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Protect, Prevent, Live Well

Testimony of the American Public Health Association
"Domestic Abstinence-Only Programs: Assessing the Evidence"
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The American Public Health Association (APHA) is the oldest and most diverse organization of public health professionals in the world. APHA represents a broad array of health officials, educators, environmentalists, policy-makers, and health providers at all levels working both within and outside government organizations and education institutions. We are pleased to present our views on abstinence-only-until-marriage programs.

The Role of Schools in Sexuality Education

The American Public Health Association (APHA) recognizes that youth face considerable risk to their reproductive health. Adolescents have the highest age-specific risk for many sexually-transmitted infections (STIs) and the United States continues to lead the developed world in the rate of adolescent pregnancy. In fact, U.S. teen pregnancy and teen birth rates are the second highest among 46 countries in the developed world (the U.S. is second to Russia in teen pregnancy rates and Armenia in teen birth rates). APHA further recognizes that abstinence from sexual intercourse is an important behavioral strategy for preventing HIV, STIs, and unintended pregnancy. Many adolescents have not initiated sexual intercourse, and many sexually experienced adolescents and young adults are abstinent for varying periods of time. We note that there is broad public support in the U.S. for abstinence as a necessary and appropriate part of sexuality education. APHA also notes that few Americans remain abstinent until marriage, and most initiate sexual intercourse as adolescents. Together, data from the 2002 National Survey of Family Growth and the 2000 U.S. Census indicate a considerable gap between the median age at first intercourse of 17 years, and the median age at first marriage of 25 in women and 27 in men. Such demographic realities raise serious questions about the feasibility of programs that promote abstinence-only-until-marriage (AOUM) as a universal strategy. Moreover, APHA notes that significant ethical and human rights concerns arise when abstinence is presented to adolescents as the sole choice, or when health information regarding other choices is limited or misrepresented.

All young people must be prepared to become sexually healthy adults and provided with the knowledge and skills necessary to avoid HIV, other sexually-transmitted infections, and unintended pregnancy. Parents/guardians and families are the first and most influential sexuality educators of their children, yet many young people report that they need additional guidance. APHA believes that the nation's K-12 schools, in concert with families, religious and community groups, and health care professionals, should implement effective sexuality education programs that are age, gender and culturally-appropriate, support the elimination of health disparities, and are based on sound science and proven principles of instruction.

Currently, there are two contrasting approaches to teaching adolescents about sexuality: 1) comprehensive sexuality education (CSE) programs, which include abstinence-based instruction; and 2) AOUM programs. In 1990, APHA adopted a policy that "Urges that a national policy on reproductive health care for adolescents include comprehensive health and sexuality education in schools extending from kindergarten through high school." Policies containing the same recommendation were adopted in 2003, 2005 and 2006. The 2006 policy also notes that "significant ethical and human rights concerns arise when abstinence is presented to adolescents as the sole choice, or when health information regarding other choices is limited or misrepresented."

Youth are at Risk for STIs, Unintended Pregnancy and HIV

Young people in the United States are at persistent risk for STIs, unintended pregnancy and HIV infection. In addition, youth of racial and ethnic minorities are at particular risk, as indicated by the following data. Eliminating such health disparities is a priority for APHA.

According to the 2005 Youth Risk Behavior Surveillance, 46.9 percent of high school students had ever had sexual intercourse. The prevalence of having had sexual intercourse was 63.1 percent of 12th graders, 51.4 percent of 11th graders, 42.8 percent of 10th graders, and 34.3 percent of 9th graders. The prevalence of having had sexual intercourse was higher among black students (67.6 percent) and Hispanic students (51.9 percent) than white students (43.0 percent). Overall, 14.3 percent of students had had sexual intercourse with more than four persons during their lifetime with higher rates among black students (28.2 percent) and Hispanic students (15.9 percent) than white students (11.4 percent). In addition, 33.9 percent of students were sexually active (meaning they had had sexual intercourse with at least one person during the three months preceding the survey) and 37.2 percent of sexually active high school students had not used a condom at last sexual intercourse.

According to the survey, every year there are approximately 831,000 pregnancies among women aged 15 to 19 years, about 9.1 million cases of STIs among persons aged 15 to 24 years, and an estimated 4,842 cases of HIV/AIDS among persons aged 15 to 24 years. This represents almost 13 percent of all pregnancies, half of new STIs, and 13 percent of HIV/AIDS diagnosis. Black and Hispanic adolescents have been disproportionately affected by the HIV/AIDS epidemic. The HIV/AIDS Surveillance Report estimates that from 2001-2005, 60.6 percent of HIV/AIDS diagnosis in 13 to 19 year olds was among blacks, and 17.3 percent was among Hispanics.

Abstinence-Only Programs: Are They Effective?

Since 1996, there have been major expansions in federal support for AOUM programming including Section 510 of Title V of the Social Security Act in 1996 and Community-Based Abstinence Education (CBAE) projects in 2000. Both Title V AOUM and CBAE programs prohibit disseminating information on contraceptive services, sexual orientation and gender identity, and other aspects of human sexuality. Programs must have as their "exclusive purpose" the promotion of abstinence outside of marriage. AOUM programs must teach that "a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity" and that "sexual activity outside of marriage is likely to have harmful psychological and physical effects." Moreover, AOUM programs are not allowed to include information about contraceptives and disease-prevention methods, except to emphasize their failure rates. A congressional report prepared for Rep. Henry A. Waxman in December 2004 on AOUM programs commonly supported by the U.S. federal programs found that 11 of the 13 most frequently used curricula contained false, misleading or distorted information about reproductive health, including inaccurate

information about contraceptive effectiveness, risks of abortion and other scientific errors. In addition, these curricula treat gender stereotypes as scientific fact, impose moral judgments and blur religious with scientific viewpoints. These program requirements have little to do with public health priorities; instead, they reflected a moral and ideological viewpoint.

To date, no AOUM program that conforms to the eight point criteria listed in Section 510(b) of Title V of the Social Security Act and focuses exclusively on promoting abstinence until marriage has shown credible evidence of significantly delaying sexual initiation or reducing the frequency of sexual intercourse. While abstinence from sexual intercourse is theoretically fully protective against pregnancy and disease, in actual practice abstinence often fails. In a nationally representative study of adolescents aged 12-17 years, adolescents who took virginity pledges, a key component of nearly every AOUM program, delayed onset of intercourse an average of 18 months longer than those who did not take a virginity pledge. The effect of pledging virginity is variable. It is effective only in the context of, and in interaction with, other youth similar to those pledging. It provides a means for young people to differentiate themselves from other people (who are non-pledgers). The effect of pledging is dependent on the number of other pledgers in the community. If there are very few, there is no real effect on initiation of intercourse because there is no real community of like-minded young people to interact with and support the pledge. Likewise, if there are too many pledgers (more than 40 percent), there is also no effect because there is no real differentiation of identity. In addition, pledging is more effective for younger teens than older teens. However, 88 percent of adolescents who took virginity pledges within AOUM programs reported engaging in sexual intercourse before marriage. Even more disturbing, the study reported that adolescents who took virginity pledges were less likely to use condoms when they became sexually active, more likely to engage in oral-genital and anogenital sexual behaviors, and less likely to seek and obtain care for STIs than non-pledgers, even though they were as likely to contract an STI as non-pledgers.

AOUM programs are often insensitive to sexually active and sexually abused teenagers, as well as to gay, lesbian, bisexual, transgender, questioning, and intersexed (GLBTQI) youth. Sexually experienced teens need access to complete and medically accurate information about condoms and contraception, their legal rights to health care, and ways to access reproductive health services. AOUM programs do not address these needs. AOUM programs also are unlikely to meet the health needs of GLBTQI youth, as they largely ignore issues surrounding sexual orientation and gender identity and may contribute to stigmatization of these young people and/or their sexual behavior as deviant and unnatural. Homophobia and stigmatization contribute to health problems such as suicide, feelings of isolation and loneliness, HIV infection, alcohol, tobacco and other drug use, and violence among and towards GLBTQI youth.

National organizations that address HIV prevention and sexual health related issues have expressed a concern that a shift in U.S. government policy stressing lack of condom efficacy within educational materials, including within a new Department of Health and Human Services' (HHS) Web site for parents, has caused confusion in the general public about whether condoms should be used and promoted for the prevention of HIV infection. However, numerous studies have demonstrated that latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases, including gonorrhea, chlamydia and trichomoniasis. While the effect of condoms in preventing human papillomavirus (HPV) infection is uncertain, the Centers for Disease Control and Prevention (CDC) has found an association between condom use an a reduced risk of HPV-associated diseases, including genital warts, cervical dysplasia and cervical cancer.

The lack of evidence supporting the effectiveness of AOUM programs, as well as evidence demonstrating the potential harm such programs have on adolescents' sexual health, have led 17 states to withdraw from Title V AOUM funding, including Arizona, California, Colorado, Connecticut, Iowa, Maine, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Ohio, Rhode Island, Virginia, Wisconsin, and Wyoming. The number of adolescents living in the states that have passed up this funding is now substantial, more than 12 million, or 42 percent of young people aged 12–18 nationwide. In contrast, the President's budget continues to increase funding for AOUM programs. As an example of this trend, the fiscal year 2008 appropriation for AOUM programs was $163 million and the President's fiscal year 2009 proposed budget requests $191 million, a $28 million increase.

The Evidence Supporting Comprehensive Sexuality Education

Experts in the fields of adolescent development, health and education recommend CSE programs that assist young people in developing a positive view of their sexuality, provide them with information necessary to protect their sexual health and help them acquire skills to make informed decisions, both now and in the future.

CSE programs emphasize abstinence from all sexual activity as the most effective and reliable method of avoiding STIs, HIV and pregnancy. In addition, CSE programs teach adolescents about contraceptives and barrier methods to reduce their risk of contracting STIs, HIV and/or becoming pregnant. Ideally, CSE programs start in kindergarten and continue through the twelfth grade, are taught by teachers who have completed CSE-related instruction and provide adolescents with developmentally appropriate information regarding a broad range of topics related to sexuality, including sexual development, reproductive health, interpersonal relationships, body image, and gender roles. Furthermore, CSE programs provide opportunities for students to develop communication, decision-making and other interpersonal skills. CSE programs also allow parents to exercise the option of taking their children out of such classes if they do not wish their children to be exposed to this information.

Research has demonstrated that parents strongly and consistently favor age-appropriate and culturally sensitive school-based sexuality education programs that stress abstinence and include information about contraception as part of a CSE program. Moreover, both parents and teens report that such programs do not send teens a mixed or confusing message. Parents also support sexuality instruction about topics such as reproductive anatomy and physiology, physical changes associated with puberty, and body image beginning earlier in school, preferably during the elementary grades. In addition, the National Coalition to Support Sexuality Education, made up of over 155 national organizations including APHA, is committed to medically accurate, age-appropriate comprehensive sexuality education for young people in the United States. These organizations represent a broad constituency of education advocates and professionals, health care professionals, religious leaders, child and health advocates, and policy organizations. Due to the epidemic of overweight and obesity among school-aged children in the United States, such sexuality instruction is particularly warranted, as overweight and obese girls are nearly twice as likely as healthy weight girls to reach sexual maturity at an earlier age and to report greater body dissatisfaction, lower self-esteem and to engage in a variety of health and sexual risk behaviors at an earlier age than healthy weight girls.

Several comprehensive sexuality education programs have demonstrated, through rigorous evaluation, to delay the onset of sexual intercourse, reduce the frequency of sexual intercourse, reduce the number of sex partners, and/or increase the use of condoms and/or other forms of contraception among teens. Some programs have demonstrated sustained positive effects on behavior for as long as three years. In fact, most of the decline in teen birth and pregnancy rates seen in the U.S. between 1991 and 2005 is attributable to

improved contraceptive use. An analysis published in the American Journal of Public Health in 2007 found that 86 percent of the decline in teen pregnancy between 1995 and 2002 was the result of improved contraceptive use and only 14 percent was the result of fewer teens engaging in sexual intercourse. In addition, teaching about contraceptives and barrier methods is not associated with increased risk of adolescent sexual activity or STIs. As reported in the April 2008 issue of the Journal of Adolescent Health, adolescents who received comprehensive sex education had a significantly lower risk of pregnancy than adolescents who received abstinence-only or no sex education.

Unfortunately, schools on average are teaching abstinence at much higher rates than the use of condoms and contraception. CDC's 2006 School Health Policies and Programs Study found that 76 percent of middle school and 87 percent of high school teachers taught abstinence as the best way to avoid STIs, pregnancy and HIV. However, only 42 percent of middle school and 65 percent of high school teachers taught condom efficacy, only 21 percent of middle school and 39 percent of high school teachers taught the correct use of condoms, and only 33 percent of middle school and 58 percent of high school teachers taught methods of contraception. Moreover, the emphasis on abstinence-only has permeated into other domestic and international health programs including family planning and HIV prevention through the incorporation of "ABC" concepts for HIV prevention counseling (that is, "A" for extramarital abstinence, "B" for be faithful in marriage or committed relationships, and "C" the correct and consistent use of condoms). This principle, developed by CDC, can now be found in the Title X of the Public Health Service Act Family Planning program, the Ryan White HIV/AIDS program and the President's Emergency Plan for AIDS Relief. However, whether ABC really represents comprehensive or effective HIV prevention has been widely questioned.

AOUM Programs Are Incompatible With Internationally Recognized Human Rights

While abstinence is often presented as the only moral choice for adolescents, APHA recognizes that the current U.S. government approach focusing on AOUM raises serious ethical and human rights concerns. Access to complete and accurate STI, HIV and sexual and reproductive health information has been recognized internationally as a basic human right and essential to realizing the human right to the highest attainable standard of health. In the context of sexual and reproductive health and rights, APHA adopted a policy in 2003 that calls for "affirming and upholding U.S. commitments under international human rights agreements" including "ensuring that government-supported sexuality education programs include comprehensive, medically-accurate information."

International treaties and human rights statements support the rights of all people to seek and receive information vital to their health. The U.N. Committee on the Rights of the Child in 2003 emphasized that "Consistent with State party obligations in relation to the rights to health and information (Articles 24, 13 and 17), children should have the right to access adequate information related to HIV/AIDS prevention and care, through formal channels (e.g., through educational opportunities and child-targeted media) as well as informal channels...The Committee wishes to emphasize that effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that consistent with their obligations to ensure the survival, life and development of the child (Article 6), States' parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality." In addition, the Programme of Action of the International Conference on Population and Development, adopted in 1994 by 179 countries including the U.S., included the principle that "States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual

health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."

These treaties and human rights statements strongly suggest that governments have an obligation to provide accurate information to their citizens and to eschew the provision of misinformation in government-funded health education and health care services. Likewise, APHA holds that individuals have rights to accurate and complete information from their health care professionals, and that health care providers and health educators have ethical obligations to provide accurate health information. While good patient care is built upon notions of informed consent and free choice, APHA holds that AOUM programs are inherently coercive by withholding information needed to make informed choices. As defined by the U.S. government's own funding requirements, these programs are required to withhold information on contraception and other aspects of human sexuality, and to promote scientifically questionable positions. These requirements, which limit topics for discussion in the classroom, place health educators in an ethical quandary, forcing them to choose either to withhold potentially life-saving information, or to breach federal government guidelines by disclosure of such.

Recommendations

Given these serious concerns about the efficacy and ethics of current U.S. support for abstinence-only education, APHA makes the following recommendations:

1. Efforts to promote abstinence should be provided within public health programs that present adolescents with complete and accurate information about sexual health. Such programs must be scientifically and medically accurate and based on theories and strategies with demonstrated evidence of effectiveness; be consistent with community standards, yet be implemented in a nonjudgmental manner that does not impose religious viewpoints on students; support positive parent-child communication and guidance; be age, developmentally, linguistically, and culturally appropriate; and be taught by well-prepared teachers who have received specialized training in the subject matter. APHA strongly supports CSE that includes information about healthy sexuality; reproductive anatomy and physiology; physiological, psychological and social changes associated with puberty and adolescent development; sexual orientation, gender identity and tolerance; healthy vs. unhealthy relationships; personal responsibility; risks of STIs, unwanted pregnancy and HIV; access to reproductive health care; and benefits and risks of condoms and other contraceptive methods.

2. All States should support school districts and local schools to implement abstinence education as a part of comprehensive sexuality education and as an integral part of comprehensive K-12 school health education. Districts should use multiple sources of data regarding student needs, knowledge and behavior to plan programs that meet the prevention needs of all students, with due attention to those who might be at greater risk for STIs, HIV and pregnancy, such as young men who have sex with men or members of populations with high prevalence rates. Schools should be required to provide this instruction to all students unless a parent or legal guardian has specifically requested that their child be excused from ("opt-out" of) the entirety of the instruction before it begins.

3. Current federal funding for AOUM programs under Section 510 and CBAE should be repealed and replaced with funding for a new federal program to promote and support CSE. The U.S. Congress should authorize and fully fund legislation that promotes CSE programs that include information about both abstinence and contraception; include parent-child communications components; and teach goal-setting,

decision-making, negotiation, and communication skills. To initiate this process, HHS should convene special advisory groups of respected experts in the fields of adolescent health and sexuality education and parents to determine how best to implement this strategy.

4. The U.S. Congress should require that all sexuality education programs supported by the federal government, and all sexual health information disseminated by federal agencies, be medically and scientifically accurate, age and context appropriate, and based on theories and strategies with demonstrated evidence of effectiveness and consistent with international human rights declarations.

5. Governments and school districts should not tolerate censorship of information related to human sexual health within the public schools.

6. Federally supported public health programs should promote social and cultural sensitivity to sexually active youth and GLBTQI youth.

7. Schools of higher education should prepare prospective teachers in the content and pedagogy of effective comprehensive sexuality education. In addition, HHS should develop a technical assistance training program between established trainers in comprehensive sexuality education and teachers in need of this training.

8. CDC's Division of Adolescent and School Health and/or the National Institute for Child Health and Human Development should provide funding for scientific research into the effectiveness of sexuality education programs.