was to reduce the high rate of teen pregnancy, adolescents were told to abstain from vaginal sex. In addition, educators were not permitted to discuss contraception except in the context of failure rates for condoms, and there was little concern for the rigorous assessment of program effectiveness (Dailard, 2006). The funding level for abstinence-only education programs remained relatively flat for the next 15 years (Dailard).

In 1996, both the focus and the funding for abstinence-only education programs expanded with the passage of the Welfare Reform Law. This law focused on preventing *all* out-of-wedlock pregnancies; it provided for abstinence-only education for both teenagers and adult welfare recipients. In Title V of Section 510(b) of the Social Security Act, abstinence-only education was placed under the jurisdiction of the Administration for Children and Families in the Department of Health and Human Services.

The Family and Youth Services Bureau allocates $50 million a year to the states, which must provide three dollars to match every four federal dollars, increasing the yearly expenditure to $87.5 million (Guttmacher Institute, 2005) and diverting state resources away from comprehensive, medically accurate sexuality education. Along with continuing annual funding of $13 million through the Adolescent and Family Life Act, an additional $104 million of programming was funded in 2005 through Community Based Abstinence Education, administered by the Faith Based and Community Initiative (Guttmacher Institute, 2005).

Programs funded through the Adolescent Family Life Act and Community-Based Abstinence Education use the 8-point definition of abstinence education found in the 1996 Title V, Section 510, of the Social Security Act (see Appendix A) to define their purpose and content. However, in the 2006 federal grant announcement for Community-Based Abstinence Education, this definition was broadened from earlier versions to specify that couples should abstain from

any type of sexual activity. Sexual activity was defined to include "any type of genital contact or *sexual stimulation* between two persons including, but not limited to, sexual intercourse" (emphasis added). Although specific prohibited behaviors have not been identified, the most intense proponents of abstinence-only education have argued that individual behaviors such as masturbation and viewing pornographic materials should be prohibited; moreover, because the definition is worded ambiguously, "sexual stimulation" could even include kissing and holding hands (Dailard, 2006).

One motivation for the broader definition of abstinence is presumed to be criticism from proponents of evidence-based sexuality education that abstinence-only-educated teens engage in anal and oral sexual practices in lieu of vaginal intercourse so that they can technically keep their virginity pledges. Due to serious omissions of factual information, these teens are less likely to know that they are at risk for STIs or, if they are aware, are less likely to know how to protect themselves against these infections.

Abstinence-Only Education: The Evangelical Version of Sex Education

The 2004 Kaiser Family Foundation survey illustrates the influence of religious beliefs on the eight defining points of abstinence-only education programs (see Appendix A). Note that the views of respondents identifying themselves as evangelical or born-again Christians differ substantially from the views of other Americans.

Issue	Evangelical or born-again Christians agree	Other Americans agree
It is morally wrong for unmarried adults to engage in sexual intercourse outside marriage.	81%	33%
Sexual activity outside of marriage is likely to have harmful psychological and physical effects.	78%	46%
School-age [youth] should abstain from any kind of arousal, including passionate kissing.	56%	31%

Goodson, Pruitt, Suther, Wilson, and Buhi (2006) studied the theoretical underpinnings of 16 of the 32 abstinence-only education programs funded in Texas in 2001 and 2002. Only 2 of the 16 programs were based on scientific theories of adolescent development or behavior change. That is, instead of being based on proven relationships between prior experiences/beliefs and subsequent behavior changes, 14 of the 16 programs were based on assumptions that are not supported by evidence: This wastes resources and can cause harm. Goodson and colleagues noted the hypocrisy of such programs that attempt to teach about the consequences of sexual activity while withholding information and refusing to discuss human sexuality. As these authors point out, this hypocrisy is a concern for health and sexuality educators.

In December 2004, U. S. Representative Henry Waxman (D-CA) released a content review of the most popular abstinence-only education curricula used by the grantees of the largest federal abstinence initiative. Over 80% of the abstinence-only education curricula used by two-thirds of the grantees under the Special Programs of Regional and National Significance Community-Based Abstinence Education "contain false, misleading, or distorted information about reproductive health" (Waxman, 2004, p. i). Thus, program participants were told that condoms were substantially less effective in preventing pregnancy and STIs than research has shown. One curriculum falsely claimed that HIV could be transmitted through sweat and tears. Another reinforced gender stereotypes, with statements indicating that women need financial support, whereas men need admiration. In addition, the religious view that life begins at conception was presented as scientific fact (Waxman).

Abstinence-only education programs frequently employ scare tactics and impose guilt for feelings experienced during normal sexual development. Below are several examples from abstinence-only education curricula:

- "Teenagers who are sexually active in high school will find their schoolwork suffers" (*Reasonable Reasons to Wait,* Student Workbook, as cited in SIECUS, 2005a).
- Question: "What are the risks of being sexually active?" Answer: "Teen pregnancy, STIs, low self-esteem, loss of reputation, feelings of being used." (*Choosing the Best PATH*, Teacher's Guide, as cited in SIECUS, 2005a).
- "Each time a sexually active person gives that most personal part of himself or herself away, that person can lose a sense of personal value and worth. It all comes down to self-respect" (*Choosing the Best PATH*, Teacher's Guide, as cited in SIECUS, 2005a).
- "The only safe sex is in a marriage relationship where a man and a woman are faithful to each other for life." (*Game Plan*, as cited in SIECUS, 2005a).

The last item indirectly indicates another problem with abstinence-only education, namely its failure to address relationships that are not heterosexual. However, it is a fact that approximately 10% of youths experience some concern about their sexual identity, and about 2.5% of high-school students identify themselves as gay, lesbian, or bisexual (Sturdevant & Remafedi, 1992). Yet these youths are completely ignored or marginalized because abstinence-only education programs focus entirely on heterosexual marriage. If the restrictive beliefs of abstinence-only education programs were forced upon these youths in combination with barriers to same-sex marriage, virtually any sexual expression would be considered immoral. Gay, lesbian, bisexual, and transsexual youths already experience high rates of depression, isolation, violence, suicide, and other negative effects of homophobia in our society (Russell & McGuire, 2006). Abstinence-only education would likely make things even worse for this already marginalized population.

Critiques of Abstinence-Only Education

A majority of adolescents become involved in sexual relationships by their late teen years: In 2005, 34% of students in ninth grade and 63% of students in twelfth grade reported that they had had sexual intercourse (Centers for Disease Control and Prevention, 2006). However, in 2003, the median age of first marriage in the U.S. was 25.3 for females and 27.1 for males (Fields, 2004). Therefore, the expectation that adolescents will remain abstinent until marriage is unrealistic. Withholding knowledge about contraception and infection-prevention leaves adolescents and young adults needlessly vulnerable to unintended pregnancy and STIs, including HIV/AIDS.

There is no evidence that consensual sex between adolescents is harmful (Santelli et al., 2006). In fact, the reported mental health problems of adolescents who have had early sexual activity seem to occur in adolescents that already had mental health problems prior to their sexual activity. (Santelli et al.). In a national sample of U. S. middle and high school students, Lehrer, Shirier, Gortmacher, and Buka (2006) found that depressive symptoms experienced at the time of initial data collection were associated with risky sexual behavior for both boys and girls. That is, depressive symptoms appeared to lead to risky sexual behavior, not vice versa. An analysis by the National Health and Social Life Survey (Laumann, Gagnon, Michael, & Michaels, 1994; Else-Quest, Hyde, & DeLamater, 2005) found that the context in which premarital sex occurs, not premarital sex *per se*, was related to poorer psychological and physical health outcomes. Participants consistently reported lower levels of well-being only when initial sexual intercourse was prepubertal, forced, with a blood relative or stranger, or the results of peer pressure, drugs or alcohol. In this random sample of U.S. households, 82.9% of respondents had had premarital intercourse. The average age for first sexual intercourse was 17.67 years old: with

men's first sexual intercourse occurring at a slightly younger age than women.

Abstinence-Only Education: Evaluation of Effectiveness

Many efforts to assess the effectiveness of abstinence-only education programs have been characterized by a lack of adherence to scientific principles of evaluation (Kirby, 2001; Manlove, Romano-Papillo, & Ikramullah, 2004). Fortunately, since 1980, some researchers in both the United States and Canada have conducted comprehensive reviews of sexuality education programs that both target students under 18 years old, as well as use a scientific research design to assess behavior, such as age of first sexual intercourse. Neither Kirby nor Manlove and colleagues found support for claims that abstinence-only education programs delay the timing of first intercourse: In fact, only three studies of five programs even met the minimal criteria for their review.

In 2002, Rector published a paper through the Heritage Foundation claiming that studies of 10 abstinence-only education programs had demonstrated that these programs reduced early sexual activity. In response, Kirby (2002) reviewed the same studies using the evidence standards developed earlier by the National Campaign to Prevent Teen Pregnancy and used in Kirby's 2001 review. Nine of Rector's ten programs failed to provide credible evidence of delayed date of first sexual intercourse or of reducing the frequency of sex. One program that used mass communication techniques may have delayed the age of first sexual intercourse among 15-17-year-olds; however, it was impossible to determine if the decline in county-wide pregnancy rates in this age group occurred because of this program or because of other influences, including other programs that the teens were exposed to. Kirby pointed out that, of the many abstinence-only education programs, these ten were chosen by Rector because they had the most encouraging results.

In 1997, Congress commissioned Mathematica Policy Research Inc. to conduct a long-term evaluation of federally funded abstinence-only education programs. Mathematica researchers assessed students four to six years after they had completed federally funded abstinence-only education programs begun in either their elementary school years or in their middle school years (Trenholm et al., 2007). At the time of program completion, these students were approximately 15 years old and 18 years old respectively, with an average age of 16.5 years. Using an experimental study design, the researchers had randomly assigned students either to participate in an abstinence-only education program (the program group) or not participate in a program (the control group). Approximately 60% of the 2,075 students who had voluntarily participated in the evaluation were in the program group, and approximately 40% were in the control group. Of the four program sites (one each in Florida, Mississippi, Virginia and Wisconsin), two were urban, one was rural and one was semi-rural. All four programs were school-based and involved at least 50 hours of contact between instructor and students. The students were African-American, Hispanic, and non-Hispanic white from families of diverse socioeconomic status and lived in communities with varying levels of available health and sexuality education resources.

In evaluating these four programs, Trenholm and colleagues (2007) found that students in the program group were no more likely than the students in the control group to abstain from or delay sexual intercourse, nor were they more likely to have fewer sexual partners. In a comparison between the program group and the control group, there were no statistically significant differences in any of the following:

- percent remaining abstinent (51%)
- percent abstinent during the 12 months prior to the evaluation (55%)

- age of first intercourse (14.9%)
- rates of unprotected sex, either at first intercourse or over the last 12 months (in the last 12 months, 23% always used condoms, 17% used condoms sometimes, and 4% never used condoms)
- number of sexual partners (about one-quarter had 3 or more partners, one-sixth had 4 or more)
- awareness of the risk posed by unprotected sex for pregnancy and understanding that condoms usually prevent pregnancy
- poor understanding of the health consequences of STIs.

The program group was better able to identify STIs compared to the control group; however, both groups reported greater uncertainty about the ability of condoms to prevent STIs compared to condoms' ability to prevent pregnancy. In addition, the program group was less likely to report that condoms are usually effective at preventing STIs and more likely to report that condoms do *not* prevent STIs compared to the control group. These findings suggest that these federally funded abstinence-only education programs have been propagating misinformation about condom effectiveness.

Trenholm et al. (2007) noted that these programs ended at middle school and might have been more effective if offered at an older age. These authors also point out that peer support for abstinence appeared to be influential in the earlier years, but declined noticeably as adolescents aged. It is important to note that control group students were involved in no program; that is, this study is not comparing abstinence-only students with students receiving comprehensive sexuality education.

Many state evaluations of abstinence-only education programs that define effectiveness

as the delaying of first intercourse have failed to find these programs effective (SIECUS, 2006a). For example, in Minnesota following the Education Now and Babies Later program, the rate of sexual activity among junior high participants almost doubled, as did the percentage of high school students indicating that they would probably have sex during their high school years (SIECUS, 2006a).

Curiously, many of those claiming that abstinence-only education programs are effective have not based their claims on whether or not participants actually delay sexual activity until marriage. Instead, these claims of effectiveness have been based mostly on the fact that at the conclusion of such programs, a high percentage of students agree to sign a virginity-until-marriage pledge (Brucker & Bearman, 2005; SIECUS, 2005b). Unfortunately, this is a highly inaccurate measure of effectiveness because research has shown that only 12% of virginity-until-marriage pledges are kept (Brucker & Bearman).

In addition, virginity-until-marriage pledges are not effective ways to reduce the prevalence of STIs: Brucker and Bearman (2005) found that students who signed, but failed to keep their virginity-until-marriage pledges ended up with the same rate of STIs as students who did not sign such pledges. These researchers also found that students who broke their virginity-until-marriage pledges were less likely to get themselves tested or treated for STIs compared to non-pledgers. In fact, in an earlier study, Bearman and Bruckner (2001) reported that students who had signed, but failed to keep virginity-until-marriage pledges were one-third less likely to use contraception than their peers who did not sign such pledges.

Using data from the National Survey of Family Growth for 1995-2002, Santelli et al. (2007) found that 86% of the decline in actual pregnancy rates among 15-19 year olds was due to increased use of contraceptives and 14% was due to a decline in the percentage of sexually active

teens. The greatest increase in contraceptive use during this period was among 15-17 years olds, which corresponded with the greatest declines in the rate of pregnancy among this age group. Although the decline in pregnancy rate among 18-19 year olds is attributable solely to contraceptive use, the increased rate of contraceptive use in that age group is not as dramatic as the increase among the younger age group during this time period.

The researchers found increased use of both individual and multiple-use contraceptive methods (e.g., birth control pills and condoms) and a decline in the number of sexually active teens reporting that they do not use any method of contraception. Despite these findings, teen pregnancy rates in the U.S. continue to exceed those in other industrialized countries. However, this may be changing because contraceptive use among American teens is becoming more like that of adolescents in other industrialized countries that have comprehensive sexuality education and easy access to family planning services (Santelli et al., 2007).

Failures of Abstinence-Only Education

A substantial percentage of American youths and even some adults receiving welfare are participating in sexuality education that withholds or distorts scientific knowledge about sexuality and relationships. In place of medically accurate facts, teaching is based on unsupported assumptions and moral platitudes that do not address the physical, social, and emotional development needs of youths. Such teachings may be harmful to later expressions of sexuality and to the development of intimate relationships. Because abstinence-only education programs have a narrow, exclusive view of morality, they seem likely to alienate many youths at what is already a difficult developmental time. Both the federal government and 42 states through matching requirements are imposing on a majority of youths the factually incorrect beliefs of a fundamentalist religious minority, and in so doing, violating the separation of church

and state, a basic tenet of our Constitution.

Despite the fact that $1.5 billion of public money has been spent on these programs (Advocates for Youth, 2007), abstinence-only education programs are not effective in encouraging participants to abstain from sex (Maynard et al., 2007) nor in reducing teen pregnancies (Santelli et al., 2007). Thus, abstinence-only education programs not only fail in their goals but also fail to meet the needs of youths and young adults.

Comprehensive Sexuality Education

Definition

Comprehensive sexuality education programming is based on scientific knowledge about human development, practices which promote sexual health, and the means to control one's fertility. As evidenced in its four primary goals (see Appendix B), comprehensive sexuality education, also called Abstinence-Plus education, views sexuality as a health and human development issue. It supports education that will advance individual well-being and prevent physical and emotional problems. This type of sexuality education is age-appropriate, medically accurate, and it encourages youths to be abstinent until they are physically, mentally, and emotionally ready for mature sexual relationships. It also teaches how to explore personal values and to let these values guide relationships. In addition, it teaches how to set limits and how to deal with social, media, and partner pressure. It teaches participants how to avoid STIs and how to avoid pregnancy by providing information about contraception - how to obtain it, how to use it, and how to negotiate with a sexual partner for its use.

Differences In Attitudes Between The U.S. And Other Industrialized Countries

The primary goals of comprehensive sexuality education are already part of the culture of many other industrialized countries. American youths have higher rates of pregnancy and STIs

compared to youths in other industrialized countries (Guttmacher Institute, 2001); however, these rates are not related to the age of first sexual intercourse, which is the same across the United States and other industrialized countries (Guttmacher Institute). What is strikingly different is the attitude of adults toward supporting the sexual development of youths. This attitude is seen in other countries' sexuality education programs: For example, youths in other industrialized countries receive unambiguous messages that sexual activity is to occur within committed relationships, and program participants are expected to protect themselves and their partners from unintended pregnancy and STIs (Guttmacher Institute). Further, messages are clear that young people are expected to delay childbearing until they are able to support themselves and their offspring (Guttmacher Institute). Additionally, in these societies, youths have ready access to comprehensive sexuality education, contraception, and health services (Guttmacher Institute).

Support for Comprehensive Sexuality Education

Comprehensive sexuality education is supported by many organizations that promote the health, education, and well-being of children and adolescents including the following: The American Academy of Pediatrics, The American Foundation for AIDS Research, The American Medical Association, The American Psychological Association, The American Public Health Association, The Institute of Medicine, The Society for Adolescent Medicine, The National Education Association and The American School Health Association. Conclusion

Every individual has the right to medically accurate, scientific knowledge about sexuality and access to health and reproductive services to foster physical and emotional well-being across the lifespan. Although abstinence-only education programs claim to promote morality, it is a sad fact that these programs are ultimately immoral because they withhold potentially life-saving

information and services related to sexuality, a fundamental biological process.

Adolescence is the period when youths prepare to become sexually healthy adults (SIECUS, 2006b). Based on the reality of the world in which youths develop, the substantial health issues involved in sexuality, and the findings from rigorous evaluations, comprehensive sexuality education programming should be provided for all children and adolescents.

Comprehensive sexuality education helps youths assume responsibility for life-long sexual health by providing medically accurate information and enhancing decision-making skills at a crucial developmental stage. Education about sexuality involves teaching youths to manage their sexual development instead of imposing guilt feelings about a natural process. Comprehensive sexuality education supports adolescent-parent communication about sexuality and encourages students to develop and adhere to their own values.

Sexuality education is a public health issue. STIs, such as HIV-AIDS, chlamydia, and gonorrhea are far too pervasive. In 2001, 49% of pregnancies among women 15-44 years of age were unintended (Finer & Henshaw, 2006). United States citizens need to be sexually healthy adults. Although parents have the primary responsibility of educating their children, the public schools, supported by government policy and funds, have a substantial responsibility in providing information that addresses the physical, social, and emotional needs of our youths. This information can lead to healthy expressions of sexuality and healthy intimate relationships as adults. The information that is taught must be based on accurate scientific knowledge, and appropriate to the age and gender of participants. Only those teachers that are appropriately trained should be permitted to teach in sexuality education programs. The public schools, supported by government policy and funds, should teach comprehensive sexuality education.

Government policy that promotes the expectation of abstinence until marriage is

based on religious ideology, not science, and is neither in the best interests of youths nor reflective of the wishes of the citizenry. The use of government funds to impose the religious beliefs of any group on the entire citizenry violates the separation of church and state doctrine enshrined in our Constitution.

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Appendix A

The 8-point definition of Abstinence Education

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

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Social Security Act of 1996, Title V, Section 510

Appendix B

The Four Primary Goals of Comprehensive Sexuality Education

1. To provide information about human sexuality, including human development, relationships, personal skills, sexual behavior, sexual health, and society and culture.
2. To provide an opportunity to question, explore, and assess sexual attitudes in order to develop values, increase self-esteem, create insights concerning relationships with members of both genders, and understand obligations and responsibilities to others.
3. To help develop interpersonal skills—including communication, decision-making, assertiveness, and peer refusal skills-and help to create satisfying relationships.
4. To help create responsibility regarding sexual relationships, including addressing abstinence, resisting pressure to become prematurely involved in sexual intercourse, and encouraging the use of contraception and other sexual health measures.

(SIECUS, 1991, p. 13.)