ETHICAL AND EFFECTIVE SEX EDUCATION TO PREVENT TEENAGE PREGNANCY

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ABSTRACT

Children born to teens are at risk for a myriad of health and education challenges in addition to being at risk for bearing children at young ages themselves. Teen mothers are likely to have low school performance and struggle financially while teen fathers are at high risk for substance abuse and legal problems. When developing sex education programs to prevent teen pregnancy, it is important to consider the rights of parents and adolescents in addition to the values that underlie them. Therefore, this thesis analyzes policy pertaining to sex education in the United States and proposes a new set of ethical and effective policy guidelines to reduce teen pregnancy.

This thesis uses quantitative and qualitative research including extensive reading on both abstinence-only and comprehensive sex education programs and the findings of those who have evaluated them. Sources include books and journal articles by leading experts, legislative documents, and newspaper articles. It goes beyond efficacy evaluations, to analyze in a comparative manner, the ethical value of several programs that operate from an abstinence-only perspective or comprehensive approach.

The research indicated that programs funded by the current legislation are not effective in protecting students from the consequences of sexual activity. Several experts argue that the current programs actually have great potential to harm and
manipulate students, which raises ethical issues. Therefore, new legislation should be established to ensure that more effective and ethical programs are implemented for America’s youth.
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INTRODUCTION

Teen pregnancy is like the ripples that result from tossing a stone into water. It affects the teen mother, it affects the father, it affects the baby, it affects their families, and then, with lesser impact, it affects society as a whole. According to current March of Dimes statistics featured on its website, only 40% of teen mothers graduate from high school (March of Dimes). The graduation rate for young women who do not get pregnant, but come from the same socioeconomic backgrounds is 75% (March of Dimes). As a result of limited education, young mothers have limited career opportunities and disproportionately live in poverty (March of Dimes). Three quarters of unmarried teen mothers have to seek welfare assistance soon after the birth of their first child (March of Dimes). Like teen mothers, teen fathers are likely to struggle financially and have lower educational attainment according to the Healthy Teen Network’s website (Healthy Teen Network). Just when they are trying to figure out who they are, they are forced to take on a new role that complicates their interactions with the world (Healthy Teen Network). Furthermore, young men who produce children in their teen years are more likely to have marital problems later in life (Healthy Teen Network).

Children of teen mothers are more likely to struggle in school and leave high school prematurely continuing a cycle of poverty (March of Dimes). Teen mothers are less likely to give up smoking while pregnant and less likely to receive adequate prenatal care than women who give birth over the age of 20 (U.S. Center for Disease Control). These factors have a huge impact on the child’s health and learning over the course of his or her lifetime.
Often becoming a teen mother will have a large impact on the teenager’s family of origin. Families are likely to provide shelter for the new baby or to offer other financial or emotional support. Many families provide a great deal of child-care help with some grandparents actually taking on a parental role.

Dr. Saul D. Hoffman of the National Campaign to Prevent Teen Pregnancy estimates that teen pregnancy costs American tax payers $9.1 billion in 2004 (Hoffman 2006, 2). This number is based on the need for publicly funded health care, welfare, lost tax revenue, and sadly, increased prison costs (Hoffman 2006, 2). This breakdown shows how negative the impact of teen pregnancy is on society, the mother, and the child (Hoffman 2006, 2).

Despite being sexually active at the same age and same rate as teens in other developed countries, American teenagers get pregnant and acquire sexually transmitted diseases (STDs) more often. This discrepancy shows that there is likely more that we could do as a nation to protect our teens from early parenthood and its adversity. Furthermore, it shows that we should be doing more to help adolescents stay healthy by avoiding STDs.

In an article entitled “Three Policy Strategies Central to Preventing Teen Pregnancy,” The Center for Health Improvement says that there are three important factors in reducing teen pregnancy in the United States. One is the implementation of more youth development programs, they write, “There is a widely held belief that one of the most effective pregnancy prevention strategies is to provide youth with a supportive environment and a positive sense of the future” (Cornerstone 2003, 3). The Guttmacher
Institute reports that one of the reasons teens get pregnant more often in the United States is that they lack “motivation to delay motherhood or to avoid unintended pregnancy” compared to their foreign counterparts (Guttmacher). Youth have to feel like there are options and opportunities, things to do with their lives beyond making babies, and a reason to avoid stepping onto that track. Services and activities that could make a difference include: “job readiness training, youth-led business ventures, peer teaching or counseling, academic tutoring, recreation, mentoring, community service work, life skills training, and other forms of opportunity and support” (Cornerstone 2003, 3).

Providing these things for youth is expensive, but we have seen that not providing them is expensive if young women continue to get pregnant. Policy should be anticipatory instead of reactionary. If the government provided the support students needed to prevent teen pregnancies instead of reacting afterwards when it becomes necessary to provide health care, teens, children, and society as a whole would be better off.

The second factor that the Center for Health Improvement believes could impact teen pregnancy rates is the availability of contraceptives. They say that health care should be confidential and “teen-friendly,” including “convenient hours and drop-in appointments, care that is non-judgmental and respectful of teens, care provided by peer providers and services provided off-site” (Cornerstone 2003, 3). The authors of this article believe that it should be easy for teens to have access to contraceptives in order to reduce teen pregnancy (Cornerstone 2003, 3). The Guttmacher Institute attributes much of the United States’ higher pregnancy rate to a lack contraceptive use because teenagers lack access to adequate reproductive health care (Guttmacher). While abstinence is
ideal, the reality screams that teens are going to have sex. The only way to significantly 
reduce the likelihood of pregnancy, at least to the rate of other developed nations, is to 
make sure students have access to contraception and that it is convenient and 
comfortable to obtain it.

The final piece of the pregnancy prevention puzzle, according to the Center for 
Health Improvement, is comprehensive sexuality education (Cornerstone 2003, 2). The 
authors believe that students should receive information about both abstinence and 
contraceptives in their sex education classes (Cornerstone 2003, 2). This helps them to 
protect themselves from unwanted pregnancy and disease. It prepares them to remain 
abstinent or to select the best birth control method for them based on complete facts.

It is unlikely that any one of these factors would work alone to impact teen 
pregnancy. All three policy initiatives should be explored and policy should be 
developed to provide a holistic approach to the prevention of teen pregnancy. Though a 
multi-faceted approach is necessary to solve this problem, this thesis will explore only 
the implications of policy pertaining to sex education, specifically whether an 
abstinence-only or a comprehensive approach is better for youth. Chapters one and two 
lay out the characteristics and criticisms for each kind of program. Chapter three 
examines several studies to identify the programs experts deem most effective. Chapter 
four explores the ethical issues involved with sex education programs and, finally, 
chapter five proposes guidelines for future legislation.

Abstinence-only versus comprehensive sex education has been the source of 
heated debate in this country for many years. Much of it is founded in the age-old battle
between religion and science, between what is held true by faith and what is proven. Many of the abstinence-only materials used have religious underpinnings and promote a morality idealized by religious groups. Comprehensive sex education is based on the science of preventing pregnancy and disease and the proven reality that teenagers do engage in sexual activity.

This debate is also one of traditional and progressive values. The abstinence-only agenda is one of tradition; it promotes traditional ideas of gender, of family, of sexual orientation, and of morality. Comprehensive sex education, on the other hand, has a more progressive view acknowledging the ways in which times have changed and embracing more diverse ideas about gender, family structure, sexuality, and what is moral.
CHAPTER ONE: ABSTINENCE-ONLY EDUCATION

The History of Abstinence-Only Funding

As a result of an increasingly early onset of maturation and the escalating birthrates of teen mothers, schools began to teach sex education in the nineteen-sixties. By 1971, over half of the school districts in the country provided some sort of sex education program. Ten years later, in 1981, the government, under the Reagan administration, first funded abstinence-only education. The legislation was called the Adolescent Family Life Act (AFLA), or the “Chastity Act.” Just two years later, the American Civil Liberties Union, along with some clergy and other concerned individuals, took legal action against AFLA. They claimed that because it reflected a particular religious perspective on issues of sexuality, it violated the separation of church and state protected under the Constitution. In 1985, a district court judge agreed and declared the legislation unconstitutional. However, the United States Supreme Court reexamined the issue in a 1988 appeal and sent the case back to a lower court. An agreement was reached out of court in 1993 stating that abstinence programs could continue as long as they complied with the following:

1) did not include religious references;

2) were medically accurate;

3) respected the ‘principle of self-determination’ regarding contraceptive referral for teenagers; and

4) did not allow grantees to use church premises for their programs or to give presentations in parochial schools during school hours. (Perrin and DeJoy, 2003 447)
In 1996, under Bill Clinton, a massive initiative called the Personal Responsibility and Work Opportunity Reconciliation Act was signed into law. The legislation was intended to overhaul the welfare system in the United States. In final negotiations, in an attempt to find a bill that the House and Senate could agree upon, Congress added a section that would provide $50 million in abstinence-only funding over five years. With little debate or public notice, significant money was allocated for abstinence programs and new guidelines were established that still exist today. Under Section 510 of the Social Security Act, the following points need to be addressed, albeit not equally, by an abstinence program to qualify for federal funds.

An abstinence-only program must adhere to the following guidelines:

(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;

(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

(D) teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;

(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;

(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances;
When President Bush took office, Special Programs of Regional and National Significance-Community Based Abstinence Education (SPRANS) Grants were established. These grants were designed to go directly to community organizations that teach abstinence bypassing the state. With these direct funds come stricter standards, however. Programs that receive money under SPRANS have to address each of the eight points in the abstinence definition directly, opposed to simply having to be consistent with them. In 2001, SPRANS granted 33 organizations $20 million, that amount doubled the next year, and by 2004 SPRANS was providing 100 grantees $75 million in funding. SPRANS spending has now reached $104 million.

In his 2007 budget proposal, President Bush asked for $204 million for abstinence-only-until-marriage programs. Considering that states are expected to contribute three dollars for every four dollars in federal funding they receive, there is a significant amount of money being spent nationwide on abstinence education.

**Abstinence-Only Education: Characteristics and Goals**

Abstinence-only programs adhere to the eight regulations mandated by Title V of the Social Security Act. They emphasize both the morality in being abstinent until marriage and the health risks of not doing so. Abstinence proponents believe that sex before marriage is inappropriate and immoral. They support the message that abstinence is the only way to avoid sexually transmitted diseases and unwanted pregnancy. Furthermore, they say that sex outside of marriage can cause, “serious, debilitating, and
sometimes deadly consequences” (Morin et. al. 2002, 12). Although abstinence programs are no longer allowed to mention religion specifically, Michelle Hecht and Elicia N. Eddington contend that “Abstinence programs often include moral undertones that traditionally are tied to religious beliefs,” they go on to say that “programs identify one moral belief and promote it,” they continue saying, “abstinence programs suggest that abstinence is the only morally correct way to deal with adolescent sexuality” (Levesque 2003, 32).

Abstinence programs include no information about contraceptives except to highlight their failure rates in preventing unwanted pregnancy and sexually transmitted disease. Abstinence advocates believe that discussing contraception encourages early sexual activity, or at least, sends mixed messages that could confuse adolescents. Focus on the Family, an abstinence advocacy group, says, “From tobacco, alcohol and drug use to fighting, gun use and drunk driving, the prevailing message is ‘don’t do it’— avoid or eliminate the risk, but when it comes to sex and all the potential dangers that accompany it the message is, ‘Use condoms to reduce your risk of unwanted pregnancies and sexually transmitted diseases’” (Morin et.al. 2002, 12). Focus on the Family believes that there should be a clear ‘just say no’ message presented to teens. The organization believes in omitting any other information that could allow young people to think that sex before marriage is safe or acceptable. Similarly, the Medical Institute for Sexual Health says that students “must not leave the sex education classroom thinking ‘I’m being responsible and safe if I use a condom’” (Morin et.al. 2002, 12).
Abstinence programs try to be fun and engaging for students. In his description of the Abstinence is Best program, which he facilitates, Dominick Urrutia testified in a U.S. Senate hearing that food, including pizza twice a month, is served at every session. He also said that students play four different games including: “STD roulette, rock around the clock, drugs are losing game, and sex and consequences” (U.S. Senate, 2004). Students in his program hear from professionals, but peer leaders also engage them in discussion (U.S. Senate, 2004).

Abstinence-only programs also highlight celebrities who have chosen to remain abstinent until marriage. Retired professional basketball player A.C. Green is the most prominent example of this trend. In addition to countless speaking engagements, Green has his own abstinence-only program called A.C. Green’s I’ve Got the Power. Furthermore, abstinence-only programs appeal to students by using colorful materials, snappy slogans, and rap music. At a Teen Aid, Inc. sponsored event in Spokane, Washington, entertainer Lakita Garth was backed by “break dancers, rappers, TV clips and Miss America herself” (Kromer, Abstinence Matters). Presenters often use casual language and slang to relate to students, Garth assured the students, “This is not some old-school presentation. We're not gonna lecture you, ah-aight?” (Kromer, Abstinence Matters). She later told the crowd, "Waiting 'til you say `I do' means `I do you and you do me and we don't do anyone else'” (Kromer, Abstinence Matters). Advocates of abstinence-only believe that students need to be able to relate to presenters and program content in order for the message impact them.
**Implemented Abstinence Programs**

There are over a thousand federally funded abstinence-only programs used in the United States. A handful of the most frequently used and reviewed will be described here.

*Best Friends* is an abstinence-only curriculum with a good record. Originally created for Washington DC’s inner-city girls, it teaches that abstaining from sex and drugs leads to a fulfilling life. Participants are encouraged to seek and maintain friendships with good friends, opposed to destructive ones, in order to achieve a successful future. Students are taught to curtail their interactions with boys to healthy platonic relationships. The program involves goal setting and students learn how to work toward the goals that they set.

*Postponing Sexual Involvement* is another program with a good track record. David Campos, author of *Sex, Youth, and Sex Education*, says that the program, designed for youth of color, emphasizes the “just say no” to sex message (Campos 2002, 8). The program uses older, popular students to teach middle school students how to say no when sexual advances are made upon them. Role-play is used to help youth practice saying no and acting responsibly.

An organization called Choosing the Best produces several abstinence-only programs. According to Campos, these curricula “stress abstinence until marriage as the key to a fulfilled, grounded life composed of healthy, meaningful relationships” (Campos 2002, 8). Each program is four to eight sessions long. They feature lessons in assertiveness, establishing appropriate boundaries, meaningful relationships, and the
difference between love and sex. Participants are shown videos and slides that feature information about STDs, AIDS and “the risks of ‘Safe Sex.’” (Campos 2002, 8) Finally, participants are given an opportunity to hear from medical experts and people their age who are contending with the hardships of unplanned pregnancies.

*Sex Can Wait* is a popular and well known abstinence program used with upper elementary, middle, and high school students. It is a five week program of over twenty lessons. At each level, the curriculum has three major components: Knowing Myself, Relating to Others, and Planning My Future. Knowing Myself covers self-esteem, puberty, reproductive anatomy and physiology, and decision making. Relating to Others focuses on communication skills, while Planning My Future focuses on setting goals. Lessons are very structured from beginning to end including an opening, a closing, and the lesson itself, which are all scripted. Supplementary materials such as worksheets and information for parents are also included. If asked about contraception, teachers are encouraged to give the message that “for persons involved in a sexual relationship, decisions about family planning and protection are important” (Denny et.al. 1999, 136).

*The Navigator* program includes an eight session workbook published by Project Reality. The program targets adolescents ages 15-19. The sessions have the following titles: Future Goals and Dreams, Seeing Media Clearly, Sexual Decision Making, Avoiding The Obstacles of Sexually Transmitted Diseases, Resisting Pressures: Alcohol, Tobacco and Other Drugs, Survival Skills, Developing Relationships, and Preparing For a Future Marriage and Family. It should be noted that the STD session in Navigator, as in all abstinence-only programs, features no instruction on the use of condoms.
Participates are taught avoidance through abstinence alone. *A.C. Green’s Game Plan* is the middle school program that precedes *Navigator* and is also a Project Reality product. It includes the same interactive curriculum and similar objectives covered in eight sessions.

*Me, My World, My Future* is a middle school program that is taught in three to six weeks. It includes worksheets, overheads, and information for parents. It covers the topics of fetal development, friendship and dating, decision making, pregnancy, STDs, and saying no. Again, STDs and pregnancy are covered from an abstinence-only perspective.

*Students Today Aren’t Ready for Sex* or *STARS* is a five session abstinence program. The first session discusses the advantages of abstinence and the consequences of not waiting to have sex. The next session discusses the media’s influences on participants’ perceptions of sex. The third session looks at relationships, peer pressure, boundaries, and saying no. Session Four teaches students how to stand up against sexual pressure without losing friends. The final session serves as a review and reinforces the message of abstinence.

Sometimes abstinence-only programs have a virginity pledge component in which students who have been learning about abstinence are given an opportunity to take a verbal or written pledge to remain abstinent until marriage. Sometimes students choose to wear a ring as an outward symbol that they have made the pledge. Some virginity pledge programs use statistics on the consequences of sex to encourage
students to take pledges and some programs encourage students to remain abstinent until marriage for religious reasons.

In a review of 21 abstinence-only curricula, Kelly L. Wilson et. al. found that all of the programs, many of which are described above, addressed abstinence thoroughly. Wilson and her colleagues found that most (95%) of the programs addressed “decision making” at length (Wilson, Goodson et. al. 2005, 93). Furthermore, the “handling of peer pressure,” “assertiveness,” and “refusal/cessation skills,” were covered in 76% of the programs (Wilson, Goodson et. al. 2005, 93). “Goal setting” and “self-esteem” were also covered in the majority of programs, 71% and 62% respectively (Wilson, Goodson et. al. 2005, 93). However, the majority of abstinence only programs did not tend to cover more controversial topics such as “masturbation” (71%), “diversity of sexual values and behaviors in American society” (67%), “human development throughout the life span” (62%), “sexual identity and orientation” (62%) or “the common occurrence of sexual fantasies” (62%) (Wilson, Goodson et. al. 2005, 93).

**Arguments for Abstinence-Only Sex Education**

Proponents of abstinence-only education say that it works to reduce teen sexual activity. An *American Journal of Health Behavior* article featured on the National Abstinence Education Association’s (NAEA) website, discusses a study which concluded “that those students receiving abstinence education were about one-half (45.7%) as likely to initiate sexual activity as students who did not receive abstinence education” (NAEA website, Abstinence Education Cuts Teen Sex).
Those who believe abstinence-only programs are best for America’s youth say
that parents prefer abstinence-only programs when they are informed. The NAEA says
that “a new survey from Zogby International shows that when parents become aware of
what abstinence education vs. comprehensive sex education, actually teaches, support
for abstinence programs jumps from 40% to 60%” (NAEA website, Zogby). According
to the Heritage Foundation, “91 percent of parents want schools to teach that
‘adolescents should be expected to abstain from sexual activity during high school
years’” (Rector, Facts About Abstinence Education).

Abstinence education proponents contend that they provide adolescents with all
of the information that they need on contraception. According to Valerie Huber, who is
the Executive Director of NAEA, “Abstinence education still provides teens information
about contraception and STDs, but always within the context that abstaining from sex is
the only way to avoid all physical and emotional risks associated with casual sex”
(NAEA website, Abstinence Education Cuts Teen Sex). Abstinence advocates, like
Huber, maintain that providing more information would confuse students and even make
them more likely to have sex.

Some say that abstinence-only education protects young people from regrets
caused by having sex prematurely. According to Robert Rector of the Heritage
Foundation, “Nearly two thirds of sexually active teens state that they regret their initial
sexual activity and wish they had waited until they were older before becoming sexually
active” (Rector, Facts About Abstinence Education). According to abstinence advocate
Freda McKissic Bush, “After becoming sexually active, 55 percent of boys and 72 percent of girls wish they had waited” (McKissic Bush).

Abstinence proponents argue that abstinence education helps teens avoid the many negative outcomes that could stem from sexual activity, and therefore, achieve more. They believe that abstinence programs prevent sexual activity that could lead to unwanted pregnancy, disease, single parenthood, poverty, abortion, and depression. Furthermore, proponents of abstinence education say that abstinence education helps teens reach their goals. For example, TeenAid, Inc. sponsored a rally at which Miss America 2003, Erika Harold, credited her personal commitment to abstinence with the achievement of her goals. "If I was sexually active or involved with drugs or alcohol, I wouldn't have been focused on the things I wanted to achieve," she said, "I wouldn't be here today" (Kromer, Facts About Abstinence Only Education).

Teenagers want abstinence education according to abstinence proponents. “Almost all teens (94 percent) believe that teens should be given a strong message from society to abstain from sex until at least after high school” (Family Research Council).

Friends of abstinence say that it enhances the status of marriage and makes it something for which to strive. The Teen Aid website features a link to the National Center for Health Statistics, which highlights a correlation between being married and being healthy. According to Edwin J. Fuelner and Sam Brownback, "When compared to women who began sexual activity in their early 20s, girls who initiated sexual activity at age 13 or 14 were less than half as likely to be in stable marriages in their 30s” (Fuelner
Criticisms of Abstinence-Only Education

Because there is no standard curriculum for abstinence-only programs, criticism is usually applied to all programs that reside under the umbrella of abstinence-only and follow the eight points laid out by Title V.

The biggest criticism of abstinence only education is that it doesn’t work. According to the Guttmacher Policy Review, “a long-awaited, congressionally mandated evaluation of four U.S. programs considered to be especially promising found that none had a statistically significant beneficial impact on young people’s sexual behavior” (Guttmacher, 2008). Several other studies have produced similar results.

Because studies have been done that concluded that abstinence-only education does not work, another criticism is that it “places ideology ahead of teen health and well-being,” as Representative Henry Waxman described in responding to a new round of proposed abstinence spending (Waxman 2006, 7). Waxman and fellow abstinence opponents believe that tax dollars are being spent on programs that push values but sequester facts, endangering adolescents. In Women’s Health Journal, Stefanie Block says that there is “no evidence that young people who participate in abstinence-only programs delay sexual intercourse longer than others” (Block 2005, 5). She goes on to say, “However, when they do become sexually active, adolescent who have received abstinence-only education often fail to use condoms or other contraceptives” (Block 2005, 5).
Opponents of abstinence education emphasize that many in the medical community oppose abstinence-only education. Among those who believe teens should have information about condoms and birth control include the following: The American Academy of Pediatrics, APHA, the American Medical Association, the American Association of Obstetricians and Gynecologists, and the American Psychological Association. In a statement before the United States Senate, Joe Fay, executive Director of the Pennsylvania Coalition to Prevent Teen Pregnancy, said, “The major medical and health organizations in the United States agree that it is not good public health policy to actively deprive young people of information that helps prevent pregnancy and disease” (U.S. Senate 2004, 18). He goes on to point out that Europe, where contraceptive education is taught, has a much lower teen pregnancy rate than the United States (U.S. Senate 2004, 18).

According to opponents, parents are against abstinence only education. According to Terry J. Parker in an article for ERIC Digest entitled School-Based Sex Education: A New Millennium Update, “89% of Americans believe that young people should receive information about contraception and prevention of STDs, and that school based sex education should focus on how to avoid unintended pregnancies and STDs, including HIV infection and AIDS” (Parker 2001).

Opponents of abstinence-only education accuse programs of being gender biased and promoting stereotypical and dated images of women. Jessica Fields describes watching one abstinence educator named Lee Ann Finch take a nicely wrapped package and say to her young audience, “You can kiss your boyfriend in the back of a car,” while
ripping a piece of the package and dropping it down to the ground, “You can do some heavy petting” as she rips off another piece of the wrapping and drops it, “You can have sex before you get married” she continues before saying, “Maybe we can fix this package. We can try to tape the paper back together. This is never going to look like it did originally. Is this the gift you want to hand your spouse on your wedding night?” (Fields 2008, 99-100) Fields said kissing your boyfriend, placing more of the responsibility, and potential shame, on females who decide to be sexually active.

Likewise, abstinence educator Darren Washington uses a sucker to demonstrate the loss of purity caused by premarital sex. He says, “Your body is a wrapped lollipop. When you have sex with a man, he unwraps your lollipop and sucks on it. It may feel great at the time, but, unfortunately, when he’s done with you, all you have left for your next partner is a poorly wrapped, saliva-fouled sucker” (Hahn, 2004). Again, it is the female who it portrayed as damaged goods.

As is demonstrated above, shame is often used in abstinence-only programs according to their opponents. Likewise, fear is thought to be used as a deterrent. According to Campos, the abstinence-only program Facing Reality, says sex will lead to an “inability to concentrate on school, shot-gun weddings, selfishness, poverty, loss of faith, fewer friendships formed, loss of self-mastery, difficulty with long-term commitments, aggression toward women, loss of honesty, depression and death” (Campos 2002, 11). According to Fields, programs such as Sex Respect and Teen Aid feature pictures of “infected and diseased genitalia” to dissuade teens from participating in sexual activity (Fields 2008, 48).
Critics say that abstinence-only education’s emphasis on marriage as the only acceptable context for sex ignores the lifestyles of many Americans. This focus on marriage as the “gateway to a fulfilled sexual life,” as Campos puts it ignores the fact that some adults don’t marry and others can’t legally marry (Campos 2002, 11). Abstinence-only programs rarely cover topics that acknowledge homosexuality, bisexuality, or anything other than “the societal standard for union is a heterosexual marriage with the expectation to procreate” (Campos 2002, 12). Campos says that this has the potential to be psychologically damaging to youth who are experiencing feelings of homosexuality by making them feel even further isolated (Campos 2002, 12).

Just as these programs are accused of not recognizing the reality of alternative lifestyles, they are accused of failing to recognize the reality of sexual activity among youth. According to Terry J. Parker, 80% of Americans have sex before they are married. Most other estimates are closer to 95%. Furthermore, a Youth Risk Behavior Survey found that fifty percent of all high schools students had had sexual intercourse and that as students age, the percentage increases starting at 39% of ninth graders to 65% of seniors (Parker 2001, 2). Twenty percent of the students had engaged in intercourse with four partners or more (Parker 2001, 2). These numbers make abstinence-only proponents look out of touch with reality. More importantly, it makes withholding information about protection look dangerous.

Abstinence-only programs are frequently accused of containing misleading or incorrect information. Congressman H. Waxman commissioned a report that analyzed thirteen programs and found eleven of them to contain factual inaccuracies. These
inaccuracies pertain to a variety of issues from effectiveness of contraception to the number of chromosomes mothers and fathers pass down to their offspring.

**Conclusion**

Abstinence-only programs differ greatly and cover a broad range of topics to varying degrees. The creators of these programs, and especially the proponents of these programs, are well intentioned and genuine in their belief that abstinence is the only way for adolescents to approach sexuality. There are many who are adamant that abstinence-only programs are the wrong way to address teen sexuality. The alternatives to abstinence-only programs are called comprehensive sexuality education programs and they will be discussed in the next chapter.
CHAPTER TWO: COMPREHENSIVE SEX EDUCATION

Funding for Comprehensive Sex Education

There are contradictory messages presented by groups on both sides of the sex education debate regarding funding. Abstinence-only proponents such as the National Abstinence Education Association, the Abstinence Clearinghouse, and the Heritage Foundation, claim that comprehensive sex education programs receive ten to twelve times the amount of government funding that abstinence-only programs receive. Comprehensive sex education advocates claim that there is no federal funding for their programs. They say that the money to which the abstinence crowd refers is actually intended for health services for low income women, including programs such as Title X of the Public Health Service Act and Medicaid (Advocates for Youth, The Truth About Abstinence-Only Programs). According to Cynthia Dailard of Guttmacher, “Title X’s main purpose is to support the delivery of a broad package of family planning and related health services to low-income adults and teenagers through a nationwide network of family planning clinics” (Dailard 2002, 3). Title X services include reproductive health such as contraception, pap smears, breast exams, and STD screening and treatment for women and girls of all ages. When services under Title X involve sexual health counseling for teens, Title X mandates that abstinence is discussed. Title X health services also include screenings for non-sexually related health issues such as hypertension, diabetes, and anemia.

Organizations such as Advocates for Youth, an advocacy group that focuses on helping young people make healthy decisions regarding sexuality, argue that while
contraception is advised about and provided under some federal programs, this money is not funding comprehensive sex education (Advocates for Youth, Truth). Conversely, Sarah D. Wire, of the Los Angeles Times, wrote in April 2008 that clinics that receive money for “family planning initiatives,” which do provide contraceptives and information for free, “are occasionally involved with teaching comprehensive sex education in public schools” (Wire, 2008). While there is truth to the abstinence-only camp’s claim that some federal funding does pay for comprehensive sex education under the umbrella of “health services,” it is inaccurate to say that all or even most of the money earmarked for Title X and Medicaid is used for services pertaining to comprehensive sex education for teens.

Experts such as Dailard say that comparing sex education programs to health programs is comparing “apples to oranges” (Dailard 2002, 3). However, she concedes that there is one federally funded program, the Centers for Disease Control and Prevention’s Division of Adolescent and School Health’s HIV prevention efforts, that could be considered comprehensive sex education (Dailard 2002, 3). She says the program spent $48 million in 2001 partially going to direct education involving both condom use and abstinence (Dailard 2002, 3). These funds also paid for HIV prevention training for teachers and administrators, curricula development, and research such as the National Youth Risk Behavior Survey (Dailard 2002, 3).

Although there is no federal money available to states to directly fund comprehensive sex education, many states have elected to cover contraception and HIV/AIDS prevention. When Title V of the Welfare Act was first implemented all of
the states, in addition to DC, Guam, the Virgin Islands, and Puerto Rico applied to receive abstinence funds. Today many states have decided to invest in comprehensive sex education forgoing the help of the United States government. Governors like Janet Napolitano of Arizona decided that the state’s three dollars for every four contributed by the federal government could better be spent on other programming. In a letter rejecting the federal money reserved for Arizona, she mentions that several studies have found abstinence-only education to be ineffective. She goes on to say, “When I find myself in the position of having to fight to protect services that clearly have an impact on the lives of Arizonans, like dental services for low-income seniors, I cannot in good conscience set funding aside for programming that is proven to be ineffective” (Boonstra 2008, 23).

**Comprehensive Sex Education Programs: Characteristics and Goals**

According to the Sexuality Information and Education Council of the United States (SEICUS, Sexuality Education), comprehensive sex education programs have four primary goals: to provide information regarding sexuality that is accurate, to give adolescents a chance define and develop their “values, attitudes, and insights about sexuality,” to help teens “develop relationships and interpersonal skills,” and to help them make responsible decisions about sex (SEICUS, Sexuality Education). Included in the final goal is instruction on abstinence, peer pressure, and the use of protection (SEICUS, Sexuality Education).

According to Advocates for Youth (Advocates for Youth, Definitions), comprehensive sex education teaches that “sexuality is a natural, normal, healthy part of life” (Advocates for Youth, Sex Education Programs). Like abstinence-only programs,
comprehensive programs, according to Advocates for Youth, teach that abstinence is the best and only guaranteed way to avoid sexually transmitted diseases and unwanted pregnancy (AFY, Sex Education). However, unlike most abstinence-only programs, comprehensive sex education covers topics such as masturbation, abortion, and sexual orientation (AFY, Sex Education). Furthermore, it includes discussion of many topics related to sexuality and sexual decision making such as: “human development, relationships, interpersonal skills, sexual expression, sexual health, and society and culture” (AFY, Sex Education). Comprehensive programs teach that condoms can reduce, but not eliminate, the risk of sexually transmitted disease and unwanted pregnancy, while other contraceptives can reduce the risk of unwanted pregnancy (AFY, Sex Education). Students are given information about sexually transmitted diseases and HIV. Comprehensive sex education programs acknowledge that religion plays a role in sexual decision making and encourages students to explore their own values as well as those of their families and communities (AFY, Sex Education). Michelle Hecht and Elicia N. Eddington say that comprehensive sex education programs maintain “that there is no single morally correct response to sexuality, and compensates for possible variations in moral beliefs” (Levesque 2003, 32). Finally, these programs teach that if a teenager does find herself pregnant she has three options (AFY, Sex Education). The options presented are to have the baby and keep it, to have the baby and give it up for adoption, or to abort the baby (AFY, Sex Education).
There are many comprehensive sex education programs being used across the country. They vary widely in their formats and content. Some of the most commonly used and researched programs are described below.

*Be Proud! Be Responsible!* is one of three curricula by the same authors, the others are *Making Proud Choices*, which is comprehensive program, and *Making a Difference*, which is an abstinence program. The *Be Proud! Be Responsible!* audience is youth between the ages of 13 and 19. The program is comprised of six 50-minute sessions given over the course of one to five days or several weeks. The goals are to “reduce unprotected sex among sexually active inner-city youth,” “to delay initiation of sex” among those who have not yet had sex, and to help adolescents “make proud and responsible sexual decisions” (ACF 2002, 16). The program gives facts about HIV/AIDS, and to a lesser degree, sexually transmitted diseases while trying to reduce the tendency toward risky sexual behaviors. There are only brief statements about preventing pregnancy. There is an emphasis on abstinence in this program but more attention is given to “safer sex,” and lowering “risks” (ACF 2002, 16). Condoms are referenced 495 times (ACF 2002, 16). Authors of the curriculum believe that it must “dispel beliefs that condoms interfere with sexual pleasure” (ACF 2002, 16). It teaches ways for students to make condom use appealing including shopping for different colored condoms and using condoms in foreplay. The programs arm students with responses for incidents when a partner expresses a desire not to use a condom. It also talks very candidly about sex, including how to reach orgasm. This program was found
to omit specifies about condom failure rates in a review done by the U.S. Department of Health and Human Services and Administration for Children and Families.

*Making Proud Choices* came after the *Be Proud! Be Responsible!* curriculum by the same authors. It has a younger target audience focusing on students 11-13. It is presented to small groups in community centers or schools in eight sessions. The goals of this program are to give students the knowledge and skills that they need to avoid STDs, HIV, and pregnancy. The program also aims to build students’ comfort with the idea of abstaining from sex or using condoms if they are sexually active. The teacher uses the words proud and responsible to stress desired behavior. For example, she might say “I just want to emphasize that if you have sex, the proud and responsible thing to do is to use condoms” or “Girls who carry condoms are smart, responsible, proud, and safe” (ACF 2002, 16). Like its predecessor, this program was thought by ACT and DHHS to lack specific success or failure rates for condoms and uses vague language (ACF 2002, 35).

*Reducing the Risk: Building Skills to Prevent Pregnancy, STD & HIV* is a widely used and widely tested comprehensive sex education program for ninth and tenth grade students. The program is comprised of 16 lessons. The goals of the program are to help students “evaluate the risks and consequences of teen pregnancy and STD infection,” and to give them information leading to the conclusion that only abstinence or contraception will allow them to avoid pregnancy, HIV, and STDs (ACF 2007, 13). Finally, the program aims to teach students how to communicate in ways that will help them remain abstinent or use protection when sexually active (ACF 2007, 13).
According to ACF and DHHS report, *Reducing the Risk* places strong emphasis on abstinence, stressing that it is the best way to avoid unintended consequences of sex (ACF 2007, 13). *Reducing the Risk* mentions abstinence more than any other program in the review (ACF 2007, 13). The program includes many references to protection and to condoms specifically. It discusses, in depth, issues surrounding protection, such as whose responsibility it is to acquire it and what could go wrong when using it. It even asks students to brainstorm some romantic ways to implement its use. Students are informed that they can obtain birth control at clinics without parental permission and they are given homework to visit a condom aisle at a local store. They are to write down information on three kinds of condoms and one kind of foam, and to take note of the store’s hours in case they need to return in the future. After completing the assignment, students are asked how comfortable they were completing the task. The ACF and DHHS review found this program to have no medical inaccuracies, but noted three statements about condoms that did not provide specific condom failure rates; instead they used phrases like “good,” and “almost all the time” (ACF 2007, 14-15).

*The Carrera Adolescent Pregnancy Prevention Program* was started over twenty years ago by Dr. Michael A. Carrera. The program takes a holistic approach to preventing teenage pregnancy. Its goal is help youth “develop personal goals and the desire for a productive future, in addition to developing their sexual literacy and educating them about the consequences of sexual activity” (Carera). This program includes five components that are meant to help students explore their interests and talents in addition to learning about sex. The first activity is called job club. It gives
students experiences such as managing money, and learning about careers. The second aspect of the program is academically focused including tutoring, test preparation for college entrance exam, and college counseling. The third component is referred to as Family Life/Sex Education. According to their website, “The content, in an age and stage-appropriate fashion, addresses body image, gender roles, social roles, family roles, sexual orientation and all other aspects of sexuality that contribute to a holistic view” (Carera). The final two activities provided by the program are arts and sports. The program also offers health care including contraception counseling and mental health care including therapy.

*Becoming a Responsible Teen or BART* is designed for African-American youth between the ages of 14 and 18. It mentions specifically HIV/AIDS rates in the black population. The program’s eight lessons are presented after-school or in classrooms during hour and a half to two hour sessions. The program aims to give students critical information about HIV/AIDS, to teach about avoiding or handling pressures surrounding sex, and to instruct on condom use. Like many other comprehensive sex education programs, *BART* tries to make buying and using condoms comfortable for students. Specifically, this curriculum asks students to share stories about buying condoms and leads them in a visualization exercise in which a successful condom purchase is made. It even encourages students to make condom use a part of their sexual daydreams. According to the ACF and DHHS review, this program does not give specifics about condom failure rates (ACF 2007, 27).
Focus on Kids is an eight session program meant to be used with fifth to tenth grade youth in urban areas. The primary goal is to teach students how to avoid acquiring HIV/AIDS. The program aims to provide students with accurate information including “modes of transmission and prevention” (ERT). Students are asked to think about and discuss their own feelings about sex and the pressure to engage in dangerous sexual behaviors. The curriculum also teaches “decision-making, communicating and negotiating with other youth regarding sexual topics” (ERT). Drug topics are also addressed and correct condom use is taught. The program is delivered in a fun, engaging way including games and “friendship groups” to create safety and support (ERT).

Safer Choices is a two part series to prevent STDs, HIV and pregnancy. The first part is completed in the ninth grade year and the second part is completed in the tenth grade year. Both parts are ten lessons long with each lesson taking about 45 minutes. The program aims to reduce the negative consequences of sex for teenagers by “reducing the number of students who have sexual intercourse and by encouraging condom use among those who do have sex” (ACF 2007, 20). It teaches specifically about HIV and five STDs. There is not a lot of emphasis placed on abstinence; in fact, the program only mentions it five times, while mentioning the phrase “not having sex” seven times (ACF 2007, 20). Safer Choices emphasizes that condoms will work and that using them can be enjoyable. It also includes a homework assignment requiring students to go to a store in order to research protective measures. The ACF and DHHS review finds the efficacy rates of condoms to be specific and technically true, but a bit misleading in a way that could instill false confidence (ACF 2007, 21).
Arguments for Comprehensive Sex Education

Those who believe that comprehensive sex education is best for adolescents support their assertion by citing the multitude of health and wellness organizations that believe it benefits youth. SIECUS lists these supporting organizations on its website: 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 (SIECUS, Sexuality Education). To this list, Stephen F. Morin and his colleagues add a few more, including: Advocates for Youth, the American College of Obstetricians and Gynecologists, and the National School Boards Association (Morin 2002, 14).

In addition to professional organizations, comprehensive sex education proponents say that the general public supports teens having access to information regarding contraception. According to SIECUS, 95% of middle school parents and 93% of high school parents believe that sex education should include information about contraception. Furthermore 88% of junior high school parents and 85% of high school parents thought that it was appropriate to teach students how to use methods of protection and where to attain them (SIEUS).

Those who support comprehensive programming assert that these programs do not encourage teens to have sex and that they reduce teen pregnancy and sexually transmitted disease. Douglas Kirby, who is thought to be the leading expert on the topic,
says of comprehensive programs, “They do not hasten the initiation of sex, they do not increase the frequency of sex, and they do not increase the number of sexual partners” (Kirby, PBS Interview). Kirby told PBS in a 2005 that his 2001 study, *Emerging Answers*, found that some programs made students less likely to have sex with multiple partners, delay initial sexual activity, and increase the use of protection when students did have sex (Kirby, PBS Interview).

Comprehensive sex education supporters believe that adolescents need information about contraception because they are having sex despite encouragement from parents and teachers to wait. According to Morin and his colleagues, at least fifty percent of high school students have had sexual intercourse (MORIN 2002, 14). These experts believe that providing teens with information about contraception makes them safer than if they are taught abstinence alone.

**Criticisms of Comprehensive Sex Education**

Those who are against comprehensive sex education believe that it sends mixed messages to youth. Kay S. Hymowitz, of the Manhattan Institute, quotes researchers who say, “Youth tend to respond especially positively to programs where the staffs are unambiguously committed to abstinence until marriage and when the program incorporates the broader goal of youth development” (Hymowitz 2003, 14). Abstinence-only proponents say that comprehensive programs present an overly simplistic perspective on sex. According to Hymowitz, opponents believe that “comprehensive sex education gives the impression that sexual intercourse is a relatively straightforward physical transaction that simply requires the proper hygienic
accessories” (Hymowitz 2003, 11). Hymowitz says, “They also believe that teens are not only incapable of mature, fully committed relationships but that teens have yet even to learn what such relationships are made of” (Hymowitz 2003, 11).

Abstinence-only proponents claim that comprehensive sex education promotes sex and encourages sexual activity in youth while briefly mentioning abstinence, therefore making them more likely to engage in sexual activity. The National Abstinence Education Association says on its website that “‘comprehensive ’or ‘abstinence-plus’ programs spend minimal time actually promoting the importance of abstinence(NAEA 2007, 1). Instead there is a presumption and often encouragement of sexual activity” (NAEA 2007, 1). It goes on to say that these programs are “promoting contraceptive use, even though the majority of teens today are not having sex” (NAEA 2007, 1).

Advocates for abstinence cite research demonstrating that those who have sex as teenagers regret it later. They believe that with more abstinence training, teens could be spared this regret. According to Kay S. Hymowitz, a survey for the National Campaign asked “If you have had sexual intercourse, do you wish you had waited longer?” They found that “Eighty-one percent of 12 to14 year olds and 55 percent of 15 to 17 year olds answered yes” (Hymowitz 2003, 14).

Those in the abstinence-only camp claim that comprehensive sex education contains misleading information. NAEA says that comprehensive programs overstate the effectiveness of condoms and the rates at which they are used. The Safer Choices program tells students that “Latex condoms can be 98% effective in preventing HIV,
other STD and pregnancy, but only if they are used correctly and consistently” (ACF 2007, 21). The NAEA states that there are studies showing that using condoms during intercourse only reduces HIV transmission by 85 percent and the risk of other STDs by 50 or less (NAEA 2007, 2). Abstinence educators feel that comprehensive programs equate abstinence with “safer sex.” They quote the program Reducing the Risk as saying “Remind the students that there are two ways to avoid pregnancy: say no to sex or use protection” (NAEA 2007, 2). Abstinence educators believe that students should only be told that abstinence is the only 100% option.

Furthermore, they believe that comprehensive programs unclearly define “abstinence.” They point to one activity that asks students to circle the activities that they could participate in while still remaining abstinent. The choices include: “reading erotic literature; cuddling naked; mutual masturbation; showering together; watching porn; talking sexy” (NAEA 2007, 4). Abstinence-only advocacy groups do not believe these activities to fall under the category of abstinence and that they are inappropriate for teens or other unmarried people.

The NAEA says that comprehensive education includes “sexually explicit and inappropriate content.” It claims that these programs teach alternative sexual acts known as “outercourse” (NAEA 2007, 3). In addition to discussion outercourse in depth, some programs cover “explicit demonstrations of foreplay” and “condom demonstrations” (NAEA 2007, 1).

Comprehensive sex education programs are thought by some to ignore the importance of parents in students’ sexuality decision making. Safer Choices and
Reducing the Risk both teach students that they can obtain birth control from clinics without permission from their parents (NAEA 2007, 5). Abstinence-only proponents believe that this lesson puts too much emphasis on personal autonomy and not enough emphasis on a parent’s role in the health and well-being of his or her child. They also believe that parents' wishes to be involved in their children’s sexuality decision-making are undermined.

Abstinence only advocates maintain that comprehensive sex education does not work. The NAEA says “According to the U.S. Department of Health and Human Services, there is little evidence that comprehensive programs actually delay the onset of sexual activity” (NAEA 2007, 6). Among those that the NAEA says result in no delay in sexual activity are: Be Proud! Be Responsible!, Safer Choices, AIDS Prevention for Adolescents in School, Teen Talk, Reach for Health Curriculum, and Making Proud Choices. Among those that they say had “mixed results” are: Reducing the Risk and Becoming a Responsible Teen.

Conclusion

There are many contradictory messages coming from the passionate poles of this debate. Both vehemently cite respectable studies proving that their approach does more to protect teens from STDs and pregnancy. Efficacy is key to this debate as neither side wants teens to acquire diseases or get pregnant. Studies that measure the efficacy of both kinds of programs will be explored in depth in the next chapter.
CHAPTER THREE: THE EFFICACY OF ABSTINENCE-ONLY AND COMPREHENSIVE SEX EDUCATION PROGRAMS

The debate over sex education is an impassioned one because the stakes are high. There is a lot to be lost by individuals and American society as a whole if teenagers get pregnant or acquire STDs or HIV. For this reason, the programs funded by tax dollars should be stringently tested and proven effective. Proponents for both abstinence-only education and comprehensive education cite studies to support that their philosophy for educating youth about sexuality is effective, and therefore, should be used. While a lot can be learned from examining the studies themselves, the most meaningful information comes from critiques of the studies by those on the other side of the debate. In looking closely at these debates we can draw conclusions about which programs are just seemingly effective on the surface, and which ones are truly scientifically proven to impact students’ lives. We can also discover the effective characteristics within programs that could be used to develop improved curricula in the future.

Ten Studies Most Frequently Touted by Abstinence Proponents

One debate commonly referenced by experts with regard to the efficacy of different sex education programs is that between Dr. Douglas Kirby and Robert Rector of the Heritage Foundation.

Dr. Douglas Kirby is a renowned sociologist widely recognized for his work in adolescent sexuality. He is a senior researcher at Education Training Research Associates (Education Training Research). He has written numerous articles about adolescent sexuality and he has reviewed a wide variety of sex education programs. He
is most well known for his *Emerging Answers* reviews of 2001 and 2007, which identified effective sex education programs by analyzing the results of numerous studies.

Robert Rector is a Senior Research Fellow at the Heritage Foundation. His focus is on Domestic Policy and his educational background is in Political Science. According to the Heritage Foundation, he is a “leading national authority on poverty, the U.S. welfare system and immigration” (Heritage Foundation). He has written many articles pertaining to those topics including some on sex education, with a proclivity toward abstinence.

In May 2001 and April 2002, Douglas Kirby and Robert Rector respectively published conflicting reports on the efficacy of abstinence-only education. In his first *Emerging Answers* publication, Kirby said, “There do not currently exist any abstinence-only programs with reasonably strong evidence that they actually delay the initiation of sex or reduce its frequency” (Kirby 2002, 1). In contrast to Kirby’s 2001 *Emerging Answers* findings and the previous statement, Rector claimed that, “There are currently 10 scientific evaluations that demonstrate the effectiveness of abstinence programs in altering sexual behavior” (Rector 2002, 4). To that Kirby responded by saying that most of the evaluations cited by Rector failed to meet the scientific criteria used in the *Emerging Answers* review. Specifically, he claimed that there were inadequacies in the interpretation of the data in addition to some questionable methodology (Santelli 2006, 846). In his article entitled, “Do Abstinence-Only Programs Delay the Initiation of Sex Among Young People and Reduce Teen Pregnancy?” Kirby wrote a response addressing each of the ten programs Rector claims to be effective in his article.
The first program that Rector cites as a successful abstinence-only program is the Virginity Pledge program in which students pledge to remain abstinent until marriage and often wear a ring as an outward symbol of their pledge. Rector says that the National Longitudinal Study on Adolescent Health “shows ‘abstinence pledge’ programs are dramatically effective in reducing sexual activity among teenagers in grades 7 through 12” (Rector 2002, 5). He quotes the study saying “Adolescents who reported having taken the pledge to remain a virgin were at significantly lower risk of early age of sexual debut” (Rector 2002, 5). Furthermore, he says, “sexual activity among students who had taken a formal pledge of virginity was one-fourth the level of that of their counterparts who had not taken a pledge” (Rector 2002, 5). Rector’s information came from a 1997 article called “Protecting Adolescents From Harm: Findings from the National Longitudinal Study on Adolescent Health,” by Dr. Michael Resnick and others.

Because the study was longitudinal, data were collected in three waves. The third wave was the focus of a study by Dr. Hannah Bruckner and Dr. Peter Bearman. In their article, “After the promise: the STD consequences of adolescent virginity pledges,” they present the STD rates of the same group of pledgers to whom Rector and Resnick refer (Bruckner 2005, 271). They agree with Rector and Resnick that those who took virginity pledges delayed their sexual debut (Bruckner 2005, 271). However, in attempt to further the research, they explore the accuracy of the following statement: “If taking a pledge indeed reduces premarital sexual activity, one might expect that pledgers are less likely to contract STDs than others because they initiate sexual activity later, have fewer sexual partners and are more likely to have sex in the context of a marital relationship
than others, all protective factors” (Bruckner 2005, 271-272). However, pledgers might be less likely to use condoms when they have sex, making them more susceptible to disease (Bruckner 2005, 272). They also consider that pledgers, because they do not want others to know that they have broken their pledge, are less likely to admit they are having sex to health professionals or relatives who could provide information about protection (Bruckner 2005, 272). With all of this in mind, the researchers set out to find STD rates among students who participated in pledge programs.

They found that there was “no significant difference in STD infection rates between pledgers and non-pledgers, despite the fact that they transition to first sex later, have less cumulative exposure, fewer partners, and lower levels of non-monogamous partners” (Bruckner 2005, 277). It is important to note that white respondents were an exception to this finding (Bruckner 2005, 277). The authors say that most pledgers are likely to have premarital sex, even if it is delayed, and that when they do, they are less likely to use condoms (Bruckner 2005, 277). They also point out that pledgers are “more likely to substitute oral and/or anal sex for vaginal sex,” which makes them increasingly susceptible to disease (Bruckner 2005, 277). While Rector was correct in his assertion that sexual activity is delayed, Bruckner and Bearman make it difficult to argue that pledgers are better off than their non-pledging counterparts in the long run.

Rector, along with Kirk A. Johnson a Senior Policy Analyst for the Heritage Foundation, responded to the Bruckner and Bearman study saying that they overstate the amount of anal and oral sex engaged in by pledgers by focusing on a small group (Rector 2005). They say that “Add Health data clearly reveal that virginity pledgers are
less likely to engage in oral and anal sex when compared to non-pledgers” (Rector 2005). With regard to the finding that pledgers and non-pledgers had similar STD rates, Rector and Johnson say that “Bearman and Bruckner examined only one of several STD measures available in the Add Health data file (Rector 2005). They say, “Analysis of the remaining measures reveals that adolescent virginity pledging is strongly associated with reduced STDs among young adults” (Rector 2005). According to Rector and Johnson, pledgers are less likely use contraception at first, but as time passes the rates of use grow increasingly similar between the two groups (Rector 2005). Rector says that pledge programs do not have perfect outcomes, but that “Pledgers are less likely to engage in sex while in high school, less likely to experience teen pregnancy, less likely to have a child out-of-wedlock, less likely to have children in their teen and young adult years, and less likely to engage in non-marital sex as young adults” (Rector 2005). He refers to Bearman and Bruckner’s work as “junk science,” and chastises them saying that virginity programs “have been unfairly maligned by two academics who should know better” (Rector 2005).

A University of Wisconsin statistician named Jordan Ellenberg followed the Rector article with one sub-titled “How the Heritage Foundation Cooked the Books on Virginity.” In the article he defends Bearman and Bruckner’s research (Ellenberg 2005). He says, “It’s an argument about math, not sex. And mathematically, the Heritage paper comes up short” (Ellenberg 2005). For example, when Rector and Johnson suggest that Bearman and Bruckner’s research is misleading because they used only one of five STD measures, they are putting up what seems like a smokescreen. According to Ellenberg
the four measures Bruckner and Bearman omitted were self-reported and, therefore, much less reliable than the urine sample that they used (Ellenberg 2005). Santelli, who also disagrees with Rector and Johnson’s criticisms of Bruckner and Bearman, points out that self-reported measures for STDs are inaccurate because STDs are often asymptomatic and pledgers are less likely to be tested for them (Santelli 2006, 848). Ellenberg concludes his article by saying that “Bruckner and Bearman aren’t campaigning,” he says that “they’re scientists, doing their jobs” (Ellenberg 2005).

Kirby refutes the success of virginity pledges by questioning the research methodology used in the study. He points out that the pledges are taken voluntarily, therefore, there is potential for “self-selection” bias (Kirby 2002, 3). In other words, students who chose to participate in the pledge process might have entered it already valuing abstinence (Kirby 2002, 3). Thus, there is little evidence that the pledges themselves directly led to the delay in sexual activity (Kirby 2002, 3).

Virginity pledges seem to act as a band aid on a problem requiring a much broader, longer lasting response. While they do delay sexual debut, that delay comes with a significant amount of guilt and stigma. When pledgers decide to be sexually active before marriage as 95% percent of Americans eventually do, the harmful effects outweigh the somewhat positive effects, such as delayed sexual debut (Kirby 2007, 27). As Drs. Bruckner and Bearman show, the guilt and stigma affect pledgers not only psychologically, but physically because they do not seek information on protection, or seek medical services if they are sexually active and may have a disease or other health problem. Adolescents in this country are not allowed to drink alcohol, smoke cigarettes,
vote, or elect to have surgery. The thought is that their judgment is not fully developed; they don’t have enough knowledge or ability to think critically through the potential consequences of their actions. Furthermore, they could be coerced by older people, especially in the case of voting, so that the decision is not truly their own. Yet, virginity pledges ask students to raise their right hands and swear to pledges that will affect them until they get married. They are encouraged by adults to do this, in a way, they are voting for virginity without having knowledge of what they are committing to or the judgment to look into the future and consider the potential psychological and physical consequences.

The debate over Virginity Pledges is representative of those that frequently happen surrounding this topic. Abstinence proponents use short-term or unproven “results” to support their arguments while actual scientists, backed by actual science and math, find that support for these programs does not really exist.

The second program to which Rector refers is the Not Me, Not Now program which was a mass communication effort intended to spread an abstinence message through media, such as television and radio, as well as billboards and posters. It includes a parent packet, interactive websites, and a classroom or community center educational component. The program was created by the Monroe Country Health Department in Rochester, New York with local funding. It was a response to high pregnancy rates in that area. According to Rector, among 15-year-olds, the sexual activity rate fell from 46.6 percent to 31.6 percent during this program (Rector 2002, 5-
6). Furthermore, the pregnancy rate among 15 to 17 year-old girls went from “63.4 pregnancies per 1,000 girls to 49.5 pregnancies per 1,000” (Rector 2002, 5-6).

In an evaluation of *Not Me, Not Now*, done by Andrew S. Doniger and colleagues, the same findings are reported (Doniger 2001, 57-58). Among some potential problems with the evaluation, they mention that some of the results could, in part, be due to other initiatives happening in the area at the same time or changes in the demographics of the area as the study was happening (Doniger 2001, 58). Furthermore, there was a national trend of decreasing teen pregnancies at the time (Doniger 2001, 58). While the researchers find these problems in the review, they still believe there is evidence, though not as strong as it could be, that this program had an independent impact on adolescents (Doniger 2001, 59). Kirby, like Doniger and his associates, found the study encouraging but also recognized the study’s weaknesses (Kirby 2002, 3). He said that it provided evidence, but not strong evidence of efficacy (Kirby 2002, 3).

Madison Avenue has used media to sell to adolescents for a long time and it has worked very well. It makes sense to use media, especially television, to sell the idea of abstinence and encourage young people to think through some of the potential consequences of sex. Obviously messages on television need to remain tasteful and appropriate for all age viewers. It is not the place to unroll a condom onto a banana, but it is a good way to reach young people and encourage them to make safe and healthy decisions by delivering an honest abstinence message.

*Operation Keepsake* and *Abstinence by Choice* are the next programs that Rector mentions as a successful abstinence-only curriculum. Kirby deemed the *Operation*
Keepake study statistically insignificant (Kirby 2002, 4). Operation Keepake evaluators only waited three and a half months to measure the impact of the program, which is not enough time (Kirby 2002, 4). Furthermore, he writes, “Although they were very close to significance, the study failed to control for statistically significant difference between the treatment of the control groups in age, gender, and ethnicity” (Kirby 2002, 4). Kirby accuses the study evaluation Abstinence by Choice of having “a very weak research design.” He specifically mentions a lack of intervention data from before and after the program’s implementation (Kirby 2002, 4).

Rector later turns his attention to the Family Accountability Communicating Teen Sexuality (FACTS) program. Rector says that this program was found to be “highly effective in delaying the onset of sexual activity” (Rector 2002, 7). He says that “Students who participated in the program were 30 to 50 percent less likely to commence sexual activity than were those who did not participate” (Rector 2002, 7). Kirby did not use the FACTS program in Emerging Answers because of an “inadequate evaluation design” (Kirby 2002, 4-5). Specifically, he says that different amounts of time elapsed between the “pre-intervention survey and the post-intervention surveys” for the group that received the intervention and the control group, therefore “baseline similarity of the intervention and comparison groups was not established” (Kirby 2002, 5). Kirby finds this very relevant because there were probably differences between the families who volunteered and the families who did not that would impact the adolescents’ decision making about sex (Kirby 2002, 5). Finally, Kirby says, “no tests of significance were provided” (Kirby 2002, 5).
It seems that abstinence proponents are so focused on winning the political and ideological debate about sex education that they lose focus of the real objective, which is to keep youth safe and healthy. Scientists find methodological errors and statistical insignificance frequently in the research studies that are presented to Americans as fact. These ten studies are the foundation for the abstinence-only side’s argument of efficacy. In article after article, they cite these ten weakly constructed studies, only four of which have been peer reviewed. If we are going to throw millions more dollars, all of our faith, and our children’s safety behind abstinence-only programming, it seems it should be based on better science.

Next, Rector discusses programs called Teen Aid and Sex Respect which were implemented in three Utah school districts with students who were at risk of early sexual debut (Rector 2002, 7). According to Rector, the programs were credited with reducing sexual initiation by a third among high school students, however, no statistically significant difference was found in middle schoolers (Rector 2002, 7). Kirby included the research from these studies in his Emerging Answers review, however, he says that these programs only worked for students who were “the most permissive,” and that less permissive students were not significantly impacted (Kirby 2002, 4).

This program is valuable because it worked for some students. More research should be done to find out what made it effective with the permissive youth and see if it could be altered to make it work for everyone or reserve it for use with groups of sexually permissive teens. When something works, even a small component of a program, studies should research further to see why it worked and then see if it can be
combined with elements of other programs that work to devise some real and lasting
solutions.

While Rector accurately refers to the program *Postponing Sexual Involvement* as
an abstinence-only program, Kirby points out that students in the study referenced in
Rector’s article were also exposed to an additional component involving contraception
(Kirby 2002, 5). Kirby says that PSI in the case of this particular study is, more
accurately, an abstinence-plus program (Kirby 2002, 5). PSI was designed for at-risk
eighth graders by Grady Memorial Hospital in Atlanta, Georgia. The program is
presented by professional counselors and trained teenagers slightly older than the
participants.

According to the study’s authors, Marion Howard and Judith Blamey McCabe,
this program has a very positive influence on adolescents. They say that almost all of
the participants who had not yet engaged in sexual activity found the information helpful
in avoiding sexual activity in the future (Howard 1990, 25). When compared with the
control group that did not have the program, participates were five times less likely to
begin having sex if they had not already (Howard 1990, 25). It appears that these are
lasting effects as 24 percent of program participants had had sex a year later compared to
39 percent of non-participants (Howard 1990, 25). The students in the 24 percent that
decided to start having sex after completing the program were “less sexually involved”
than non-participants who were having sex a year later (Howard 1990, 25). According
to the authors, the program had no effect on students who were already having sex
before the program (Howard 1990, 25). It did not make them less sexually active or
more likely to use protection (Howard 1990, 25). Those who participated in the program were more likely to delay sexual involvement and to use contraception when they did have sex (Howard 1990, 25). Unfortunately, the majority of students in both the control group and the study group did not use contraception if they were sexually active (Howard 1990, 25).

Kirby agrees that there is some evidence supporting the effectiveness of the program, but does not think that it is particularly strong (Kirby 2002, 5). He also points out that when the PSI portion, without the contraception piece, was taught in California, a “rigorous evaluation” found it ineffective in delaying the initiation of sex (Kirby 2002, 5).

Given what we know about adolescence and the importance of peer relationships, it makes sense, developmentally, to use peer leaders for these programs as was done in the Postponing Sexual Involvement Program. While Rector included it in his article as an abstinence program, it did, in fact, include information about contraception and it was mildly successful. This program is definitely worth considering when developing future curricula. It should be examined to see what could be added to increase condom use.

The Mathematica Study on Abstinence-Only Programs

The Mathematica study, which was government funded, measured the effectiveness of four abstinence-only programs: My Choice, My Future!, ReCapturing the Vision, Families United to Prevent Teen Pregnancy, and Teens in Control. Mathematica Policy Research Inc., according to its website, is “a nonpartisan firm,” that, “conducts policy research and surveys in healthcare, education, welfare, employment,
nutrition, and early childhood” (Mathematica). Its self-reported mission is to provide work of “Uncompromising objectivity and quality” (Mathematica).

The abstinence programs that Mathematica studied differed greatly in their locations and included both urban and rural communities (Thenholm 2007, xv). Three of the programs served mostly African-American and Hispanic students while one program served predominantly white youth (Thenholm 2007, xv). The latter usually came from two parent homes that were working or middle class (Thenholm 2007, xv). While the former were mostly from low income households headed by one parent (Thenholm 2007, xiii). The programs differed greatly. For example, some happened during the school day and were mandatory, while others happened after school (Thenholm 2007, xv). Some were weekly and some were daily (Thenholm 2007, xv). The programs ranged from one year programs to four year programs and they targeted all different grades between third and eighth (Thenholm 2007, xv).

Overall the programs, according to the study, did not impact students’ likeliness to remain abstinent (Thenholm 2007, 59). About fifty percent of students in the study, and in the control group that did not receive abstinence education, remained abstinent (Thenholm 2007, 59). There was also no difference shown between study participants and the control group in the age of sexual debut or the number of sex partners (Thenholm 2007, 59). The study says that contrary to concerns by those who question abstinence education, participants in the abstinence education program were no more likely to have unprotected sex than those who did not participate (Thenholm 2007, 59).
Very similar proportions of both groups reported not using a condom at first sex and not consistently using a condom over the course of the last year (Thenholm 2007, 59).

The study shows greater knowledge of STDs in the program participant groups opposed to the non-participants (Thenholm 2007, 60). They were also more likely to know that birth control pills do not protect against STDs (Thenholm 2007, 60). One program, *My Choice, My Future!* is credited with greatly influencing this statistic (Thenholm 2007, 60). While the program group was more knowledgeable about the STDs themselves, the control group was more likely to “perceive condoms as effective at preventing STDs” including “HIV, chlamydia and gonorrhea, and herpes and HPV” (Thenholm 2007, 60). The abstinence-only participants said more times than the control group that “condoms are never effective at preventing these STDs” (Thenholm 2007, 60).

The lack of understanding about the effectiveness of condoms discovered in this study demonstrates the harmful effects of the misinformation given to students in abstinence-only programs. These programs were effective in delivering this message, but the message was inaccurate. It is obvious that the programs focused on STDs to dissuade students from having sex. While the discussion of STDs probably succeeded in scaring them, students walked away with the false notion that condoms are never effective. When the images of the diseased genitalia are forgotten, all students will be left with is the idea that condoms do not work and therefore are not worth the hassle.
Response to the Mathematica Study

Dr. Stan Weed of The Institute for Research and Evaluation discusses the shortcomings of the Mathematica report in an article entitled “‘Abstinence’ or ‘Comprehensive’ Sex Education?” Weed points out that the study did not research comprehensive education and therefore, no conclusion can be drawn that comprehensive education is any more effective than abstinence programs (Weed 2007, 3). What he fails to acknowledge is that this study was conducted to measure the efficacy of abstinence programs because they were the programs that the government was funding. The Mathematica study mentioned comprehensive sex education one time and did not draw any conclusions about it being more effective.

Dr. Weed points out that the students were not isolated in either the participant group or the control group, therefore, there was likelihood of cross-contamination between the two groups wherein “new values or behaviors adopted by each group are shared across the groups” (Weed 2007, 4). The authors assume that the longer the interaction between these groups continues the more the difference between them will disappear (Weed 2007, 4). The Mathematica study did not take this into account when reporting its findings (Weed 2007, 4).

Weed also criticizes the study’s sample saying that because it included mostly poor, minorities, it is not representative of the U.S. population and cannot be applied to all groups (Weed 2007, 4). As is the case with many of the studies on abstinence-only curricula’s effectiveness, the Mathematica study focused on groups that are at high risk for experiencing the negative outcomes of early sexual activity.
Finally, Weed questions the length of time that elapsed between the end of the program and the follow-up, which was two and a half to five and a half years (Weed 2007, 4). He considered this too much time without reinforcement to provide “a realistic indication of program effectiveness” (Weed 2007, 4). Challenging comprehensive programs be held to the same standard Weed and his colleagues say, “We are not aware of any evaluations of comprehensive sex education programs that have shown positive changes in teen condom use after three years, and are aware of only two that have shown impact after two years, and these were using the lower standard of success” (Weed 2007, 4). It is true that all programs should be held to the same standard and produce lasting results.

**Emerging Answers**

The most recent and most thorough review of sex education programs is *Emerging Answers 2007* by Dr. Douglas Kirby. Kirby selected 56 sex education curricula studies that met rigid requirements for inclusion; eight were abstinence only curricula (Kirby 2007, 103). Some of the programs were implemented in the community, and in health clinics, but more than half were in schools only (Kirby 2007, 103). The majority of the programs were used in areas at high risk for STDs and HIV such as low-income and urban areas (Kirby 2007, 103). Some programs focused on just pregnancy prevention, but most focused on just STD/HIV prevention or on both pregnancy and disease prevention (Kirby 2007, 105). The 56 studies involved programs that did not discuss drugs use, alcohol, or other non-sexual risky behavior (Kirby 2007,
All of the comprehensive programs promoted abstinence in addition to discussing contraception (Kirby 2007, 105).

**Emerging Answers: Abstinence Programs**

Four of the eight abstinence only curricula were in the Mathematica study previously discussed (Kirby 2007, 113-114). Kirby emphasizes the reliability of this study by saying, “They employed rigorous experimental designs and tracked respondents for multiple years” (Kirby 2007, 113-114). Kirby says that the studies evaluating the remaining four abstinence programs discussed in *Emerging Answers* “were much less rigorous and included only quasi-experimental designs” (Kirby 2007, 114).

*Sex Can Wait* was the only program that was shown to delay sexual activity and Kirby calls the delay “modest” (Kirby 2007, 114). The other three programs were not shown to delay teen sexual activity (Kirby 2007, 114). For teens who had already had sex, *Sex Can Wait* and a program called *For Keeps* “reduced the frequency of sex” (Kirby 2007, 114). *For Keeps* was also found in one study to reduce “the number of sexual partners” (Kirby 2007, 114). Only one study measured condom use and found that “abstinence programs had no significant impact on its use” (Kirby 2007, 114). Kirby goes on to note that “an abstinence-focused version of the *Making a Difference* program” was reported at a professional conference to have delayed participants’ sexual debut for two years (Kirby 2007, 114). However, the results were not officially released and, therefore, were not included in *Emerging Answers* (Kirby 2007, 114).

Overall, Kirby finds abstinence programs ineffective in delaying sexual involvement among teenagers (Kirby 2007, 115). He does, however, believe that future
studies could show positive impact by some programs (Kirby 2007, 115). He again says that the current evidence is “very modest” (Kirby 2007, 115). Nevertheless, Kirby does not want abstinence programs to be completely discarded as there are many that have not yet been tested (Kirby 2007, 122). He suggests that, “More effort should be directed toward carefully developing and evaluating these programs (Kirby 2007, 122). When strong evidence demonstrates that particular programs are effective, those programs should then be disseminated more widely” (Kirby 2007, 122).

It is important that more studies be done on the very few effective abstinence-only programs to see what makes them work. We should glean insight from areas of the program where they are successful, such as delaying sexual debut, and use that insight in developing future programs. It is possible that elements of successful abstinence programs could be combined with elements of successful comprehensive sex education programs to make them truly abstinence-plus programs using the best work of each side’s experts.

**Emerging Answers: Comprehensive Programs**

According to Kirby, studies showed that fifteen of 32 comprehensive programs measured “delayed the initiation of sex and none hastened it” (Kirby 2007, 115). Six of 21 programs measured “reduced the frequency of sex or increased the return to abstinence and none increased the frequency of sex” (Kirby 2007, 115). Eleven programs out of 24 “reduced the number of sexual partners, but one increased the number” (Kirby 2007, 115). Kirby summarizes saying, “The results therefore provide
strong evidence that comprehensive programs do not increase sexual behavior” (Kirby 2007, 115).

This finding is very important because one the most frequent and fervent criticisms of comprehensive sex education is that it encourages students to have more sex sooner. Comprehensive sex educations critics believe that hearing about how to use a condom, and learning about birth control options, will increase students’ sexual activity. These findings show that that is not the case. Furthermore, several programs did delay sexual debut, and encouraged students to have fewer partners and sex less frequently, all of which make them safer.

Studies show that teens who participate in comprehensive sex education are more likely to protect themselves when they have sex (Kirby 2007, 115). Fifteen of 24 studies showed a decrease in unprotected sex rates among program participants (Kirby 2007, 115). Fifteen of 32 studies showed “increased use of condoms,” while four in nine studies showed “increased contraceptive use” (Kirby 2007, 115). One study found decreased contraceptive use. The majority of the programs were also found to reduce “risky sexual behavior” (Kirby 2007, 115).

Given the fact that so many teens are having sex whether anyone likes it or not, these findings on their likelihood to protect themselves are important. Almost everyone agrees that it is ideal for teenagers to be abstinent, but the reality is that they often are not. For their own health, and the interest of public health, it is crucial that they protect themselves each time they have sex. Several comprehensive programs, according to
Kirby, increase condom use among teens. We need to look at what makes those programs effective and use it to develop programs in the future.

**Emerging Answers: Reliability**

Kirby emphasized the statistical strength of these studies, frequently using the word rigorous to describe them (Kirby 2007, 116). He says “the positive results are unlikely to result from weak study methodologies” (Kirby 2007, 116). Furthermore, Kirby reports, studies on a few programs have been replicated producing continued positive results (Kirby 2007, 116). For example, *Be Proud!, Be Responsible*, which was eventually supplemented and renamed *Making Proud Choices!* was shown to have a positive impact on teen sexual behavior in many different kinds of communities and settings and with both genders and different races (Kirby 2007, 116). One replication, however, did not show a positive impact on teen behavior (Kirby 2007, 116). In this case, *Making Proud Choices!* was implemented during the standard school day in high schools and it did not show the same positive results as it had previously (Kirby 2007, 116). Kirby suggests that this could be the result of students’ fatigue which is not present on the weekend, forced participation, the older age of the students, saturation of content, or a variety of other factors (Kirby 2007, 116). *Reducing the Risk* and *Becoming a Responsible Teen* were also replicated in other settings and parts of the country (Kirby 2007, 116). *Reducing the Risk* showed positive impact each time it was presented and *Becoming a Responsible Teen* was successful in two of three settings (Kirby 2007, 116-117). The ineffective program was a truncated version presented in a juvenile penitentiary (Kirby 2007, 117).
Kirby points out that while the findings in the comprehensive program studies are strong, and the programs are impactful, the magnitude of the impact is not great enough to consider sex education in itself a solution to the problem of teen sexual activity (Kirby 2007, 116). There are several comprehensive sex education programs that do now produce the results they need to, and they should be discontinued. Other programs are successful but not as successful as we need them to be. Any program that is used should be proven to impact students behaviors in ways that make them safer over and over again. There are enough programs that show increased condom use and knowledge that we should focus on those and implement them in more places.

**Emerging Answers: Involving Parents**

In addition to previously discussed programs, *Emerging Answers* also reviews programs that are less traditional. For example, Kirby looks at studies of programs that aim to involve parents in multiple ways (Kirby 2007, 139). These programs include “programs for parents only, programs for parents and teens together, homework assignments in school sex education classes requiring communication with parents, and video program with written materials to be completed at home” (Kirby 2007, 139). Although Kirby says too few studies have been done to “warrant firm conclusions,” there are positive results from the studies that do exist (Kirby 2007, 141). Students who participated in a program in which parents were involved were sometimes less sexually risky and used condoms more (Kirby 2007, 141). Overall, Kirby says the evidence is not strong, but that these programs positively impact young people (Kirby 2007, 141).
Studies of both kinds of programs show that parental involvement is key in adolescents’ sexual decision making. Because sex is a difficult topic for many parents to discuss with their offspring, programs that help facilitate those discussions could prove very helpful and effective in helping parents influence their children in meaningful ways. Studies show that parents’ opinions matter to teens, parents just need help expressing them.

**Emerging Answers: Incorporating Technology**

Consistent with the times in which we are living, sex education programs are available via computer and video technology (Kirby 2007, 142). These programs can be implemented in a variety of settings and are cost effective because they don’t require a facilitator (Kirby 2007, 142). Kirby writes, “Some studies have indicated that interactive video and computer programs can improve knowledge and attitudes, even about sexuality” (Kirby 2007, 142). Based on three studies included in *Emerging Answers*, Kirby concedes that “Short, non-interactive videos alone may not have any effect on behavior (Kirby 2007, 142). However, longer, interactive videos that are viewed several times may have an impact on some behavior, possibly for as long as six months” (Kirby 2007, 142). However, he cautions that not enough information has been gathered to draw serious conclusions (Kirby 2007, 142).

While these videos and computer programs have not been proven effective enough to become programs, we can use these findings to consider more technology into other programs. Teens are very technologically minded will likely only grow more so. Incorporating a medium that they respond to is a good idea to increase the efficacy of
future programs. This was also shown by the abstinence-program Not Me, Not Now’s success using a multi-media campaign to promote abstinence.

**Emerging Answers: Sex Education in Clinics**

More traditional sex education happens in health clinics. Clinics provide contraception to teenagers in addition to counseling and other medical services (Kirby 2007, 145). Kirby includes six studies of such programs in his review (Kirby 2007, 145). He makes sure to point out that the distinction between comprehensive sex education programs and clinic programs is that clinic programs happen on an individual basis as opposed to being presented in a classroom or other group setting (Kirby 2007, 145). He also points out that sometimes clinics are used as venues for group comprehensive sex education and that when this happens, it is effective (Kirby 2007, 147). Kirby found the programs and services provided were “brief and modest,” but effective (Kirby 2007, 147). He says, “All six of the programs focused on sexual and contraceptive behavior, sent clear messages about appropriate behavior, and included one-on-one consultation about the client’s own behavior” (Kirby 2007, 147). He encourages clinics to continue to develop and evaluate these programs (Kirby 2007, 147). He also encourages medical providers to spend more time talking with teens about their sexual health (Kirby 2007, 147).

This finding supports the notion that “it takes a village to raise a child.” Parents, teachers, and health professionals must be involved in teaching youth to make healthy decisions about their sexuality. They receive so many messages from so many different
places, such as friends, television, and the internet, they need trusted adults to give them clear, accurate information.

**Emerging Answers: Characteristics of Effective Programs**

There are several characteristics that Kirby believes are present in effective curriculum-based sex education programs. He says that programs need to be “focused on clear health goals—the prevention of STD/HIV, pregnancy, or both” (Kirby 2007, 131). He does not mention focusing on other risky behaviors such as drug and alcohol use (Kirby 2007, 131). Kirby says content should cover strategies for meeting these goals such as abstinence or contraceptive use (Kirby 2007, 131). He also says that content should prepare students by discussing circumstances that lead to unhealthy sexual decision making and how to avoid difficult situations (Kirby 2007, 131). Kirby acknowledges the importance of psychosocial elements such as “knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy,” and influencing them in a way that keeps youth healthy (Kirby 2007, 131). Furthermore, Kirby says that effective programs happen in environments where youth feel comfortable participating and involve students in a variety of activities that honestly address the psychosocial elements involved in sexual decision making (Kirby 2007, 131). Kirby finds that good programs use sound instructional methods that make students identify personally with the information (Kirby 2007, 131). Specifically, Kirby found that effective programs “Employed activities, instructional methods, and behavioral messages that were appropriate to the teens’ culture, developmental age, and sexual experience” (Kirby
2007, 131). Finally, Kirby says that topics in effective programs were also covered in “logical sequence” (Kirby 2007, 131).

Many of Kirby’s suggestions are simply based in sound learning theory. Students have to be engaged with information in order to retain it and have it influence their lives. Students learn best when they identify with and connect emotionally to the curriculum. Both abstinence-only programs and comprehensive sex education programs include hands on activities to engage students. No program is going to be effective if it does not apply the basics of learning theory.

**Kirby’s Critics**

Kirby is highly esteemed by his colleges in the field of adolescent sexuality. There are not many articles available that question his methods or analysis. However, the National Abstinence Education Association does have a press release on its website entitled, “Emerging Answers Begs the Question of Objectivity: Report Skews Public’s Understanding of Abstinence Education” (NAEA). In this statement the NAEA says “Dr. Douglas Kirby, the author of the research, is one of sex education’s most noted advocates. He also serves on the staff of the company that publishes many of the sex education curricula featured in the study” (NAEA). The release contains no specific criticisms of Kirby’s scientific methods or analysis except to say that the study "offers a very narrow definition of 'high risk' behavior, and gives the medically inaccurate impression that condoms make sex safe” (NAEA).

It is true that Dr. Kirby created many of the programs positively reviewed in *Emerging Answers* and, therefore, benefits financially from their success. This conflict
of interest is acknowledged in the foreword of *Emerging Answers*, which was written by Sarah S. Brown, CEO of the National Campaign to Prevent Teen and Unplanned Pregnancy. Brown states that because Kirby “has a well developed reputation as a high-quality evaluation researcher, a number of Kirby’s own studies of programs appear in this publication” (Kirby 2007, 4). This is not totally unheard of, for example, *Sex Can Wait* was evaluated by its author Michael Young and Andrew S. Doniger, Director of the Monroe County Department of Public Health, developed and evaluated that county’s program, *Not Me, Not Now*. Furthermore, the authors of *Postponing Sexual Involvement*, Marion Howard and Judith Blamey McCabe, also did their own evaluation, which was included in Rector’s Heritage Foundation article.

**Response to Emerging Answers: Rebuttal in Support of Abstinence**

Robert Rector and Christine C. Kim followed Kirby’s 2007 *Emerging Answers* with an article entitled “Abstinence Education: Assessing the Evidence.” The article features 21 studies intended to measure the effectiveness of abstinence-only programs. Six studies analyzed virginity pledges and 15 looked at “abstinence programs that were primarily intended to teach abstinence” (Kim 2008, 1). This paper was slightly more balanced than Rector’s 2002 response to Kirby’s 2001 *Emerging Answers* findings. This time around he included six studies that showed abstinence-only education to be ineffective. However, of the eleven studies that Rector says prove abstinence-only education effective, four—*Not Me, Not Now, Abstinence by Choice, Project Taking Charge, and Teen Aid and Sex Respect*—appeared in his 2002 article, which Kirby severely criticized for the studies’ methodology and data interpretation. Rector even
uses most of the same words to discuss them. He also uses the same data to discuss the
efficacy of virginity pledges as was used in the previous article. However, he concedes
that Drs. Bruckner and Bearman found “no significant differences in STD infection rates
between pledgers and non-pledgers” (Kirby 2008, 13). The programs that are new to
this article are Reasons of the Heart, Sex Can Wait, Heritage Keepers, For Keeps, Best
Friends, HIV Risk-Reduction Intervention, and Stay SMART. Their results of almost all
of these programs are contended by experts, but a few of the more enlightening studies
are presented below.

Reasons of the Heart (ROH) was presented in Northern Virginia middle schools
over the course of twenty class periods (Rector 2008, 4). According to Kim and Rector,
after a year, 9.2 percent of the students who were virgins at the beginning of Reasons of
the Heart were no longer virgins, on the other hand, 16.4 percent of those in the control
group who were virgins at the study’s origin were no longer virgins after the year
elapsed (Rector 2008, 4). The Sexuality Information and Education Council of the
United States (SIECUS, Marginally Successful) agrees with these positive findings on
the Reasons of the Heart program (SIECUS, Marginally Successful). However, they say
that the research design used was “weighted heavily in favor of ROH” (SIECUS,
Marginally Successful).

SIECUS experts explain that the control group was shown two videos on the
prevention of STDS and HIV along with a thirty minute video on abstinence, which,
Rector and Kim note, is the “state’s standard family life education” (SIECUS,
Marginally Successful and Kim 2008, 4). SIECUS estimates that the students in the
study received three times as much instruction as the students in the control group (SIECUS, Marginally Successful). Furthermore, the teachers who presented the ROH program were trained while teachers for the control group received no training (SIECUS, Marginally Successful). SIECUS points out that comparing ROH to a control group that received no instruction, or one that received a full comprehensive sex education program, would have done more to prove its efficacy.

Again, we have the Heritage Foundation giving the impression that a program is highly effective based on a comparison of apples and oranges. Any time students receive three times as much instruction on anything it is going to have a greater impact on them. This is good evidence for the need for continuous and complete sex education, showing that more is more impactful, but it is not evidence for abstinence-only education.

*Sex Can Wait* is presented to students in three parts, the first is in upper-elementary, the second is in middle school, and the third is in high school. Rector and Kim cite an 18-month follow-up study by George Denny and Michael Young (Kim 2008, 5). Denny and Young found that the upper-elementary and middle school students who participated in the program were less likely than non-participants to engage in sexual activity (Kim 2008, 5). They found reduction of sexual activity in high school students right after the program, but the results did not last through the 18-month follow up (Kim 2008, 5). As in the ROH study, the participants were compared to students who were given “their school district’s standard sex education curricula” (Kim 2008, 5). As noted earlier, in his *Emerging Answers* report, Kirby acknowledges that *Sex Can Wait*
was shown effective in delaying sexual activity and reducing frequency of sex among those who are already active (Kirby 2007, 114). However, he points out that in a more rigorous study, Mathematica found it ineffective when combined with the program *Postponing Sexual Involvement* (Kirby 2007, 114). Overall, the program seems to have a modest effect.

One thing that *Sex Can Wait* does that many other abstinence-only programs do not is provide a three part series. The messages are presented to students at three different levels of development providing a consistent message and reminding them of what they have learned. Studies show that students need multiple exposures to information before they retain it. Furthermore, students are getting messages that contradict abstinence messages daily, they need to be reminded of what is safe and healthy. Many of these programs show that they have an effect for the months directly following the dissemination of information, however the results seem to wear off as time passes. This consistent message year after year would reduce the likelihood of losing the programs’ effects.

*HIV Risk-Reduction Intervention* was evaluated in a 1998 study. It involved African-American students in Philadelphia who volunteered to take part in a health program lasting the duration of one weekend. According to John B. Jemmott and his colleagues at JAMA, the study was, “Designed to be educational, but entertaining and culture sensitive, each intervention involved group discussions, videos, games, brainstorming, experiential exercises, and skill-building activities” (Jemmott 1998,1530). The program was led by extensively trained adult and peer facilitators. The
adults were highly educated and had extensive experience working with the study’s population (Jemmott 1998, 1531).

Participants were randomly placed in one of three groups. The first was an abstinence program that “acknowledged that condoms can reduce risks but emphasized abstinence to eliminate the risk of pregnancy and STDs, including HIV” (Jemmott 1998, 1531). The second was a safer-sex program that “indicated that abstinence is the best choice but emphasized the importance of using condoms to reduce the risk of pregnancy and STDs, including HIV, if participants were to have sex” (Jemmott 1998, 1531). The final group, the control group, “focused not on AIDS or sexual behavior, but on behaviors associated with risk of cardiovascular disease, stroke, and certain cancers—health problems that are among the 7 leading causes of premature death among African Americans” (Jemmott 1998, 1531).

According to Kim and Rector, after three months, “students in the abstinence programs were less likely to report having engaged in recent sexual activity compared with students in the control group and that they were marginally less likely to report having engaged in recent sexual activity compared to students in the safer-sex program” (Kim 2008, 8). At the six and twelve month follow-ups, those students who were sexually active before the study, and who participated in the safer-sex version of the program “reported fewer days of sexual activity on average than students in the control group and the abstinence group reported” (Kim 2008, 8). The study’s authors concluded “Both abstinence and safer-sex interventions can reduce HIV sexual risk behaviors, but
safer-sex interventions may be especially effective with sexually experienced adolescents and may have longer-lasting effects” (Jemmott, 1998, 1529).

The study says that the “abstinence” program acknowledged that condoms reduced risks, this makes it sound more like an abstinence-plus program than an abstinence-only program. Abstinence-only programs, by definition, only talk about condom failure rates, not their ability to reduce risk. This study may in fact be showing the effectiveness levels of varying degrees of comprehensive education. While they both had success, the program with a little more emphasis on protection had longer lasting results, which is very important.

**Conclusion**

While none of the programs discussed above offer an unquestionable or highly effective solution, it seems that there is more evidence that comprehensive sex education programs do more to prevent the negative outcomes of early sex and delay sexual debut. Those who believe comprehensive sex education is more effective, or at least that abstinence does not work, tend to be scientists. Proponents of abstinence-only tend to be political advocates and people with a strong philosophical objection to comprehensive programs. The studies cited to prove the benefits of abstinence are usually highly and easily criticized by scientists, while there is not much to support the inaccuracy of the studies that support comprehensive sex education. That is not to say that there aren’t things to be learned from the few things that have worked within these programs. These programs could be used to strengthen the abstinence message within comprehensive
programs. More research, and perhaps more creativity and cooperation, is needed on both sides of this issue.
CHAPTER FOUR: HOW COULD ABSTINENCE BE UNETHICAL?

In addition to questioning the efficacy of abstinence-only programs, experts also question their ethics. Many human rights organizations have issued declarations asserting that all people are entitled to full and accurate health information. For example, the United Nations Committee on the Rights of the Child declared in 2003 that “effective HIV/AIDS prevention required States to refrain from censoring, withholding, or intentionally misrepresenting health-related information, including sexual education …” (Kantor 2008, 5). The International Covenant on Civil and Political Rights, a document which the United States signed, “contains general support for the right to education and information about health, and acknowledges individuals’ right to ‘seek, receive and impart information of all kinds,’ including information about their health,” (Kay 2008, 27). Furthermore, at the 1994 International Conference on Population and Development the United States and other countries established that: “information and services should be made available to adolescents to help them understand their sexuality and protect themselves from unwanted pregnancies, sexually transmitted disease and subsequent risk of infertility” (Kay 2008, 27). Despite participation in these conferences and outward agreement with the above statements, U.S. abstinence-only programs are widely accused of presenting inaccurate and misleading information as scientific fact. Furthermore, by nature, they withhold information about effective condom use and the acquisition and use of other contraceptives.

Concerned with the departure from these commitments under the Bush administration, Reprehensive Henry A. Waxman of California ordered a report
analyzing the accuracy of some of the most widely used abstinence-only education programs. Waxman’s staff found that “Eleven of the thirteen curricula most commonly used by SPRANS programs contain major errors and distortions of public health information” (Waxman 2004, 7). SPRANS stands for Special Projects of Regional and National significance and refers to the funding of community based programs that receive funds straight from the federal government, bypassing the state. The misinformation Waxman’s staff found in these programs pertains to “the effectiveness of contraceptives,” and the “risks of abortion” (Waxman 2004, i). Other criticisms in the report include: “blurring religion and science,” the presentation of “stereotypes about girls and boys as scientific fact,” and other “scientific errors” (Waxman 2004, ii).

**Exaggerated Condom Failure Rates**

According to federal guidelines, abstinence-only education programs are required to present abstinence as the only way to avoid sexually transmitted diseases and pregnancy. When these programs talk about contraception, they do so only to highlight failure rates. According to the Waxman staff, the failure rates presented to students in abstinence-only programs are grossly exaggerated and, therefore misleading (Waxman 2004, 8). Despite the fact that the Centers for Disease Control and Prevention say that, “Latex condoms, when used consistently and correctly, are highly effective in preventing the transmission of HIV, the virus that causes AIDS,” abstinence-only programs give students the idea that HIV can pass through condoms and that condoms have a 31% failure rate (Waxman 2004, 9). Waxman’s staff found that that 31% failure rate was drawn from a 1993 study by Dr. Susan Weller (Waxman 2004, 8). Waxman’s staff says,
the Department of Health and Human Services dismissed Dr. Weller’s conclusions in a 1997 statement that read the “FDA and CDC believe this analysis was flawed” (Waxman 2004, 8). One reason for this finding was that she combined the data on consistent condom use with inconsistent condom use (Waxman 2004, 8).

A study in the New England Journal of Medicine found that “there was not a single case of HIV transmission between HIV-positive individuals and their HIV-negative partners using condoms consistently, despite a total of 15,000 acts of intercourse” (Waxman 2004, 10). One abstinence-only curriculum tries to discredit this study by saying “This study has been criticized by three different university groups as being seriously flawed in at least six areas, and therefore the results are questionable and not statistically significant” (Waxman 2004, 10). However, Waxman’s staff found that “university groups” actually refers to “individuals who sent letters to the editor to the journal in which the study appeared” (Waxman 2004, 10).

Just as abstinence-only advocates often use poorly conducted studies or parts of studies to show that programs are effective, they use the same kind of half information to distort data to sway students. Because abstinence is the only 100% effective way to avoid unwanted pregnancy and sexually transmitted disease, abstinence-only advocates believe it is the only method that should be taught and that all other methods should be discredited. The problem is that it is unethical to discredit other methods using false and misleading information.

Abstinence-only programs present the message that increased condom usage actually increases rates of STD acquisition (Waxman 2004, 11). They base this claim on
the fact that in the time period when condom use was increasing, diagnosis rates for the sexually transmitted disease chlamydia were also increasing (Waxman 2004, 11). However, the U.S Center for Disease Control (CDC) attributes this increase not to increased cases, but to better detection and more screening for the infection, which is asymptomatic (Waxman 2004, 11). Abstinence-only curricula use this coincidence to mislead participants. However, they fail to mention decreases in the acquisition of syphilis by men and women, decreases in gonorrhea in women, less urethral infection in men and fewer negative effects of HPV, all of which are shown to be associated with consistent condom usage (Waxman 2004, 11).

Along with failure rates for protection against HIV and STDs, abstinence-only curriculums also exaggerate condom failure rates in preventing pregnancy (Waxman 2004, 11). Furthermore, they provide no information that can be used to select a birth control method or to implement the use of birth control (Waxman 2004, 11). One abstinence-only curriculum tells parents that even when using condoms “scrupulously for birth control,” 14% of women become pregnant within a year (Waxman 2004, 12). Two other curricula give 14 and 15% failure rates as well without explaining that those percentages are not based on correct consistent use. These statistics convey the idea that sex with a condom is much more likely to end in pregnancy than it really is (Waxman 2004, 12). They also demonstrate the importance of students knowing how to use condoms correctly and understanding that it is vital that they use them at every encounter.
In fact, when condoms are used consistently and correctly at every sexual encounter, the failure rate is two to three percent, caused by condom breakage or slippage (Waxman 2004, 12). In the case of which a teen could obtain an emergency contraceptive, if she had the wherewithal to do so. Instead of teaching students the perfect use failure rate and then teaching them how to use a condom consistently and correctly, and giving them a backup plan in case of breakage or spillage, the abstinence-only crowd simply hopes that students will be convinced by the inaccurate failure rates not to have sex.

The claims that abstinence-only curricula make about contraception are based on manipulated facts. Ignoring the majority of scientific experts, they find rare studies that are poorly conducted and cite them as fact to justify misleading adolescents. The result is that students have the perception that condoms don’t work and aren’t worth bothering with when they do have sex. They feel that they might as well skip the cost, inconvenience and embarrassment of buying them since they don’t work anyway. Sending this message to youth in attempt to convince them to be abstinent is highly unethical and dangerous since their health and safety are at stake. Given the fact that 63% of teens have sex by the time they are seniors in high school, those who exaggerate condom failure are placing ideology above a very obvious reality (SIECUS, Questions and Answers).

According to Julie F. Kay, condom use at first sex is a predictor for condom use in the future (Kay 2008, 16). Failing to give students accurate information about condoms before they start having sex puts them at higher risk over the course of their
lifetimes (Kay 2008, 16). Specifically, Kay says that women and girls between the ages of 15 and 19 who do not use condoms or other contraception at their sexual debut are twice as likely to get pregnant as teenagers (Kay 2008, 16). Youth look to educators for answers and truth about how to live their lives and stay safe; they are failed when it comes to these curricula.

**False Claims Regarding the Effects of Abortion**

The Waxman report claims that in addition to manipulating data on contraception, abstinence-only curricula overstate the physical and psychological dangers of abortion (Waxman 2004, 13). They often use data from the 1970s to demonstrate the dangers of abortion, however, the American Medical Association Council on Scientific Affairs says, “the risk of major complications from abortion-related procedures declined dramatically between 1970 and 1990” (Waxman 2004, 13). One curriculum tells students that people who have abortions are at high risk of infertility, birth defects, premature birth, and tubal and cervical pregnancies, in concurrent pregnancies (Waxman 2004, 13). According to the Waxman staff, obstetrics textbooks state that there is no increase in any of these problems as a result of abortion (Waxman 2004, 14).

Abstinence-only programs also overstate the psychological effects of abortion (Waxman 2004, 14). Among the potential negative effects, one curriculum includes: anxiety, grief, regret, guilt, depression, and a greater risk of suicide (Waxman 2004, 14). However, according the American Psychiatric Association, “for the vast majority of
women, an abortion will be followed by a mixture of emotions, with a predominance of positive feelings” (Waxman 2004, 14).

It seems that abstinence-only programs overstate potential negative outcomes of abortion as scientific fact to promote a religious agenda consistent with the beliefs held by most abstinence-only proponents. Many advocates for abstinence-only education are also advocates for anti-abortion movements. For example, Leslee Unruh, the founder of the Abstinence Clearinghouse, also led a 2006 campaign to end abortion in South Dakota (Kay 2008, 16). This makes it clear that this issue is being approached with an agenda, not with common sense or pure intentions to give honest information based on factual scientific findings. Information is manipulated to encourage students to act in a manner desirable to a particular group rather than in their own best interests. These messages could cause students to make life-altering decisions based on false claims.

**Religious Beliefs Presented as Science**

The Waxman Report says that abstinence-only curricula blur science and religion by presenting religious beliefs as scientific facts (Waxman 2004, 15). Consistent with the previously presented beliefs about abortion, abstinence-only curricula tend to have religious undertones (Waxman 2004, 15). Sometimes the influence of religion is blatant, such as when one government funded program’s author accompanied a curriculum with a newsletter including the following line, “No longer were we valued as spiritual beings made by a loving Creator,” and later signs “In His Service” (Waxman 2004, 15). More subtle examples that demonstrate the influence of religion on these programs involve teachings about when life begins.
Most programs teach that it is when the sperm and egg unite. Waxman’s staff says, “Several curricula offer as scientific fact moral or religious definitions of early fetuses as babies or people, in the process supplying inaccurate descriptions of their developmental state” (Waxman 2004, 15). One curriculum in particular, calls a blastocyst, which consist of 100 to 256 cells, a baby, furthermore, it describes uterine implantation as the baby “‘snuggling’ into the uterus” (Waxman 2004, 15). Another curriculum teaches that a fetus is a “thinking person,” when it is 43 days old (Waxman 2004, 16). It also says that after ten to twelve weeks a fetus can hear and see (Waxman 2004, 16). The source cited by the curriculum’s author actually says “Can the fetus see inside the uterus? We do not know” (Waxman 2004, 16). Again, sources and studies are manipulated to convey a message that is desirable to abstinence-only proponents.

Obviously, the creators of these curricula are trying to convince students of the humanity of a growing fetus. It can be assumed that their intentions are to dissuade students from seeking abortions by overstating the development and personhood of a fetus. The anti-abortion sentiment has a religious foundation, but is presented as scientific fact. This is manipulative of students trust in science and in their teachers. It could be argued, also, that it is inappropriate to teach such a religiously impacted message using federal tax dollars.

**Stereotypes as Scientific Fact**

Abstinence-only curricula teach traditional gender roles and gender stereotypes as though they are researched scientific facts. For example, one curriculum says, “Women gauge their happiness and judge their success by their relationships. Men’s
happiness and success hinge on their accomplishments” (Waxman 2004, 16). This could make adolescent girls feel as though achievement is not expected of them or that it is abnormal to seek success in areas other than relationships. It could cause them to put too much emphasis on relationships or to be swayed too much by peers in order to have successful relationships because they think that is where they will find worth. Likewise, it could cause young men to feel less masculine if they seek to preserve and strengthen their relationships.

Another curriculum lists “domestic support,” as one of men’s major needs, and “financial support” as one of women’s major needs (Waxman 2004, 17). This enforces the archaic notion that women belong in a sphere of domesticity while men should be breadwinners. These rigid, traditional gender roles are also reinforced in the discussion of marriage. One curriculum states, “The father gives the bride to the groom because he is the one man who has had the responsibility of protecting her throughout her life. He is now giving his daughter to the only other man who will take over this protective role” (Waxman 2004, 17).

Abstinence-only curricula often put the responsibility for what happens between girls and boys on the girls. The Choosing the Best curriculum tells girls that when they think they are being talkative and friendly, they might be giving their male counterparts the wrong idea, “To the male, however, he perceives that the girl wants him sexually. Asking herself what signals she is sending could save both sexes a lot of heartache” (Waxman 2004, 20). Likewise the Heritage Keepers curriculum says, “girls have an added responsibility to wear modest clothing that doesn’t invite lustful thoughts”
(Waxman 2004, 20). Furthermore, according to Kay, “Most abstinence-only texts fail to meaningfully discuss rape, sexual assault, or coercion, and even fewer give guidance to victims of sexual violence” (Waxman 2004, 20). Not only is it unfair to burden girls with all of the responsibilities of sexual decision making, it places them in danger of accepting sexual harassment, and sexual assault as normal male behavior. They might even wonder if they are to blame or if they somehow “asked” for the unwanted sexual attention (Kay 2008, 20).

Abstinence-only programs leave girls vulnerable to assault and to unnecessary hardship and psychological distress in the time following an assault. In addition to telling girls that they are responsible for not waking the sleeping lion of male sexuality, they are also told that if they want to be sexual they are bad, or wrong (Kay 2008, VIII). This notion that good girls are not knowledgeable of sexuality or are promiscuous just for being interested in sex is dangerous. If girls are ashamed of their sexuality, they are less likely to talk openly with their partner about what they want and what is comfortable for them. They are less likely to carry condoms because they will be seen as having planned to have sex (Kay 2008, 21).

Stereotypes about gender roles and sexuality are dangerous as they can lead members of both genders to feel that they are abnormal or to have unfair or unrealistic expectations of the other sex. They put people in boxes that are too simple to explain the complexities of gender and human sexuality. They affect males’ and females’ sense of self just as they are developing their adult personalities and deciding on the ways in which they want to interact with the world. Being told certain things that men and
women do and are will severely limit students in pursuing their passions and capitalizing on their talents. These rigid definitions of gender have the potential to be especially harmful to transgendered adolescents who are already struggling to figure out the gender with which they most identify. According to Kay, these stereotypes are especially harmful to girls, she writes, “Often these stereotypes undermine female sexual decision-making as well as female achievement by invoking age-old myths” (Kay 2008, 20). They also say that “abstinence-only curricula reinforce traditional gender roles and inhibit young men and women from articulating healthy feelings and needs.” (Kay 2008, 20).

**Overstated Dangers of Sexual Involvement**

While sexual activity is serious and can have very severe consequences, many abstinence-only curricula overstate the dangers of sex and represent their statements as scientific fact (Waxman 2004, 18). For example, one teaching manual makes the following statement about cervical cancer, “It is critical that students understand that if they choose to be sexually active, they are at risk” (Waxman 2004, 19). The curriculum doesn’t mention that regular pap smears significantly reduce the risk of acquiring cervical cancer (Waxman 2004, 19). Not only is this misleading and meant to scare students, it forgoes a very valuable opportunity to emphasize to students the importance of regular health screenings. This is an example that could demonstrate to students that preventative health care can be life saving. Instead, this information scares them and leaves them unaware of simple measures that could save their lives. Information about
regular health screenings, such as pap smears, is needed even if students do wait until they are married to have sex.

The curricula in the Waxman report also use inaccurate HIV information to scare students. For example, one curriculum uses a CDC chart titled “HIV infection cases in adolescents and adults under age 25, by sex and exposure category” (Waxman 2004, 19). The chart provided a breakdown of the different ways HIV positive people under 25 acquired the virus (Waxman, 2004, 20). One piece of data reported that “41% of female teens with HIV reportedly acquiring it through heterosexual contact,” meaning that of those who were HIV positive, 41% had been exposed to the virus through heterosexual sex, opposed to homosexual sex or intravenous drug use (Waxman 2004, 20). However, the curriculum implies that “41% of heterosexual female teens have HIV,” which is not at all what the CDC’s data or chart reported (Waxman 2004, 20). This data is just plain wrong, whether it was a mistake or information intentionally included to scare students, it is untrue and misleading.

Another untrue and misleading claim presented as scientific fact in an abstinence-only curriculum pertains to the STD chlamydia. It claims that chlamydia is found in the plaque that hardens the arteries and causes heart attacks and strokes and, therefore, “Some researchers are suggesting that chlamydia may actually cause this problem” (Waxman 2004, 20). The Waxman report reads, “In fact, the research cited in the curriculum found an association between heart disease and a type of chlamydia that is not sexually transmitted” (Waxman 2004, 20). As in many of the cases and examples given, these curricula cite credible resources but they manipulate the findings and their
reports and interpretations simply are not true. There is either a serious lack of reading comprehension on the part of the authors or an intentional manipulation of facts to scare students and deter them from having pre-marital sex. While most people agree that deterring students from premarital sex, or at least sex at an early age, is a good thing, few believe that we should lie to students in order to achieve this goal.

One student who participated in an abstinence-only sex education program said, “The program made it seem that those diseases came straight from sex, not unprotected and unsafe sex” (Kay 2008, 24). This program may have succeeded in scaring some kids away from sex for some short period of time, but the majority of students know better. Giving blatantly manipulative information discredits the educator and the program which is a disservice, because students need information and trusted adults when they are making these decisions.

In addition to the physical health problems abstinence-only programs say are caused by pre-marital sex, the Waxman staff reports that these programs attribute several mental health problems to premarital sex. According to one curriculum, those problems include “isolation, jealousy, poverty, heartbeat, substance abuse, unstable long-term commitments, sexual violence, embarrassment, depression, personal disappointment, feelings of being used, loss of honesty, loneliness, and suicide” (Waxman 2004, 20). These problems, the curriculum says, “can be eliminated by being abstinent until marriage” (Waxman 2004, 21). The report goes on to say “Other curricula teach that mental health problems are a consequence of sexual activity, without considering the evidence that these problems might themselves cause premature sexual activity, or that
they might have a common origin” (Waxman 2004, 21). Telling students that the extensive list of problems given could all be avoided by being abstinent is a gross misrepresentation of the power of abstinence. Many students suffer from those problems whether they are sexually active or not. As the Waxman staff points out, for many, the decision to become sexually active might have resulted from mental suffering.

Because this claim is so far-fetched it is easily discredited by students based on their own experiences and observations. This puts educators in jeopardy of losing the trust of their students and therefore their influence on their decision making. Students need to feel like they are getting accurate information, or else they will not come back for more or confide in those who distribute it.

**Scientific Errors**

Some scientific errors in the report are seemingly less intentional and less manipulative than the previously discussed misinformation. For example, one curriculum states that a mother and father each provide twenty-four chromosomes to make new life, in reality there are twenty-three chromosomes provided by each parent (Waxman 2004, 21). The same curriculum says that “Girls produce only female ovum, boys, however, have both male and female sperm” (Waxman 2004, 21). Really, males produce sperm containing either X or Y chromosomes while females produce ovum containing only X chromosomes (Waxman 2004, 21). One curriculum says that gynecomastia is a condition in which both boys and girls experience small breast lumps during puberty, really gynecomastia refers to “general increase in breast tissue in boys” (Waxman 2004, 21). Finally, another curriculum says that HIV can be transmitted by
“tears” and “sweat,” which the CDC disputes (Waxman 2004, 21). These inaccuracies, while concerning, are not as troubling and those that seem to have been included to manipulate students and to lead them to decisions about sex based on lies, which is highly unethical.

Response to the Waxman Report

Melissa G. Pardue of the Heritage Foundation wrote a response to the Waxman report entitled “Waxman Report Is Riddled with Errors and Inaccuracies.” In the piece she says that “A 2003 Heritage Foundation analysis of these data found that sexually active teens are significantly more likely than their non-sexually-active peers to be depressed and attempt suicide” (Pardue 2004). That Heritage Foundation Report, by Robert Rector, Kirk Johnson and Lauren Noyes, cites data from the National Longitudinal Survey of Adolescent Health. The survey asked students about their sexual activity to classify them as either “sexually active,” or “not sexually active” (Rector 2003). Then it asked questions about emotional health such as “how often, in the past week, they “felt depressed” (Rector 2003). They found that mental ills such as depression were associated with sexual activity; they did nothing to find that they were caused by sexual activity (Rector 2003).

John Santelli and his colleagues say that even though the regulations for abstinence-only education require programs to teach that there are adverse psychological effects of sex outside of marriage, “there are no scientific data suggesting that consensual sex between adolescents is harmful” (Santelli 2006, 74). They acknowledge that it is true that psychological hardships and early sexual activity often
go hand in hand, but that the mental hardships are preexisting conditions and not the result of sex (Santelli 2006, 74). Therefore, the Waxman report seems to have a legitimate concern about abstinence-only curricula’s claims that these problems can be avoided by abstaining from premarital sex.

Pardue next questions the Waxman report’s assertion that abstinence-only education does not work (Pardue 2004). She cites the ten evaluations previously discussed, most of which were discredited the rest of which were not very convincing (Pardue 2004). It seems that abstinence proponents continue to mention those ten weak studies, only four of which appeared in peer-reviewed journals, because they are all that they have to support that abstinence-only education is effective. That might be an indication that there are serious problems with these programs. It seems unethical to bolster political support by continuing to claim the legitimacy of the same studies over and over despite the fact that they have been disproven.

**Teachers’ Rights in Sex Education**

Abstinence-only programs put educators in a very tough position ethically since they are on the frontlines delivering the inaccurate information and stereotypes. The International Covenant on Civil and Political Rights says that individuals have the right not only to receive accurate health information, but to “impart” it. A Human Rights Watch survey conducted in Texas found that teachers were very troubled by not being able to talk about the accurate statistics on contraception (Kay 2008, 18). While they felt that students deserved accurate information and knowledge about contraception, they felt that teaching it would jeopardize their jobs (Kay 2008, 18). They were likely right since
the funding guidelines under Title V forbids discussion of contraceptives except to highlight their failure rates (Kay 2008, 18).

Curricula Stigmatize Certain Groups of People

Abstinence-only education by definition, “teaches abstinence from sexual activity outside marriage as the expected standard for all school age children,” “teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity,” “teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents and society” (Collins 2002, 6). These three requirements of abstinence-only programs have great potential to stigmatize students. Homosexual teens might feel that they will never be able to have socially accepted, healthy sex lives because homosexuals are not allowed to marry. Teens with gay parents might be led to feel that their families are flawed. Students from single parent homes might feel that they are a detriment to their parents or to society. Other students might use what they learn to ostracize teens that are in these situations. Herein lies great potential to do major psychological harm to students who do not fit perfectly into the ideal presented by the current legislation.

Homosexuality is presented as an unacceptable lifestyle in abstinence-only sex education programs. According to Advocates for Youth the abstinence-only program, Facing Reality, tells parents and teachers that “presenting homosexuality as intrinsically dangerous is actually in the best interests of students and is not homophobic” (Advocates for Youth, Abandoning Responsibility). Another program teaches that “ Sexual love, also called conjugal love, is the love between a man and a woman in marriage”
(Advocates for Youth, Abandoning Responsibility). These messages could be psychologically harmful to students who are experiencing homosexual feelings. They might feel isolated or ashamed.

Making the experience even more difficult, abstinence-only programs teach stigmatizing stereotypes about homosexuals. According to Advocates for Youth, *Sex Respect* lists among the best ways to avoid AIDS, “Avoid homosexual behavior” (Advocates for Youth, Abandoning Responsibility). This spreads the untrue and homophobic notion that gays are responsible for the AIDS epidemic and are the only infected group. According to John Santelli and his colleagues, “Homophobia contributes to health problems such as suicide, feelings of isolation and loneliness, HIV infection, substance abuse, and violence among GLBTQ youth” (Santelli 2006, 78). While abstinence-only programs are well intentioned, they have the ability to do very serious harm to the one and ten students who may be experiencing homosexual thoughts and feelings” (Santelli 2006, 78).

Even if homosexual students are not harmed by the information, they do not benefit because the message does not apply to them. Because gay marriage is illegal in the wide majority of the country, waiting until marriage is not an option even if it is something to which they would have aspired. Advocates for Youth says that gay students who receive gay-sensitive sex education are less likely to engage in risky behaviors compared with those who do not receive gay-sensitive training (Advocates for Youth, Abandoning Responsibility).
Parents’ Rights

According to the Universal Declaration of Human Rights, article 26, “Parents have a prior right to choose the kind of education that shall be given to their children” (United Nations). Those who support abstinence-only sex education and those who support comprehensive sex education claim that parents are in favor of their way of educating youth. Both groups cite studies to prove their points. The discrepancy usually lies within the questions asked in the survey.

The abstinence-only crowd most frequently cites a study conducted by Zogby International on behalf of the National Abstinence Education Association. The Zogby poll showed that parents wanted their children to remain abstinent, that they prefer abstinence-only education over comprehensive education, that they think condom messages distract from abstinence messages, that students should be given messages about self-worth and self-control, and that they should be given condom failure rates (NAEA 2007). The Guttmacher Institute sheds light upon the method used to draw these conclusions about parents’ desires.

According to the Guttmacher Institute, “The survey relies on outright falsehoods in its representation of abstinence-only and comprehensive sex education, and contains leading questions designed to steer respondents toward desired answers.” (Guttmacher 2007, 1). For example, the questions ask about “age appropriate discussion of contraceptives” and “condom usages skills” (Guttmacher 2007, 1). However, the discussion of contraceptives almost always includes inflated failure rates and there is no instruction on condom usage, therefore, an affirmative answer from a parent is not really
an answer in support of abstinence-only education (Guttmacher 2007, 1). Furthermore, it is unlikely that “age appropriateness” translates to dishonesty in the minds of those responding to the question. Another questions asks, “If you knew that typical abstinence education courses place a higher emphasis on building healthy relationships, bolstering self worth and self-control, rather than on condom usage skills, would you be more likely/less likely to support teaching abstinence education in place of comprehensive sex education?” (Guttmacher 2007, 2). Of course parents would rather students have self-worth and self-control than be able to use a condom (Guttmacher 2007, 2). Furthermore, it says a “higher emphasis” meaning that the condom usage skills were still being taught, which they are not. An affirmative answer to this question just means that parents believe that more time should be devoted to building self-worth and healthy relationships, perhaps because those things take more time to learn than how to put on a condom.

This Zogby poll is cited by all of the major abstinence supporters including the Heritage Foundation, the Abstinence & Marriage Education Partner, Catholic Charities, the Abstinence Clearinghouse and many others. However, the communications director at Zogby International, Fritz Wenzel, said that this was not intended to be a public opinion poll, but “message-testing” poll (Jarvik 2007). He said, “the results of a message-testing polls aren’t released to the public but are used instead to ‘develop the message, then the message goes to the public’” (Jarvik 2007). In other words, the study so many abstinence advocates are citing to support parental opinion of abstinence-only education, was not even designed as a public opinion poll.
A public opinion poll conducted by the Kennedy School of Government at Harvard, NPR, and the Kaiser Family Foundation found that only fifteen percent of Americans believed that abstinence-only education was best for youth (NPR 2004, 1). Forty-six percent support an abstinence-plus approach in which abstinence is emphasized but contraception is discussed, while thirty-six percent expressed a belief that abstinence “is not the most important thing, and that sex education should focus on teaching teens how to make responsible decisions about sex” (NPR 2004, 1). Only 19% of those surveyed said that they did not want homosexuality discussed as part of sex education, while the majority of Americans thought it should be discussed in a neutral manner (NPR 2004, 2). With so many differing opinions and attitudes about sex it is difficult to grant parents their right to determine what their children are taught. However, several polls make it clear that they do want their children to receive at least some information about protecting themselves from pregnancy and disease, which abstinence-only programs fail to do.

**Sexually Explicit Content**

There are ethical concerns with comprehensive sex education as well. Many abstinence-only proponents say that they contain sexually explicit and inappropriate material. The most commonly cited sexually explicit aspect of comprehensive sex education programs is the discussion of outercourse. Outercourse is sexual activity that does not involve intercourse; it is taught as an alternative with fewer consequences. *The Be Proud! Be Responsible* programs tells students that, “Touching and stroking can lead to orgasms for both males and females. It is a safe way to avoid pregnancy and STD”
(NAEA, Straight from the Source, 3). *Making Sense of Abstinence* asks students to brainstorm sexual activities that could involve “stroking, petting, squeezing, hugging, sucking, nuzzling, licking, and kissing,” on different parts of the body “from head to toe” (NAEA, Straight from the Source, 3).

Furthering the annoyance of those who strongly believe in abstinence, many of the comprehensive sex education programs suggest that these highly sexual activities are a part of being abstinent. Specifically, *Making Sense of Abstinence* lists the following activities as choices for remaining abstinent: “reading erotic literature, cuddling naked, mutual masturbation, showering together, watching porn, and talking sexy” (NAEA, Straight from the Source, 4). While the program believes that students define abstinence for themselves, abstinence-only advocates believe that abstinence means abstaining from all sexual activity until marriage.

This exemplifies the differing goals of the two camps. While comprehensive sex education proponents offer alternatives to sex to help students avoid intercourse and its consequences, abstinence-only proponents want students to remain pure and chaste for reasons other than avoiding pregnancy and disease. While avoiding pregnancy and disease are noble goals, explicitly suggesting sexual activities to teens goes beyond the human right of heath information. It crossed into the realm of pleasure education which is unnecessary. It is unfair as it could make students uncomfortable who are not ready to think about sex so vividly.
Omission of Condom Failure Rates

Some programs do not discuss failure rates for condoms at all. Just as overstating condom failure rates is dangerous and manipulative, withholding this information is dangerous, manipulative and, therefore, unethical as well. Students are entitled to have all of the facts so that they can make totally informed decisions.

Some comprehensive sex education programs promote condom use by teaching students how to make it sexy. It is a widely held belief that one of the reasons that young people do not use condoms is that it interrupts the progression from foreplay to intercourse. *Be Proud! Be Responsible!* tries to debunk this perception by including an activity called “How to make condoms fun and pleasurable” (NAEA, Straight from the Source, 4). It includes ideas like “eroticize condom use with partner, store condoms under a mattress, use condoms as a method of foreplay, think up sexual fantasy using condoms, hide them on your body and ask your partner to find them, wrap them as a present and give them to your partner before a romantic dinner” (NAEA, Straight from the Source, 4). Another suggestion is, “Go to the store together. Buy lots of different brands and colors. Plan a special day when you can experiment. Just talking about how you’ll use all of those condoms can be a turn on” (Souder 2006, 27). Giving students tips for becoming turned on or eroticizing anything, again, moves beyond providing health information. All of the information given to students should be biologically based and focused on increasing their chances of staying healthy, not increasing their pleasure. After all, human rights declarations only promise health information, not sex advice.
Conclusions

There are many ethical issues to consider when legislating sex education. It is especially important to honor adolescents’ right to accurate health information. We must listen to health experts’ recommendations for keeping our youth safe and keeping society as a whole healthier and safer as a result. Above all we should aim to do no harm. We should not allow programs to be funded that violate young people’s rights to accurate information and put them at risk. We should not allow for programs that are detrimental to the psychological welfare for students whose families are different than the ideal outlined in the current legislation. We should not allow girls to feel an unnecessary and unjust burden when it comes to sexual decision-making and responsibility. Finally, we should not allow for our already vulnerable homosexual youth to be stigmatized in their own classrooms.
CHAPTER FIVE: FUTURE GUIDELINES AND CONCLUSIONS

As students grow so should their knowledge about sexuality. The following guidelines are designed for middle and high students with the depth of discussion increasing as students’ likelihood of engaging in sexual activity increases. These guidelines proposed by the author are meant to replace the current guidelines that define abstinence-only education. Some are very similar, even using the same words, and some are very different than those to which programs currently subscribe.

Proposed Government Funded Comprehensive Education:

A) Teaches the “social, psychological, and health gains to be realized by abstaining from sexual activity.”

B) Teaches that abstinence from sexual activity is the “only certain way” to avoid unintended pregnancy (formerly out-of-wedlock), “sexually transmitted diseases, and other associated health problems.”

C) Teaches accurate efficacy rates for condoms and how to use condoms correctly, additionally provides a backup plan for instances of condom failure from breakage or slippage.

D) Teachers’ self-esteem, self-sufficiency and skills for avoiding peer pressure to engage in sexual activity.

E) Teaches the biology of sexuality free from religious undertones, bias, or stereotypes, including health screening pertaining to sexual health and the importance of testing for STDs and STIs.

F) Teaches a variety of birth control methods including accurate efficacy rates and methods for perfect use.

G) Teaches definitions for sexual harassment and sexual assault while providing resources for the future should students find themselves in these situations.

H) Teaches students methods for reflecting upon their own values and attitudes about sex, examining their origins and setting goals for the future.
I) Teaches homosexuality, bisexuality, and the experience of being transgendered in a neutral way.

J) Teaches programs that are proven by multiple rigorous studies to have long term effects and keep students healthy while preventing teen pregnancy.

**Recommendations**

When developing new curricula, experts should use what they have learned from previous studies on programs of both the abstinence-only and comprehensive variety. For example, one of the reasons that *Sex Can Wait* is somewhat effective in some studies is that it provides a consistent message over the course of a number of years (Denny 1999, 135). Consistent education on these topics will lead to greater long term results.

Remaining age appropriate, programs should start when children are young and build each year to provide more and more information as students are ready for it. There should be a natural progression of information starting young with topics such as the anatomical differences between boys and girls and what is appropriate and inappropriate touching, to issues and challenges of puberty, to sex education that covers the processes and consequences of sexual involvement.

Douglas Kirby found that the *Becoming a Responsible Teen* program “delayed the initiation of sex, reduced the incidence of sex, reduced the number of sexual partners, increased the use of condoms, and reduced the frequency of unprotected sex during a 12-month period” (Kirby 2007, 193). These are all results we should expect from our sex education curricula, this program would be a great place to start to see if it lines up with the criteria above and to make additions to make it even more effective. Perhaps an
addition could involve more technology and media. The abstinence media campaign *Not Me, Not Now*, although poorly evaluated, had some promising results worth exploring further (Doniger 2001, 27). Furthermore, high-tech video programs were shown to have modest potential. Researching effective ways to use these avenues might really benefit adolescents because they have grown up in a media age and they are accustomed to interacting with technology. Furthermore, whether they realize it or not, they are always being shaped by what is in the media.

Knowing what we know about adolescence, it is very smart to use peer educators, which was done in several programs. Adolescents, by nature, value highly the ideas and perceptions of their peers; therefore, peers are an excellent source from which to glean information. Having well-trained, mature, students lead discussion and present material is sound learning theory as it is student-centered rather than teacher-centered. It is likely that peer leaders will inspire students to be more invested, engaged, and comfortable.

As is mandated by several human rights documents, students are entitled to information about their health and teachers are entitled to give it to them. Health and biology should be the focus of sex education classes. Students should be given thorough and accurate information about the menstrual cycle, how one becomes pregnant, and how to prevent pregnancy. They should learn about the different kinds of STDs, how they are contracted, what their symptoms are, and how to avoid them. They should be informed of reproductive health screenings including what to expect and why they are vital to their health.
Programs should offer parents help in discussing issues of sexuality with their sons and daughters. Parents should know what their sons and daughters are learning and know that they have the potential to make an impact on their adolescents’ decision-making now and down the road. However, while programs should do everything they can to involve parents; they should also make it clear that teenagers do not usually need permission from their parents to obtain birth control prescriptions, depending on the state. They should be reminded that no parental or medical professional’s permission needs to be granted to buy condoms.

It seems that if abstinence-only proponents and comprehensive sex education proponents worked together to develop programs with expertise from both sides of the debate, the result could be very strong programs. The parts of abstinence-only programs that are honest and empowering to students while making them think about their values, desires, and self-esteem are all valuable and should be replicated. The parts of comprehensive programs that offer clear, accurate information on contraceptives and sexual health are essential. Both sides will have to compromise a bit if they are going to work together. Abstinence proponents will have to acknowledge the realities of teen sexual activity and the need for accurate information and contraception. Comprehensive sex education proponents will have to scale back some of the more sexually explicit material.

As is the case with most political debates in the United States, a middle-of-the-road-approach based on honest motives, common sense, and genuine compromise would most effectively benefit its citizens. Since the citizens in question are some of its most
vulnerable and those next in line to join adult society, all that much more care should be taken to make sure they are given the best possible chance of realizing the American Dream and benefiting from America’s promise.
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