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ABSTINENCE-ONLY UNTIL MARRIAGE AND ABSTINENCE PLEDGE  
PROGRAMS

A policy review for stakeholders

By

JEFFREY P. SCHADE

B.S., GEORGIA STATE UNIVERSITY

A Capstone Submitted to the Graduate Faculty of Georgia State University in Partial

Fulfillment of the Requirements for the Degree

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2013

ABSTINENCE-ONLY UNTIL MARRIAGE AND ABSTINENCE PLEDGE  
PROGRAMS

A policy review for stakeholders

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# ABSTRACT

JEFFREY P. SCHADE

ABSTINENCE-ONLY UNTIL MARRIAGE AND ABSTINENCE PLEDGE  
PROGRAMS: A policy review for stakeholders

Sexually transmitted infections (STIs) and unplanned pregnancy are significant public health concerns. Abstinence-only until marriage (AOUM) and abstinence pledge programs have received a significant amount of government funding in an attempt to address these problems. Despite receiving over two billion dollars in funding, the programs have not been shown to be effective in achieving their stated goals. In addition, there are significant concerns about the content of AOUM curriculums, including medical inaccuracy and use of outdated gender stereotypes.

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# INTRODUCTION

Sexually transmitted infections (STIs) and unplanned pregnancy are significant public health concerns in the American adolescent population. Adolescents are viewed as vulnerable and impressionable; as such, much public policy focuses on educational programs to reduce these concerns.

There is a significant split in policy on how to best address public health issues stemming from teenage sexual activity. For some, sexuality is considered a part of natural development, and while sexual activity is far from promoted, it is presented as normal, and potentially pleasurable. For others, teenage sexual activity is inherently risky (individually and socially). In this view, the only way to avoid the potential negative outcomes of sexual activity is to remain abstinent and chaste until marriage. This “sex-as-risk” ideology has enjoyed a sizeable political advantage since the mid-1980s. The promotion of abstinence-only until marriage (AOUM) and abstinence pledging through school and community based programs has received over \$2 billion of federal and state grants since 1980.

There is an extensive body of research on both AOUM programs and abstinence pledge programs. Various experimental designs have gauged efficacy of the programs, often measuring changes in participant knowledge and beliefs about abstinence and sexual activity. Some studies purport to show that the programs have at least a limited efficacy; other research shows that the programs are not only ineffective, but may in fact have a negative effect.

This guide compiles a portion of the vast body of available literature and reviews several elements of both abstinence education programs and abstinence pledge programs.

In its initial form, it was intended to focus solely on the efficacy of abstinence pledges. However, because pledging behavior is intricately intertwined with AOUM (and in some cases vice-versa), it became necessary to include sizeable discussion of both aspects to provide a nuanced policy guide.

The guide is organized as follows:

**Chapter I** is a history of the changes in public policy that led to the adoption of AOUM. This chapter traces the history of abstinence education and abstinence pledge programs in the United States. The funding of school and community based abstinence education programs is provided from their initial funding in 1981, through expansion under the Welfare Reform Act, and to current government programs. A specific example of a more highly ritualized abstinence pledge, the “purity ball” is also reviewed.

**Chapter II** is a review of literature on AOUM programs. There is extensive research on these topics; however several research studies were not included in discussion. Discussion and literature review is limited to peer-reviewed journals. AOUM programs vary significantly in their content, for example in level of medical accuracy, focus on sex-as-risk, or promotion of personal responsibility and goals as a reason to avoid sexual activity. As such, in sections about AOUM programs, only studies which specifically name the curriculum used were included.

**Chapter III** is a review of literature on abstinence pledge programs. There is limited research on outcomes of abstinence pledging programs and I was unable to find any that were limited to a single named program. As such, sections on abstinence pledging are macro-focused. While there are variations in the different programs, I was unable to find significant differences in the stated goal of the program (i.e., to encourage

adolescents to make a formal pledge to abstain from sexual activity until heterosexual marriage).

Additionally, there are no peer-reviewed studies on purity balls, although they are referenced in the context of examining gender role reinforcement. Within the literature review, these are grouped with formal abstinence pledges, although they are discussed separately in Chapter I.

**Chapter IV** is a critique of specific macro-level problems with AOUM and abstinence pledge programs.

**Chapter V** is a policy outline for what effective sexuality education might look like. Several reference guides and extensive data are provided in the appendices.

Finally, the **Appendix** provides fact sheets, questions and answers, and resources specific to parents, educators, and policy makers about abstinence education and abstinence pledge programs.

# CHAPTER I: HISTORY OF ABSTINENCE EDUCATION AND ABSTINENCE PLEDGE PROGRAMS

## 1.1 ABSTINENCE MOVEMENT

In the 1960s and '70s, perceptions of sexuality in the United States (US) were changing. The birth control pill, relaxed decency laws, limited acceptance of homosexuality, and the legalization of abortion led to calls for increased sexual education to adolescents (Moran, 2000). Increased funding initiatives were short-lived though, as social conservatives blamed increased sexual education and access to contraceptives for high rates of teenage pregnancy and STIs (Greslé-Favier, 2010). In response to calls for action to address the perceived high rates of teenage pregnancy, the US government, under President Ronald Reagan, began funding school based abstinence education programs.

## 1.2 FEDERAL FUNDING FOR AOUM PROGRAMS

In 1981, the Adolescent Family Life Act (AFLA), an amendment to Title X of the Public Health Service Act, allocated \$4 million a year to school-based AOUM programs. AFLA-funded programs were administered by the Office of Population Affairs (OPA) and Department of Health and Human Services (DHHS); they were intended to reduce teenage pregnancy rates by fostering “chastity and self-discipline” and eschewing abstinence from sexual activity as the expected social norm (Greenblatt, 2008; SIECUS, 2010). OPA monitored the content of AFLA-sponsored programs and purportedly

required certain levels of scientific accuracy and age-appropriate content in the curriculum.<sup>1</sup>

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), a component of welfare reform, was passed by Congress with bipartisan support. Title V, Section (§) 510 of PRWORA included \$50 million in annual funding for AOUM programs. Under PRWORA, programs were required to comply with the “A-H” criteria for abstinence education programs (see Table 1). Initially, the grants

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**Table 1: “A-H” criteria for abstinence-only education**

...[T]he term “abstinence education” means an educational or motivational program which:

- A. has as its exclusive purpose teaching the social, psychological, and health gains to be 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 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 increase vulnerability to sexual advances
- H. teaches the importance of attaining self-sufficiency before engaging in sexual activity

Source: Title V, §510 (b)(2)(A-H) of the Social Security Act (P.L. 104-193).

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had some flexibility and programs did not necessarily have to meet all eight criteria; however, programs were *strictly forbidden* from providing information that contradicted

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<sup>1</sup> The actual attention to content in the programs is debatable. AFLA-funded programs have had their share of controversy, including several lawsuits alleging violation of separation of church and state.



any of the criteria. Funded programs were not intended to provide a comparison of sexual risk reduction methods –their exclusive purpose was to teach “the social, psychological, and health gains [of] abstaining from sexual activity...” (Government Accountability Office, 2006).

The first grants for Title V programs were issued in 1998, and by 2000, over 700 programs had been funded nationally (Trenholm et al., 2007). Initially, DHHS dispersed funding under an existing block grant, the Maternal and Child Health (MCH) grant. Funding was dispersed to both public and private entities. States that received grants were required to match 75% of the federal funding through non-federal funding (state funds, private contributions, etc.). In 2004, President George W. Bush moved the funding from MCH to Administration for Children, Youth, and Families (ACYF), a move that was made largely for ideological reasons (Howell, 2007).

Funding for AOUM programs was further increased in 2000 when the *Special Projects of Regional and National Significance Community-Based Abstinence Education* (CBAE) (under Title XI, §11110 of the Social Security Act) was signed into law. In contrast to programs authorized under Title V, CBAE grants were dispersed directly to community based organizations and did not require a matching contribution from state governments (Greenblatt, 2008).

In total, it is estimated that the US federal government has spent at least \$2 billion since 1981 to fund AOUM programs (see table 2). This amount does not include funds allocated through state matching grants. AFLE and CBAE were allowed to expire in 2009 by the administration of President Barack Obama. Funding for PRWORA also

expired in 2009; however, \$50 million of annual funding was restored as an amendment to the Patient Protection and Affordable Care Act (2010).

<b>Program Name</b>	<b>Funding from inception through 2009</b>	<b>Current Status</b>
<b>AFLA (first funds released in 1982)</b>	\$209 million	Expired in 2009
<b>Personal Responsibility and Work Opportunity Act (first funds released in 1998)</b>	\$1.05 billion	Expired in 2009, reinstated as an amendment to Patient Protection and Affordable Care Act (2010)
<b>Community Based Abstinence Education Programs</b>	\$733 million	Expired in 2009
<b>Other funding</b>	\$8.9 million	

## 1.2 AOUM PERFORMANCE MEASURES

AOUM programs are required to meet six performance standards, four uniform federal standards (see Table 3) and two state-specific standards.<sup>2</sup> In at least some states, efficacy is measured based on the number of program participants that complete a formal virginity pledge during or after the program (Government Accountability Office, 2006).

**Table 3: National Performance Measures for AOUM**

**AOUM programs are evaluated based on their ability to meet the following criteria:**

1. Lower the pregnancy rate for teenagers aged 15-17;
2. Reduce the percent of adolescents 17 years and younger who have engaged in sexual intercourse;
3. Reduce the incidence of youths aged 15-19 who have contracted one of the sexually transmitted diseases (e.g., gonorrhea, syphilis, or chlamydia);
4. Lower the rate of births to female teenagers aged 15-17

Source: Maternal and Child Health Bureau

<sup>2</sup> These requirements are not enforced. Multiple programs have been shown to be ineffective but continue to receive funding under various AOUM programs.

AOUM programs administered by MCH were required to be medically accurate. When ACF assumed control, it did not review the content of curriculums for scientific or medical accuracy (Government Accountability Office, 2006) and multiple curriculums were later found to have significant factual inaccuracies (Greenblatt, 2008; Trenholm et al., 2007).

For example, several curriculums misstated the failure rate of condoms while others gave misleading information about how STIs are transmitted (ACLU, 2007).

### 1.3 ABSTINENCE PLEDGES

Abstinence pledges are formal or informal promises made by adolescents to abstain from all sexual activity until a predetermined time (usually marriage). The terms “abstinence pledge,” “virginity pledge,” and “purity pledge” are often used interchangeably (for example, Bersamin (2005) refers to “virginity pledges,” while Uecker (2008) refers to “abstinence pledges”). It is understood that these terms refer to the same concept; they are used interchangeably herein.

The first formal abstinence pledge program, *True Love Waits*, was founded by the Southern Baptist Convention in 1993 (Brückner & Bearman, 2001). Similar programs have launched across the US and internationally, including *Silver Ring Thing*, and the *Pure Love Alliance*. These programs teach adolescents to abstain from all sexual activity (i.e., not limited to just penis-vaginal intercourse), usually until marriage. Many of these programs use a public symbol of the pledge –*Silver Ring Thing*, for example, is signified by a ring, engraved with a pro-abstinence message, and worn on the ring finger.

Most abstinence pledge programs are based on religious principles or use religious tenants as motivation for participants to make a pledge. These religious

connotations have resulted in legal action to prevent the programs from receiving public funding (see, e.g., *ACLU of Louisiana v. Gov. Foster*, 2002).

Estimates of participation in public or private virginity pledges vary –from 10% of boys and 16% of girls (Baumgardner, 2007) to 16% of adolescent men and 23% of adolescent women (Bersamin, Walker, Waiters, Fisher, & Grube, 2007). There is high variability in these figures because they rely on self-reported data.

There are also some irregularities in the data on pledge behavior. For example, several studies have drawn data from *The National Longitudinal Study of Adolescent Health (Add Health)* to estimate sexual activity of pledgers compared to non-pledgers (Harris, 2009). Some participants in that study reported that they had participated in a virginity pledge, but when asked again at one of the follow-up surveys, denied having done so (Rosenbaum, 2009; Uecker, 2008). Martino et al. (2008) speculated that perhaps some of those that denied having participated had in fact broken the virginity pledge in-between follow-ups.

#### 1.4 PURITY BALLS

While abstinence pledge programs often include both male and female participants, a more exclusive event has become popular in the past two decades –the “purity ball.” The first such event, the “Father-Daughter Purity Ball,” was organized by a private group in Colorado Springs, Colorado in 1998. Founder Randy Wilson intended the event to honor the role of a father in his daughter’s life and further that relationship – by encouraging women to pledge their virginity to their future husband (with their father acting as the temporary guardsman). To the pledgers, their virginity (or “purity”) was something that should be saved to give to their future husbands. After the success of the initial purity ball, similar events were held across the US, with some estimating that over

1,000 occur annually (Gibbs, Silver, & Sayre, 2008) –although that number has been disputed (Oppenheimer, 2012).

In contrast to AOUM, messages on sexuality or sexual activity are more obscure and abstract in purity conferences. Women are taught that they are to remain “pure” for their “future husbands,” and until then, they are to be guided in life by their fathers (Fahs, 2010). “Purity,” while most certainly a euphemism for virginity, is still left up to individual interpretation. In fact, while the implication is clear that the pledged girls are to avoid pre-marital sex, participants may have different opinions on what constitutes their purity. To some, purity balls provide an impetus to “...resist peer pressure to drink, do drugs and have sex,” (Gillis, 2007); others may have more modest expectations (Reed, 2008).

Traditional gender-roles are reinforced in excruciatingly clear ways during these events, drawing comparisons to Biblical patriarchal roles. The patriarchal theme encompasses a father’s “ownership” of his daughter’s sexuality, wherein he guarded and protected it (Baumgardner, 2007). Such messages are understandably controversial, but media attention and some public disapproval have not led to any substantive change in the messaging of these events.<sup>3</sup> While the patriarchal, “father-as-guardian” analogies are more apparent in purity balls, they share many familiar stereotypical gendered messages with other abstinence programs.

For girls without a father able or willing to participate, they are encouraged to bring another person to serve as their mentor and guardian. The website for the Central

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<sup>3</sup> Randy Wilson, organizer of the original ball has clarified that the intention was to promote father-daughter relationship building, rather than abstinence pledging. However, virginity pledges remain a part of many purity balls (Reed, 2008).

Illinois Father-Daughter Purity Ball, for example, states: “For those girls who have no father, we ask that a mentor escort her instead. This could be a grandfather, a family friend, an uncle, a pastor, or someone else who can serve as a godly male role model...”  
(Father-Daughter Purity Ball, n.d.).

## CHAPTER II: AOUM PROGRAM EVALUATIONS

### 2.1 PREFACE

There are multiple peer-reviewed reviews of AOUM curriculums published in the past several years. The purpose of this guide is not to duplicate such material, but rather to expand upon the evaluations and present a nuanced guide with a greater focus on macro-level issues with the curriculum. As such, the curriculums noted in this chapter have been limited; however I do consider it important to highlight a selection of curriculums before addressing a macro-level critique of AOUM.

### 2.2 EVALUATION MEASURES

Evaluations of AOUM programs often assess participants' knowledge, attitudes, or beliefs about sexual activity and abstinence. This evaluation method –measuring changes in self-reported *beliefs* –is questionable. A more reasonable measure of efficacy would be the *behavior* of adolescents such as contraceptive use at sexual debut or reduction in teenage sexual activity.<sup>4</sup> AOUM programs have consistently been shown to be ineffective in changing behavioral measures (Kirby, 2001).

### 2.3 WEAKNESSES IN AOUM EVALUATIONS

Several published evaluations of AOUM suffer from limitations including participants lost to follow-up, non-generalizable intervention effects, small or convenient sample populations, and inadequate control groups. In some interventions (e.g., the *Reasons of the Heart* evaluation), the control groups were provided little or no alternative

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<sup>4</sup> I posit that reduction of adolescent sexual activity is an ill-suited evaluation measure –sexuality should not be discouraged, rather curriculums should teach safety (see Chapter 5). Nevertheless, because this is commonly used measure, it will be included in program evaluations discussed in this section.

sexuality education and thus were “...destined to fail” (Sexuality Information and Education Council of the United States (SIECUS), n.d.)

Other evaluations reach conclusions that are not consistent with the results of their research. For example, one evaluation of the *Not Me, Not Now* program in New York measured changes in attitudes about sexual activity and pregnancy among a convenience sample of teens that were the target of a media campaign. Following the intervention, the sample population showed an increase in knowledge of the risks of sexual activity and decrease in self-reported levels of sexual activity. The authors conclude that because these measures changed at a rate different than national trends, that the intervention was effective (Doniger, Adams, Utter, & Riley, 2001) –a conclusion that cannot be logically supported without controlling for multiple other factors.

Finally, some of the evaluations were co-authored by authors of the intervention curriculum. While it does not necessarily follow that these evaluations are biased, it does provide context when reviewing them and such involvement has been noted herein.

## 2.4 SELECTED PROGRAM EVALUATIONS

An early evaluation of abstinence education programs studied the California-based *Postponing Sexual Involvement* curriculum, part of the “Education Now and Babies Later” program. In the study, participants were enrolled in one of three groups: the *Postponing Sexual Involvement* AOUM program taught by adults, the *Postponing Sexual Involvement* AOUM program taught by peers with adult supervision, or a no-intervention control-group. The evaluation showed no statistically significant long-term difference between treatment and control groups in multiple evaluation measures. Participants in the treatment group showed some changes in attitudes and beliefs about sexual activity during a short-term follow-up; the difference between groups was not observed in a 17-



month follow-up. Participants in the program also showed no significant difference in STI incidence or pregnancy rates when compared to the control group. There was one exception to these findings –participants in a treatment group led by peers had a higher rate of pregnancy than the control group (Kirby, Korpi, Barth, & Cagampang, 1997).

The *Sex Can Wait* curriculum was reviewed by Denny & Young (2006). Their evaluation, co-written by one of the authors of the curriculum, measured effects of the five-week program among three different groups: upper elementary, middle school, and high school. They reported a long-term change in middle school participants' knowledge of sexual risks and a decrease in their self-reported intentions of engaging in sexual activity. The high school cohort showed a small short-term benefit but no statistically significant effects at long-term follow-up. However, the study had a large sample lost to follow-up, the treatment and control groups attended the same school, and there were logical problems in reporting (e.g., responses were recorded that indicated a participant had never had intercourse, but had engaged in intercourse within the last 30 days). The initial results of program efficacy on middle school participants suggests that earlier interventions may be more effective (e.g., programs designed to discourage sexual activity before most teens are reasonable able to engage in it); however, such statements are largely speculative and require further research.

The *Life's Walk* program, based in rural Missouri, was evaluated in a pre-test/post-test design to measure participants' knowledge and attitudes toward sexual activity. In two evaluations by Barnett & Hurst (2003), there were some changes in knowledge about sexual behavior and risk as well as communication abilities. There were no significant changes in regards to attitudes about sexual activity. Interestingly, the

evaluation noted an increase in sexual behavior from pre-test to post-test. Due to limitations from school administration, the definition of sexual behavior in the study is vague because they were not allowed to ask if participants had engaged in “intercourse.” A critique of their study noted that there was no control group in the program, and the evaluation did not control for changes in participant maturity (Denny & Young, 2006).

The Virginia-based *Reasons of the Heart* curriculum was evaluated by Weed et al. (2008) Their research indicates the program, which is provided to 7<sup>th</sup> graders in a nine-unit, 20 session course, is effective in reducing the rate of sexual initiation among participants. Participants in the program were 46% less likely to engage in sexual activity than participants in the control group. While these results are positive, further analysis discredits many of the findings. As noted by SIECUS (n.d.), the program was administered to younger adolescents (12-13 years old), and not evaluated for long-term efficacy; the Centers for Disease Control and Prevention (CDC) reports that only 6.2% of adolescents report engaging in sexual intercourse before the age of 13 (Eaton, Danice K., et. al., 2006), thus, efficacy of a program that seeks to delay initiation of sexual activity must be evaluated for long-term results.

The evaluation also used a controversial control group for the program. The intervention group received 20 hours of classroom-based, interactive content from instructors specifically trained in the program. The control group was shown a series of three short films about HIV/AIDS, STIs, and abstinence by school faculty that received no additional training.<sup>5</sup>

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<sup>5</sup> In addition to the previously mentioned limitations, research team lead, Dr. Stan Weed has provided research for other abstinence programs directly, and spoken at conferences promoting these events (SIECUS, n.d.).

## CHAPTER III: ABSTINENCE PLEDGE PROGRAMS

### 3.1 PREFACE

Abstinence pledges are public or private promises to abstain from sexual activity until a predetermined date. Abstinence pledges may be made as part of a formal public commitment (e.g., *The Silver Ring Thing*), or as an informal private pledges by an individual (Bersamin et al., 2005).

In reviewing abstinence pledge programs, it is difficult to ignore the effect of religiosity on sexual behavior. Rostosky & Wright (2003) found that religiosity may have a significant restrictive effect on sexual activity in some populations, including age of first sexual encounter and number of lifetime sexual partners. The protective effects of religiosity may be moderated by other factors and there is some evidence that it is not generalizable between various denominations (see Rotosky et al. 2004).

Uecker (2008) further noted that abstinence pledging was reasonably more effective in religious individuals and the efficacy of abstinence pledging is *heavily dependent on factors intricately tied to religiosity*. The salience of the program messaging, while potentially organic, is more likely a result of internalization of religious beliefs –a process that could occur with regular participation in religious activities. In other words, participants *may be more inclined to participate in these programs* if they identify with the values and beliefs of the program. Among religious youth, pledge behavior and the efficacy of pledge programs also varies between denominations. In other words, the efficacy of abstinence pledges is not generalizable and there is no

evidence that abstinence pledging as part of a school based sexual education program would have any effect on patterns of teenage sexual activity.<sup>6</sup>

### 3.2 INFORMAL ABSTINENCE PLEDGES

Informal purity pledges are personal commitments that one will abstain from sexual activity until a predetermined date or event (such as age of majority or marriage). The informal pledges reviewed in literature were credited as occurring prior to sexual debut (Bersamin et al., 2005). Pre-sexual debut pledges must be distinguished from more common post-debut pledges, sometimes referred to as “born again virgin[ity]” or “secondary virgin[ity]” –the act of reclaiming ones’ virginity for religious or moral purposes (Carpenter, 2011).

Informal virginity pledges made prior to sexual debut were shown to correlate with a later age of sexual debut among younger adolescents in a small-sample study (Bersamin et al., 2005).

### 3.3 FORMAL ABSTINENCE PLEDGES

Formal abstinence pledges are made as part of a public ceremony, such as participation in the *True Love Waits* program. Formal pledges are often signified with some sort of tangible object or symbol –a ring or charm bracelet, for example.

In an initial review of data from the *ADD Health* study, Bearman & Brückner (2001) found that teens that had participated in a formal virginity pledge were less likely to use a condom at sexual initiation. However, later, they reversed this finding and found no statistical difference in condom usage between non-pledgers and pledgers who engage in sex after their pledge (Brückner & Bearman, 2005). Similarly, other evaluations of

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<sup>6</sup> I make this point because, despite the previously mentioned evidence, abstinence pledge participation is considered a measure of efficacy of some abstinence education programs.

abstinence education programs do not indicate a statistically significant difference in use of condoms between participants in the program and control groups (Trenholm et al., 2007). Further studies have suggested that the rate of condom usage is related to other confounding factors, which, while not a direct result of AOUM programs, may be related to acceptance of the programs.

Martino et al. (2008) found that formal abstinence pledges were effective in delaying sexual initiation among adolescents previously inclined to make such a pledge. Propensity to make a pledge is associated with older age, higher parental involvement, increased religiosity, perception of parental disapproval of sex, and perception of lower peer approval of sex. The results indicate that individuals that are more *likely* to make an abstinence pledge are also more likely to keep their pledge. However, for individuals not inclined to make a pledge (i.e., those that did not have the high levels of parental involvement, etc.), virginity pledges are not effective. The authors are also careful to note that their study does not provide evidence that formal abstinence pledges should be imposed on students –even if students are more likely to make such pledges voluntarily. Rather, they advocate inclusion of abstinence pledges in addition to comprehensive sex education in schools and inclusion of content on contraception and sexual risk.

## CHAPTER IV: CRITIQUE OF AOUM AND ABSTINENCE PLEDGES

### 4.1 INEFFECTIVE IN REDUCING SEXUAL RISK BEHAVIOR

Some limited research has suggested that abstinence pledgers may be more likely to engage in sexual activity other than coitus in the belief that they are maintaining their virginity (Brückner & Bearman, 2005). AOUM and abstinence pledge programs often describe “abstinence” and “virginity” in vague terms. There is a lack of consensus (among the general population –not just adolescents) on the definition of abstinence and virginity which may contribute to inconsistencies in the data about actual efficacy of abstinence pledges (Bersamin et al., 2007; Fantasia, Fontenot, Harris, Hurd, & Chui, 2011). For example, in a representative sample, most adolescents (99.5%) agreed that penile-vaginal intercourse resulted in the loss of one’s virginity; slightly fewer (81%) considered anal intercourse to result in virginity loss; far fewer (60%) equated oral sex (giving or receiving) with loss of virginity (Sanders, 1999). Other research has correlated these findings, suggesting that some adolescents consider anal sex to not be sexual activity (Haglund, 2003), or that anal sex is safer than coitus because it cannot result in pregnancy (Werner-Wilson, 1998).

In a study by Strayhorn and Strayhorn (2009), regionally higher scores of religiosity also entailed regionally higher rates of teen pregnancy. Strayhorn posits that conservative states (traditionally higher in religiosity scores) are effective in teaching adolescents not to use contraceptives (with the intention, of course, being that they are to abstain). These beliefs are commonly included in state level policies and programs –in the form of abstinence-only education programs (SIECUS, 2009). These variables

complicate program evaluations, because it is difficult to control for things such as religiosity, especially when many evaluations examine the efficacy of programs compared to a control group in a geographically close school. Messages that children receive at home, from other peers, and adults in these regions would certainly interact with their likelihood to use a condom at first sexual encounter.

#### 4.2 “SEX-AS-RISK” PARADIGM

AOUM curriculums create a “sex-as-risk” paradigm that limits educational efficacy. This paradigm suggests that sexual activity outside the confines of a monogamous, heterosexual marriage is “risky.” The “sex-as-risk” paradigm does not equip adolescents to navigate varied sexual experiences (Schalet, 2011) nor does it permit discussion of sexuality that differs from the heteronormative narrative that is central to AOUM programs (Hess, 2010).<sup>7</sup>

AOUM generally ignores the positive and pleasurable aspects of sexual activity. This exclusion is *not unintentional* –AOUM programs goal is to encourage sex *only within the confines of heterosexual marriage*. Thus, any discussion of positive elements of sex (e.g., outside of the “sex-as-risk” paradigm) could be seen as counteracting that goal (Greslé-Favier, 2010). In the rare instance that a curriculum does discuss pleasure, it is almost certainly in a negative context. For example, in their review of four AOUM programs, Lamb, Graling, & Lustig (2011) noted that sexual pleasure was portrayed as “...dangerous and addictive when outside the context of heterosexual marriage”.

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<sup>7</sup> As noted by Hess (2010), in many programs, sexuality outside of the strict heterosexual AOUM model (e.g., homosexuality) is “the literal and symbolic embodiment of immorality, danger, and perhaps even death...”

### 4.3 FAILURE TO EXPLAIN ABSTRACT CONCEPTS

Abstinence education and purity pledges promote vague and largely undefined or abstract concepts (such as “purity”) as the expected norms for an ordered society; in this view, adolescent sexuality is nearly always dangerous. This binary categorization does not provide teens the necessary skills other than teaching them to “just say no” to penis-vaginal intercourse (Schalet, 2011). Adolescents are also expected to act on the information obtained in these courses. Research suggests that is not the case –Allen (2001), for example, noted that teens may be more skeptical of the information contained in AOUM (and therefore not act on it), because they view it as failing to cover “real information” such as pleasure, emotions, and communication of sexual needs and desires. The underlying belief (both in curriculum writers and in many evaluators) is generally that the way in which the message is delivered impacts the efficacy (Gordon & Ellingson, 2006); thus, some promoters of AOUM programs have tried to adopt *how* the message is delivered, rather than focusing on problems with the *content* of the message (Bailey, 2011).

### 4.4 INACCURATE MEDICAL CLAIMS

AOUM curriculums have been criticized for multiple distorted or untrue statements about sexual risk. Both the *Teen Aid* program (Roach & Benn, 1998) and the *Why kNOw* (Swearingen & Sulser, 2002) curriculums teach that condom usage is not an effective means of preventing STIs: *Teen Aid* states teaches that condoms have been shown to “break...and even with proper usage to allow the transmission of HIV” (p. 214). *Why kNOw* uses a class demonstration to imply that because HIV is smaller than human sperm, it is possible for it to pass through a condom (p. 97). The *WAIT* curriculum teaches that exposure to sweat and tears can lead to infection with HIV (p. 219) which



has been disproven in multiple studies (e.g., ACLU, 2007; Panlilio, Cardo, Grohskopf, Heneine, & Ross, 2005).

The *Why kNOw Abstinence Education* program teaches that 24 chromosomes each from a mother and father join during fertilization (p. 166) –there are actually 23 chromosomes (Committee on Government Reform --Minority Staff, 2004). The program also incorrectly cites a preliminary study on condom usage, and claims that this study showed that condoms have a failure rate of 31% (ACLU, 2007). The study actually showed a 69% risk reduction of HIV transmission when condoms were used –in other words, those that used condoms were 69% less likely to contract HIV. The curriculum implied that because the risk reduction was not 100%, that there was a 31% failure rate, when in fact, no such conclusion can be made (in addition, the cited study has been criticized for methodology problems).

The *Teen-Aid* curriculum, as with several other curriculums, portrays condoms as not effective in preventing STIs.<sup>8</sup> In one section, it compares condom usage to a game of “Russian Roulette,” implying that if one uses a condom regularly, an STI or pregnancy will not be prevented, only delayed (p. 215, 258). The implication herein is that STI or pregnancy is unavoidable (and deadly) if one engages in sexual activity outside of marriage.

In another example, the *Teen Aid* curriculum includes an example story about an artificial insemination clinic and implies that the risk of contracting HIV after a single sexual encounter with an HIV-positive individual is as high as 50% (p. 214-15). The

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<sup>8</sup> Statements that condoms are not “always” effective are technically true, however, the context in which many of the curriculums present these statements is to downplay the role of condom usage in safe sexual practices, and promote abstinence as the best alternative.

actual risk is approximately .08%-.14%, (see e.g.: Anderson, Wilson, Doll, Jones, & Barker, 1998).

The *Teen Aid* curriculum further states the failure rates of condoms among homosexual men as “7.3%, 8% and 25.5%,” (p. 214) a figure which is taken out of context from a study examining self-reported failure rates of a few, specific condoms that were not commercially available. The referenced study is also outdated (see e.g.: Griensven, Vroome, Tielman, & Coutinho, 1988). The curriculum also implies that adolescents are less able to properly use contraceptives and experience higher failure rates for unspecified reasons (ACLU, 2007).

#### 4.5 REINFORCEMENT OF GENDER ROLE STEREOTYPES

Static gender roles are heavily enforced in the messaging of abstinence education and purity pledges. Browning (2010) noted in an observational study noted that many abstinence-oriented programs portrayed men as repeatedly referencing sexual “conquests” and “needs.” Women, on the other hand, were portrayed as using sex to obtain love. The messages to promote abstinence were then modified on gender lines – men were encouraged to abstain from sex to avoid negative consequences such as STIs and unplanned pregnancies; women were encouraged to remain virgins in order to be more attractive to their future husband.

The portrayal of women as seductive and men as unable to refuse an advance is another theme reinforced in many abstinence related programs. The Biblical tale of Eve, known for tempting Adam with the fruit of the Forbidden Tree, is thematically tied into many abstinence curriculums. The *Heritage Keepers* curriculum (Badgley, Musselman, Casale, & Badgley-Raymond, 2008) teaches that men are “aroused by sight” and instructs women to “dress modestly” to prevent “lustful thoughts” (p. 46). It also teaches that co-

habitation leads to weaker relationships (p. 26) and that more than one sexual partner results in an inability to build a lasting relationship (p. 56).

The *Why kNOw* curriculum states “...women need to realize what they may be communicating. Asking herself what signals she is sending could save both sexes a lot of heartache,” (p. 121). It further enforces gender roles by having students participate in a quiz that divides common household tasks between a mother and father, with the expectation that tasks are assigned around traditional gender norms (Shatz, 2008).

Other curriculums further this theme –teaching that women require “financial support” and hinge their personal happiness on their romantic relationships; men require “admiration” and hinge their happiness on “accomplishments” (Committee on Government Reform --Minority Staff, 2004). Stated differently, women are taught that their value is dependent on others; men are given the opportunity to prove their value through accomplishments.

## CHAPTER V: CONCLUSION AND RECOMMENDATIONS

### 5.1 AOUM PROGRAMS AND ABSTINENCE PLEDGING ARE INEFFECTIVE

There is overwhelming evidence that AOUM education and abstinence programs are ineffective in producing their intended results. The programs have been noted to include inaccurate information, promote outdated gender roles, and ignore sexual experiences that are outside of a narrow ideological scope. There is no evidence that continued funding of these programs will change the results. To combat the public health risks of teenage pregnancy and STIs, sexual education programs and interventions must be designed that are comprehensive, age-appropriate, and evidence based.

### 5.2 ADOLESCENTS SHOULD BE PROVIDED A COMPREHENSIVE EDUCATION

Comprehensive sex education programs have been extensively researched and shown to be effective in reducing risky sexual behavior among adolescents. Adolescents should be taught information that is unbiased, accurate, and evidence-based. Failure to provide adolescents with a balanced curriculum –or worse, providing information that is factually incorrect may put teens at higher risk for risky sexual behavior.

### 5.3 VARIATION SHOULD BE PRESERVED

A one-standard curriculum is not appropriate for comprehensive sexual education programs because it does not acknowledge the regional and cultural variations across the country. Local school districts and state education boards should continue to exercise some control over curriculums with the requirement that independent evaluations occur regularly and modifications be made when necessary. Empowering local leaders to adapt programs to regional variations is essential to create “buy-in” among stakeholders.

## 5.4 RECOMMENDED PROGRAM GUIDELINES

A list of recommended guidelines for comprehensive sexual education courses is included in Table 4. These guidelines are adapted in part, from recommendations developed by SIECUS. They are, in many respects, the antithesis of the Federal “A-H” guidelines for AOUM programs.

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**Table 4: Proposed Guidelines for Comprehensive Sex Education Programs**

**A comprehensive sex education program should:**

1. Educate teens about sexuality, including biological aspects of development and reproduction, human sexual behaviors, sexual health, and social and cultural influences and expectations on sexuality.
  2. Encourage diversity and incorporate topics about diversity into curriculum. Many sex education programs are exclusionary to lesbian, gay, bisexual, and transgender, or queer (LGBTQ) youth. An effective comprehensive program must respect individuality and be accessible to all students.
  3. Equip teens to navigate varied sexual experiences. Some may choose to be abstinent; others may choose to be sexually active. The role of an educator in a comprehensive program is to help teens navigate varied experiences, while providing comprehensive education and information. In addition, comprehensive programs must convey the importance of personal responsibility to teens.
  4. Engage students in open, honest, conversation about sexuality and sexual health. Programs should allow teens to seek answers provide teens with resources specific to their needs.
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## 5.5 SUGGESTED TOPICS

Suggested topics are included in Table 5. This list is not exhaustive and is provided as a general outline of course topics. These topics are not intended to be included in all levels of a comprehensive program. Rather, they are to be introduced in an incremental and age-appropriate manner. For example, puberty (and associated biological changes) is suitable for younger audiences, while STIs may be too advanced. Similarly, high school students would likely find puberty to be less relevant, but discussion of contraceptives and reproductive health to be pertinent.

**Table 5: Suggested Topics for Comprehensive Sex Education Programs**

<b>Biological aspects of sexuality</b>		
Anatomy and physiology	Contraception	Abstinence
STIs, including HIV infection	Reproductive health, pregnancy, childbirth & abortion	Sexual dysfunction
<b>Sexuality and the person</b>		
Body image	Fantasy	Friendship
Families	Dating	Love
Marriage and lifetime commitments		
<b>Diversity in expressions of sexuality</b>		
Sexual orientation	Sexual identity	Diversity of sexual expression and experiences
<b>Communication</b>		
Decision-making	Negotiation	Assertiveness
Looking for help		
<b>Sexuality and society</b>		
Gender roles	Diversity	Sexuality and religion
Sexuality and the law	Sexuality and the arts	Sexuality and the media
<b>Sexuality across the lifespan</b>		
Puberty	Sexual abuse	Aging

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# APPENDIX: REFERENCE MATERIALS FOR STAKEHOLDERS

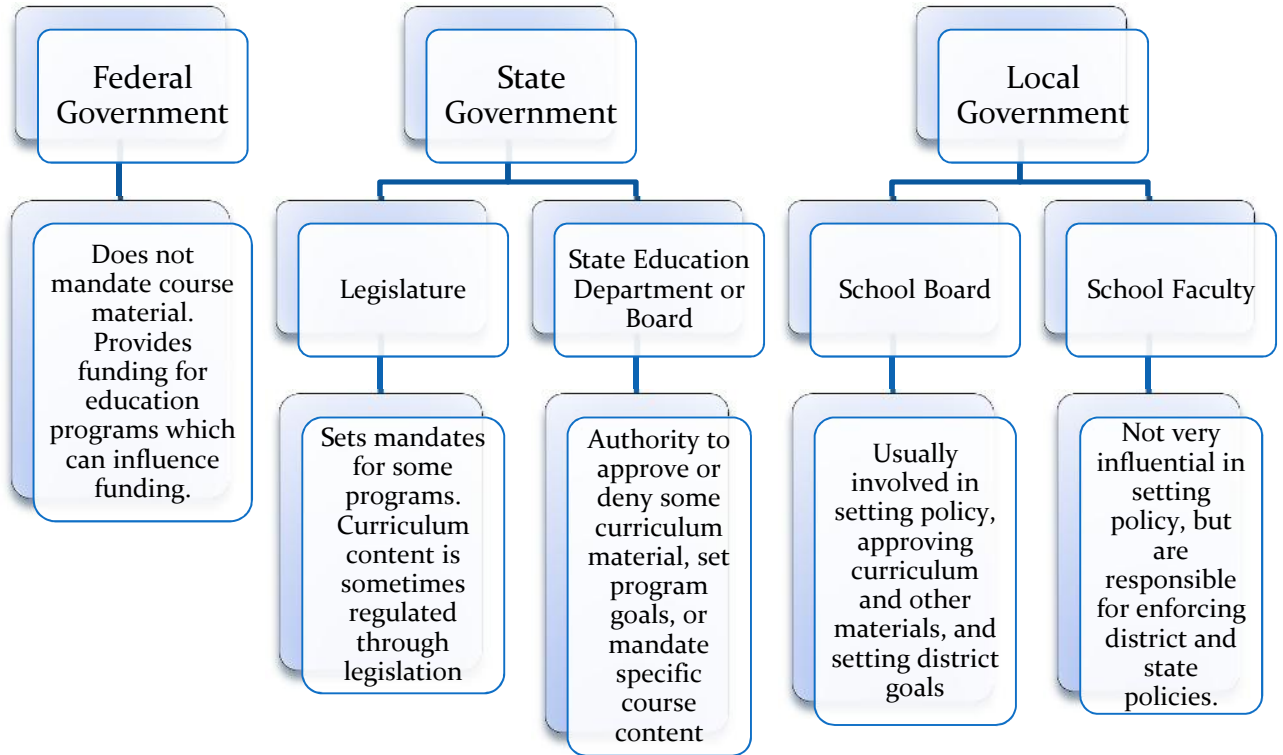
## INTRODUCTION

This section provides information for policymakers, concerned community members, parents, and educators on effective sex education for students. It has been designed to provide accessible information for use in advocating for comprehensive sex education programs.

## **GLOSSARY OF COMMONLY USED TERMS**

<b>Abstinence</b>	The practice of restraining from participating in something.
<b>Abstinence-Based Programs</b>	School or community programs that discuss or stress abstinence as a method of preventing pregnancy and STIs. Abstinence-based programs (sometimes called “abstinence-plus programs”) include some discussion on other methods of contraceptives and safe-sex practices.
<b>Abstinence-Only Until Marriage (AOUM) Programs</b>	School or community based programs that teach abstinence as the only way to prevent pregnancy and STIs. AOUM programs often teach that abstinence is the expected social or moral norm.
<b>Comprehensive Sex Education Programs</b>	School or community based programs that teach a broad overview of sexuality. Comprehensive programs include discussion of contraceptives, pregnancy, and individual responsibilities in sexual behavior.

# FACT SHEET: WHO MAKES DECISIONS ON SCHOOL POLICIES?



# FACT SHEET: SEX EDUCATION REQUIREMENTS BY STATE

## ALABAMA

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm. In addition, curriculums are required to stress that homosexuality is not an acceptable lifestyle and that it is a criminal offense.

**STIs:** A health-based course on HIV/AIDS is required from grades 5-12.

**Opt-Out:** Parents may opt-out from sex education courses.

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## ALASKA

There are no laws governing sex education in Alaska. The state's Department of Education provides a reference list of evidence-based programs, but it does not officially endorse any of them.

**STIs:** There are no requirements for instruction on STIs.

**Opt-Out:** There are no state laws governing parental opt-out.

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## ARIZONA

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm. Schools may choose to offer the course as part of the health curriculum, or as an elective (supplemental) course. In addition, curriculums are not allowed to discuss homosexuality in a positive manner.

**STIs:** There are no requirements for instruction on STIs.

**Opt-Out:** Parents may opt-out from sex education courses. In addition, parents must "opt-in" if the supplemental course is offered.

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## ARKANSAS

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm.

**STIs:** A health-based course on HIV/AIDS is required from grades 5-12.

**Opt-Out:** There are no state laws governing parental opt-out.

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## CALIFORNIA

Sex education is not required by state statute. However, when taught, curriculums are required to be comprehensive in nature, including both abstinence and contraceptives. Curriculums are also required to be inclusive of all races, genders, and sexual orientations.

**STIs:** A health-based course on HIV/AIDS is required at least once in middle school and once in high school.

**Opt-Out:** Parents may opt-out from sex education courses.

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## COLORADO

Sex education is not required by state statute. However, when taught, curriculums are required to be comprehensive in nature, including both abstinence and contraceptives, although abstinence is required to be emphasized.

**STIs:** There are no state laws governing STI instruction.



**Opt-Out:** Varies depending on the program. Some allow parental opt-out while others require parental opt-in.

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**CONNECTICUT**

Sex education is not required by state statute.

**STIs:** There are no state laws governing STI instruction.

**Opt-Out:** Parents may opt-out from sex education courses.

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**DELAWARE**

Sex education is required by state statute. The programs are required to emphasize abstinence, but there is no statute governing whether contraceptives can be discussed or not.

**STIs:** An HIV prevention course is required.

**Opt-Out:** There are no state laws governing parental opt-out.

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**DISTRICT OF COLUMBIA**

Sex education is required by statute. The programs are required to be comprehensive in nature.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** Parents may opt-out from sex education courses.

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**FLORIDA**

Sex education is not required by state statute. A comprehensive sex education course was previously required; however, school districts have the option of substituting it with other health courses.

**STIs:** There are no state laws governing STI instruction.

**Opt-Out:** Parents may opt-out from sex education courses.

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**GEORGIA**

Sex education is required by state statute. The programs are required to emphasize abstinence, but there is no statute governing whether contraceptives can be discussed or not.

**STIs:** Instruction on STIs is included in the required course.

**Opt-Out:** Parents may opt-out from sex education courses.

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**HAWAII**

Sex education is required by statute. The programs are required to be comprehensive in nature.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** There are no state laws governing parental opt-out.

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**IDAHO**

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm.

**STIs:** There are no state laws governing STI instruction.

**Opt-Out:** Parents may opt-out from sex education courses.

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**ILLINOIS**

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on STIs is required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**INDIANA**

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on STIs is required.

**Opt-Out:** There are no state laws governing parental opt-out.

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### **IOWA**

Sex education is required by state statute. The programs are required to be comprehensive in nature.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** Parents may opt-out from sex education courses.

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### **KANSAS**

Sex education is required by state statute. The programs are required to be comprehensive in nature.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** There are no state laws governing parental opt-out.

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### **KENTUCKY**

There are no state laws regarding sex education; however, the state school board's guidelines include a sex education course that stresses abstinence.

**STIs:** There are no state laws on STI instruction.

**Opt-Out:** There are no state laws governing parental opt-out.

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### **LOUISIANA**

Sex education is not required by state statute. Statutes allow classes to be taught after sixth grade (except in Orleans Parish where they may be taught after third grade). When taught, programs are prohibited from providing contraceptives and from portraying homosexuality in a positive manner.

**STIs:** There are no state laws on STI instruction.

**Opt-Out:** Parents may opt-out from sex education courses.

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### **MAINE**

Sex education is required by state statute. The programs are required to be comprehensive in nature and are taught from kindergarten through 12<sup>th</sup> grade.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** Parents may opt-out from sex education courses.

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### **MARYLAND**

Sex education is not required by state statute. However, comprehensive health education courses are required by the state school board. In units dealing with sexuality, the content is comprehensive. Local school boards can also opt to provide a supplemental (elective) course.

**STIs:** Instruction on HIV/AIDS is required at least once in elementary school, once in middle school, and once in high school.

**Opt-Out:** Parents may opt-out from sex education courses. In addition, parents must "opt-in" if the supplemental course is offered.

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### **MASSACHUSETTS**

Sex education is not required by state statute. If such programs are offered, they are required to include content on STIs and pregnancy prevention.

**STIs:** Instruction on STIs is strongly encouraged by the state school board.

**Opt-Out:** Parents may opt-out from sex education courses.

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**MICHIGAN**

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on STIs is required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**MINNESOTA**

Sex education is required by state statute. The programs are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on STIs is required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**MISSISSIPPI**

Sex education is required by state statute. The programs are required to be either AOUM or abstinence-plus.

**STIs:** Instruction on STIs is required.

**Opt-Out:** Parents must opt-in to sex education courses.

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**MISSOURI**

Sex education is not required by state statute.

However, when taught, curriculums are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on HIV/AIDS prevention is required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**MONTANA**

Sex education is not required by state statute. However, a general course in health is required and limited content on HIV/AIDS is included.

**STIs:** Instruction on HIV/AIDS is included in the general health course.

**Opt-Out:** There are no state laws governing parental opt-out.

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**NEBRASKA**

Sex education is not required by state statute. However, the state school board has adopted a framework that encourages the teaching of abstinence in school programs.

**STIs:** There are no requirements for instruction on STIs.

**Opt-Out:** There are no laws regarding parental opt-out.

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**NEVADA**

Sex education is required by state statute. The specific content of the course is set by a local school board advisory committee.

**STIs:** Instruction on STIs is required.

**Opt-Out:** Parents must opt-in to sex education courses.

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**NEW HAMPSHIRE**

Sex education is required by state statute. The programs are required to be comprehensive in nature.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** Parents may opt-out from sex education courses.

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**NEW JERSEY**

Sex education is required by state statute. The programs are required to be comprehensive in nature although abstinence is emphasized as the expected social norm.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** Parents may opt-out from sex education courses.

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**NEW MEXICO**

Sex education is not required by state statute.

**STIs:** Instruction on HIV/AIDS is required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**NEW YORK**

Sex education is not required by state statute.

**STIs:** Instruction on HIV/AIDS is required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**NORTH CAROLINA**

Sex education is required as part of a broad health education program. The content of the programs vary, although they are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on HIV/AIDS is required as part of the general health education program.

**Opt-Out:** Varies depending on the program.

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**NORTH DAKOTA**

There are no state laws regarding sex education.

**STIs:** There are no state laws on STI instruction.

**Opt-Out:** There are no state laws governing parental opt-out.

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**OHIO**

Sex education is not required by state statute. However, the state school board requires local school districts to include some limited sex education as part of their health education courses. These courses are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on STIs is required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**OKLAHOMA**

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on HIV/AIDS is required at least once in elementary school, once in middle school, and once in high school.

**Opt-Out:** Parents may opt-out from sex education courses.

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**OREGON**

Sex education is required by state statute. The programs are required to be comprehensive in nature.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** Parents may opt-out from sex education courses.

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**PENNSYLVANIA**

Sex education is not required by state statute.

**STIs:** Instruction on HIV/AIDS is required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**RHODE ISLAND**

Sex education is required by state statute. The programs are required to be comprehensive in nature although abstinence is emphasized as the expected social norm.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** Parents may opt-out from sex education courses.

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**SOUTH CAROLINA**

Sex education is required as part of a broad health education

program. The programs are allowed to discuss contraception only in the context of future family planning.

**STIs:** Instruction on STIs is required; instruction on HIV/AIDS is not required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**SOUTH DAKOTA**

Sex education is not required by state statute. However, the state school board requires limited sex education as part of a broad health education program.

**STIs:** There are no state laws on STI instruction.

**Opt-Out:** There are no state laws governing parental opt-out.

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**TENNESSEE**

Sex education is not required by state statute unless teenage pregnancy rates reach a specific level. However, when taught, the programs are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on STIs is required as part of a broad health education program.

**Opt-Out:** Parents may opt-out from sex education courses.

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**TEXAS**

Sex education is not required by state statute. However, when taught, curriculums are required to emphasize abstinence as the expected social norm.

**STIs:** There are no state laws on STI instruction.

**Opt-Out:** Parents may opt-out from sex education courses.

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**UTAH**

Sex education is required by state statute. The programs are required to be AOUM. In addition, instructors are prohibited from discussing any material that may facilitate or encourage criminal behavior (pre-marital sex is illegal in Utah).

**STIs:** There are no state laws on STI instruction.

**Opt-Out:** Parents must opt-in to sex education courses.

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**VERMONT**

Sex education is required by state statute. The programs are required to be comprehensive in nature.

**STIs:** Instruction on STIs is included in the comprehensive program.

**Opt-Out:** Parents may opt-out from sex education courses.

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**VIRGINIA**

Sex education is not required by state statute. However, when offered, the programs are required to emphasize abstinence as the expected social norm.

**STIs:** There are no state laws on STI instruction.

**Opt-Out:** Parents may opt-out from sex education courses; however they are required to justify their requests.

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**WASHINGTON**

Sex education is not required by state statute. However, when offered, the programs are required to be comprehensive in nature and are specifically prohibited from teaching abstinence in lieu of comprehensive content.

**STIs:** Instruction on STIs is required; instruction on HIV/AIDS must be provided annually.

**Opt-Out:** Parents may opt-out from sex education courses.

**WEST VIRGINIA**

Sex education is not required by state statute.

**STIs:** Instruction on HIV/AIDS is required from 6<sup>th</sup> through 12<sup>th</sup> grade.

**Opt-Out:** Parents may opt-out from sex education courses.

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**WISCONSIN**

Sex education is encouraged, but not

required by state statute. However, when offered, the programs are required to emphasize abstinence as the expected social norm.

**STIs:** Instruction on STIs is encouraged, but not required.

**Opt-Out:** Parents may opt-out from sex education courses.

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**WYOMING**

Sex education is not required by state statute.

**STIs:** Instruction on HIV/AIDS is required by the state school board.

**Opt-Out:** Parents may opt-out from sex education courses.

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## **FACT SHEET: MYTHS ABOUT COMPREHENSIVE SEX EDUCATION PROGRAMS**

### **Providing comprehensive sex education courses is like telling students not to smoke --but if they do, to use filtered cigarettes.**

This statement improperly characterizes the nature and content of comprehensive sex education programs. Comprehensive sex education is about much more than just "using a condom" --the programs provide students with knowledge and skills to navigate diverse sexual experience throughout their lifespan.

### **Comprehensive sex education programs encourage teens to have sex.**

There are many factors that affect teenage sexual activity, but there is no evidence that comprehensive sexual education courses encourage students to be more sexually active. Providing students with information about sexual behavior (including both abstinence and contraceptives) has been shown to be more effective in reducing teen sexual activity and risk behaviors.

### **Comprehensive sex education and abstinence are mutually exclusive.**

Comprehensive sex education can include abstinence as one of many ways for teens to make responsible choices. The problem with abstinence-only education is that it does not provide realistic information for students outside of abstinence as the expected behavior – an expectation that is naïve.

### **The government already funds comprehensive sex education under Title X of the Public Health Service act.**

The appropriations for funds from Title X of the Public Health Service Act can be confusing. According to DHS: "Title X is the only Federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services." These services are not school-based education programs though, they are primarily services rendered to low-income individuals at public health clinics, hospitals, tribal health centers, and other facilities.

## **FACT SHEET: WHAT'S WRONG WITH ABSTINENCE PLEDGES?**

### **Abstinence pledges set kids up for failure.**

Abstinence pledges encourage kids to pledge their virginity (itself an abstract concept) to better their future. The programs don't teach teens how to navigate sexual communication other than to just "say no" (an idealistic but naïve approach). They also usually invoke messages of shame, physical or emotional harm, or even death as results of not maintaining abstinence. Teens that have engaged in sexual activity may deny such actions<sup>1</sup>, hindering interventions of healthcare providers or parents to assess risk behavior and provide education and treatment.

### **Abstinence pledging puts a narrow focus on virginity while ignoring other sexual risk behavior**

Putting a heavy emphasis on preserving one's "virginity" may make teens more likely to engage in other sexual behavior. Research has not found a consensus among what teens consider "sex" and thus, whether a teen has maintained their pledge or not is up to individual interpretation.<sup>2</sup> This focus may prevent pregnancy, but it doesn't always mean that teens will abstain from *other* forms of "sex." Sexual activity other than coitus also carries risks of STIs and unless teens are provided accurate information, the programs could put them at higher risk.

### **Abstinence pledges use fear tactics to encourage adolescents to participate.**

Take, for example, verbiage from the *East Texas Abstinence Program*, a community based program that provides AOUM education and promotes pledging:

*I am not ready to become a mom or dad; I do not want the emotional or physical risk of casual sex.*

The message here is clear: *if you engage in sexual activity outside of marriage, you will become pregnant or risk serious emotional or physical harm.* The risks of sexual activity should be explained to teens in a realistic, age-appropriate manner.

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<sup>1</sup> Fantasia et al. (2011) for example note problems in assessing whether teens are sexually active because of differing interpretations of "sex" and "virginity." Using fear tactics to further adherence to a message in this case could lead to underreporting of sexual activity and increased risk.

<sup>2</sup> Bersamin et al. (2007), for example, noted problems with trying to define virginity among a sample of teens.



## **SUGGESTED PROGRAM GUIDELINES: EDUCATE, ENCOURAGE, EQUIP, & ENGAGE**

The following suggested program guidelines are adopted, in part, from recommendations developed by the *Sexuality Information and Education Council of the United States*, a nationally recognized advocacy group. They provide a framework for a comprehensive education program and the basic principles that should be observed.

*A comprehensive sex education program should:*

**Educate** teens about sexuality, including biological aspects of development and reproduction, human sexual behaviors, sexual health, and social and cultural influences and expectations on sexuality.

**Encourage** diversity and incorporate topics about diversity into curriculum. Many sex education programs are exclusionary to lesbian, gay, bisexual, and transgender, or queer (LGBTQ) youth. An effective comprehensive program must respect individuality and be accessible to all students.

**Equip** teens to navigate varied sexual experiences. Some may choose to be abstinent; others may choose to be sexually active. The role of an educator in a comprehensive program is to help teens navigate varied experiences, while providing comprehensive education and information. In addition, comprehensive programs must convey the importance of personal responsibility to teens.

**Engage** students in open, honest, conversation about sexuality and sexual health. Programs should allow teens to seek answers provide teens with resources specific to their needs.

# QUESTIONS AND ANSWERS FOR POLICY MAKERS

## **What is comprehensive sex education?**

Comprehensive sex education is a school-based education program that provides incremental, age-appropriate, lessons about human sexuality and sexual behavior, reproduction, and contraceptives. Comprehensive curriculum topics include sexual and biological development & reproduction, variations in sexual experience (e.g., sexual orientation), interpersonal relationships, contraceptives, and risks of unsafe sexual activity (STIs and pregnancy). This is not an exhaustive list of topics, and each curriculum varies in the order and method in which these subjects are presented. The goal is to encourage adolescents to gradually acquire knowledge about sex.

## **Shouldn't parents be the ones that teach their children about sex?**

Parents should be encouraged to provide sexual education at home that conforms to their own moral, religious, and cultural beliefs and standards. However, some content within sex education (for example, contraception use) may be difficult for parents to discuss with their children. Parents may also not be able to provide the most current and up-to-date information to their children. For that reason, it is important that students receive a comprehensive, evidence-based sex education curriculum.

## **Does providing comprehensive sex education encourage children to be sexually active?**

No. In fact, this is one of the most dangerous myths propagated by pro-abstinence groups. There is *no evidence* that comprehensive sex education programs result in higher levels of sexual activity among adolescents.

## **As a policymaker, will parents be upset about proposals to implement a comprehensive sexual education program?**

While it is impossible to predict the potential outcome of every situation, research suggests that parents are more open to the idea of comprehensive sexuality education when presented with data on the programs, recommendations of health professionals, and information on the failings of current programs, a majority of parents support a comprehensive approach to sexuality education. There will always be people that disagree with a position, but presenting facts on the failings of AOUM programs and findings on comprehensive programs will help assuage the fears of some parents.

## **What if parents object to their child receiving comprehensive sex education for religious or cultural reasons?**

Many states allow parents to opt-out of sex education programs if it interferes with their religious or cultural beliefs. In these cases, it is best to discuss the objections with the parent, and then withdraw the student from the class if the parent requests it

## QUESTIONS AND ANSWERS FOR PARENTS

### **What is comprehensive sex education?**

Comprehensive sex education is a school-based education program that provides incremental, age-appropriate, lessons about human sexuality and sexual behavior, reproduction, and contraceptives. Comprehensive curriculum topics include sexual and biological development & reproduction, variations in sexual experience (e.g., sexual orientation), interpersonal relationships, contraceptives, and risks of unsafe sexual activity (STIs and pregnancy). This is not an exhaustive list of topics, and each curriculum varies in the order and method in which these subjects are presented. The goal is to encourage adolescents to gradually acquire knowledge about sex.

### **If schools teach comprehensive sex education, what is my role in teaching kids about this topic?**

Comprehensive sexual education programs are no substitute for parents engaging their children and addressing their individual needs. In fact, this policy guideline encourages you to provide sexual education at home that conforms to your own moral, religious, and cultural beliefs and standards. However, some content within sex education (for example, contraception use) may be difficult to discuss and you may not have the most current information, which is why it is key that teens receive complete, accurate, and age-appropriate information in an educational setting.

### **Will providing comprehensive sex education encourage my child to be sexually active?**

No. In fact, this is one of the most dangerous myths propagated by pro-abstinence groups. There is *no evidence* to support that comprehensive sex education programs result in higher levels of sexual activity among adolescents.

### **Why is this so important? I thought abstinence education programs were effective.**

There is *no scientific evidence* that abstinence-only education programs have any positive effects. Because the programs have been shown to be ineffective, it is important that parents demand accurate, evidence-based educational programs in schools.

### **What if I object to my child receiving comprehensive sex education for religious or cultural reasons?**

Many states allow parents to opt-out of sex education programs if it interferes with their religious or cultural beliefs. If you have concerns about the content of your child's curriculum, you are encouraged to speak with school administrators about your concerns. If necessary, you may request withdrawal from the program.

## **NEXT STEPS FOR PARENTS: HOW TO GET INVOLVED**

### **Talk to other parents**

Advocating for comprehensive sex education programs is not a task that can be completed alone. Successfully changing public policy will require a strong community coalition of parents, educators, and school board members. Engaging other parents to advocate for comprehensive sex education is the first step, as school boards will be more willing to listen to parental concerns if there are multiple parents involved.

### **Talk to the school board**

Do you know the names of your local school board officials? If not, get to know them. Introduce yourself, and be present at school board meetings. Effective advocacy requires being able to navigate the existing power structures. If school board officials see you as an outsider, this is likely to be more difficult.

Engaging the school board to discuss comprehensive sex education will take time, but it is more effective to broach the subject once you have introduced yourself to them and given them a chance to see that you are committed to being involved.

### **Work with local leaders to advocate for comprehensive sex education in public schools.**

While national organizations have been advocating for comprehensive programs for many years, abstinence-education and abstinence pledging still receive funding. In addition to talking to other parents, work with other local and community leaders that may be influential in bringing attention to the need for comprehensive sex education.

### **Contact groups that advocate for comprehensive sexual education**

Groups like the Sexuality Information and Education Council of the United States (SIECUS - [www.siecus.org](http://www.siecus.org)) and Advocates for Youth ([www.advocatesforyouth.org](http://www.advocatesforyouth.org)) have extensive policy guidelines, fact sheets, and information on how to advocate for better sexuality education for teens.