

SIECUS State Profiles: Sexuality Education and Abstinence-Only-Until-Marriage Programs in the States

An Overview Fiscal Year 2009 Edition

SIECUS pulled together this seventh edition of the *SIECUS State Profiles* as we were witnessing a significant shift in how the federal government addresses sex education—away from the failed experiment of abstinence-only-until-marriage programs and toward a more comprehensive, evidence-based approach. Advocates for comprehensive sexuality education are finally seeing, and beginning to build upon, the fruits of our labor. After nearly thirty years of strong support from the federal government for abstinence-only-until-marriage programs, the Obama administration and Congress have ushered in a new era of sex education in this country, eliminating two-thirds of federal funding for ineffective abstinence-only-until-marriage programs and providing funding for evidence-based teen pregnancy prevention and comprehensive sex education initiatives totaling nearly \$190 million. The White House has begun to heed the evidence and the urgings of the nation’s leading medical and public health organizations and has come out strongly in support of programs that can be comprehensive in scope, have demonstrated their effectiveness, and are age-appropriate and medically accurate. It has also signaled the importance of addressing the inter-related health needs of adolescents by establishing the Office of Adolescent Health, charged with coordinating all activities within the U.S. Department of Health and Human Services that relate to adolescent “disease prevention, health promotion, preventive health services, and health information and education.”¹

Leadership and success on this issue are not only coming from the White House and Congress but also from across the country. States and cities around the country are jettisoning the failed policy of abstinence-only-until-marriage in favor of more comprehensive approaches while others continue to push the boundaries of how far we can go in the effort to reach all young people with comprehensive sexuality education.

SIECUS delivers this edition in 2010 with a clear mission: to build on our successes and institutionalize the investment and policies that are slowly being implemented to support comprehensive sexuality education, and to continue the trend of eliminating all federal funding and state policies for failed abstinence-only-until-marriage programs.

This year’s edition mirrors the national shift; while we continue our tradition of “following the money” by documenting all federal abstinence-only-until-marriage dollars, we are also highlighting more comprehensive approaches to sex education that are happening across the country. For the first time, the *SIECUS State Profiles* identifies examples of model programs, policies, and best practices being implemented in public schools across the country that provide more comprehensive approaches to sex education for young people. To this end, a new section, “Comprehensive Approaches to Sex Education,” in each profile provides examples under four different categories: Revised State Sex Education Policy, Updated State Health Education Standards, Revised School District Policy, and Comprehensive Sex Education Programs in Public Schools. The content in this year’s *State Profiles* is by no means a complete list of all comprehensive programming happening across the country, but rather some examples of best practices and model programs that SIECUS has identified thus far.

This year’s edition of the *SIECUS State Profiles* was compiled through extensive research and monitoring, tracking of state and local developments around comprehensive sexuality education, conversations with state health officials and state advocates, and the solicitation of state and federal records on federal abstinence-only-until-marriage grantees (using Freedom of Information Act and Public Records Requests, when necessary). In addition, we have also added new features to provide advocates and educators with even more useful information. Among this edition’s new features are additional youth sexual health statistics

detailing current data on teen pregnancy and birth, HIV/AIDS, Chlamydia, gonorrhea, and, when available, syphilis for each state; a list of commercially available curricula used by some abstinence-only-until-marriage grantees in each state (when applicable); and a list of progressive political blogs in each state to assist with media outreach efforts. The current edition also includes the very latest in adolescent health statistics from the 2009 Youth Risk Behavior Surveillance System (YRBSS) which was conducted by the Centers for Disease Control and Prevention (CDC) and released just a few weeks before this publication.

SIECUS continues to be a resource for advocates and agencies across the country working to implement comprehensive sexuality education in public schools and communities and eliminate harmful abstinence-only-until-marriage programs. Our in-depth research allows us to provide not just detailed information on each state but thoughtful analysis on the overall trends we are seeing at both the federal and state levels.

MAJOR FISCAL YEAR 2009 HIGHLIGHTS

- There were eight states that did not receive any federal abstinence-only-until-marriage funding in Fiscal Year 2009: Delaware, Idaho, Maine, Minnesota, Montana, Rhode Island, Vermont, and Wyoming.
- During their 2009 and 2010 legislative sessions, 18 states introduced legislation to require that sexuality education provided in public schools be medically accurate, age-appropriate, and include instruction on both abstinence and contraception, among other topics. States that introduced such legislation were diverse in geography, size, and political leanings.
- Based on SIECUS' research, there are school districts in at least 21 states and the District of Columbia that provide more comprehensive sex education programs to students.
- By the time the Title V abstinence-only-until-marriage program expired on June 30, 2009, 23 states and the District of Columbia had rejected these federal funds.
- The five states receiving the highest amounts of federal abstinence-only-until-marriage funding in Fiscal Year 2009 include Texas (\$10,225,188), Georgia (\$9,986,442), Florida (\$8,960,656), Illinois (\$7,951,804), and Ohio (\$4,948,806).

THE STATUS OF ADOLESCENT SEXUAL HEALTH

While we have seen policies and funding take a major turn this year, it is clear that much of this has yet to lead to real program implementation on the ground. Data released over the last year prove that we have not yet gotten the right messages to enough young people and teen health statistics show that we are not making needed progress.

Every two years, the CDC conducts the Youth Risk Behavior Surveillance System (YRBSS). This extensive study monitors several health risk behaviors among youth and young adults, including sexual behaviors that may contribute to unintended pregnancies, HIV, and other sexually transmitted diseases (STDs). Over 14,000 high school students throughout the country were surveyed for the 2009 study.

When compared with data from 2007, we see that no real progress has been made in the status of adolescent sexual health practices. A similar lack of progress was found between the 2005 and 2007 surveys with one exception. Between 1991, when the YRBSS was first conducted, and 1999 there were sharp increases in positive sexual health behaviors and decreases in negative behaviors. Since then, however, that progress has stalled or regressed. While the number of youth who have engaged in sexual activity has decreased since 1991, when 54% of high school students reported ever having had sexual intercourse, it has been hovering around the 46% mark since 2001. And the number who engaged in riskier sexual activity (such as unprotected sexual intercourse, illustrated by no condom use) has not seen an improvement since 2003. Every time the YRBSS comes out and shows these flat numbers, we have to remember that it represents another two years gone by where young people are not getting the information and education they need to protect themselves. To that end, perhaps the most alarming statistic from this year's YRBSS shows that the number of high school students reporting having learned about HIV or AIDS in school is 87%—the lowest percentage since 1997.

In addition, the data continue to show disparities in sexual health behaviors based on race, ethnicity, and geographic location. For example, the survey shows that Black and Hispanic students were more likely than white students to have had sexual intercourse for the first time before age 13, had sexual intercourse with four or more partners during their life, and not have used birth control pills or Depo-Provera before last sexual intercourse to prevent pregnancy. In addition, Hispanic students were the least likely of the three groups to have used a condom during last sexual intercourse.² Similarly, compared to their counterparts in the rest of the country, a larger percentage of youth surveyed in the South engage in riskier sexual health behaviors. For example, in 2009, all Southern states for which data are available report having a higher percentage of students who have had sexual intercourse prior to age 13; with Mississippi's rate being the highest at 13.4%, over double the national average of 5.9%.³ Mississippi also reports the highest percentage of high school students who have had intercourse with four or more people, 23.7%, and percentages in this category for all Southern states save one, Kentucky, are above the national average of 13.8%.⁴

Key 2009 Adolescent Sexual Health Data
2009 Youth Risk Behavior Surveillance System⁵

- 46.0% of students reported ever having had sexual intercourse (47.8% in 2007)
- 5.9% of students reported having had sexual intercourse before age 13 (7.1% in 2007)
- 13.8% of students reported having had sex sexual intercourse with four or more sexual partners in their lifetime (14.9% in 2007)
- 34.2% of students reported being currently sexually active, defined as having had sexual intercourse in the three months prior to the survey (35.0% in 2007)
- 61.1% of sexually active students reported that either they or their partner had used a condom during last sex (62.5% in 2007)
- 87.0% of students reported having been taught about AIDS or HIV in school (89.5% in 2007)

The YRBSS data is just the most recent addition to our overall understanding of the sexual health issues that face young people. Other statistics show that the United States still faces significant challenges, particularly relating to rates of unintended pregnancy, HIV, and other STDs among young people. For example, after a 14-year decline, birth rates for young women ages 15–19 rose 3% from 2005–2006, with seven states experiencing an increase of 10% or higher.⁶ While in the United States, one-half of all pregnancies are unintended,⁷ research has shown that approximately 75% of teens who become pregnant did not plan their pregnancies and the number of unintended pregnancies among sexually active young women in the 15–17 age group (147 per 1,000) is over double the national average of 69 per 1,000 for all women.⁸

According to the Guttmacher Institute, the significant drop in teen pregnancy rates in the 1990s was overwhelmingly the result of more and better use of contraceptives among sexually active teens. However, this decline started to stall out in the early 2000s, at the same time ideological programs aimed exclusively at promoting abstinence-until-marriage—and prohibited by law from discussing the benefits of contraception—became increasingly widespread and teens' use of contraceptives was declining.⁹ Notably, California saw the steepest decline in their teen pregnancy rate between 1992 and 2005 (52% decline versus a national decline of 37%) and is the only state that never accepted federal abstinence-only-until-marriage funding from the failed Title V abstinence-only-until-marriage program. The state had ended its own experiment with ineffective abstinence-only-until-marriage programs in the mid-1990s, shifting its resources to comprehensive sex education programs.¹⁰

While making up only one-quarter of the sexually active population, young people ages 15–24 account for roughly half of the approximately 19 million new cases of STDs each year.¹¹ One in four young women ages 14–19 is infected with at least one STD.¹² Furthermore, an estimated 1.1 million people are currently

living with HIV/AIDS, with over 56,000 new infections every year. In 2006, the most recent year for which incidence data is available, the 13–29 age group was most affected, suffering 34% of the infections. This translates to one young person every hour becoming infected with HIV in the United States.¹³ Among that age group, HIV infection was most prevalent in Black/African American men and Hispanic/Latino women, with 42% and 34% of the infections, respectively.¹⁴ Men who have sex with men are also disproportionately affected—they account for 53% of all new HIV infections, even though they represent only four percent of the U.S. population aged 13 and over.

These statistics serve as a call to action for policymakers across the country and in Washington, DC to invest only in policies and programs that can truly change the course of young people’s health. Federal funding for more comprehensive approaches to sex education has not yet started getting out into communities but these trends certainly highlight the need for a significant and long-term investment in effective, evidence-based interventions that provide all young people with the age- and culturally appropriate information they need to lead healthy lives.

FEDERAL FUNDING FOR ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS SLASHED

In Fiscal Year 2009, there were three federal funding streams for abstinence-only-until-marriage programs, totaling over \$160 million: the abstinence-only-until-marriage portion of the Adolescent Family Life Act (AFLA) at \$13 million, the Title V abstinence-only-until-marriage funding at \$50 million, and the Community-Based Abstinence Education (CBAE) program at \$99 million. After nearly thirty years of federal funding and strong support by the federal government, and over one-and-a-half billion taxpayer dollars for these failed and ineffective programs, advocates briefly saw the end to all three funding streams, marking a notable shift in the federal approach to sex education and a significant win for sexual and reproductive health and rights advocates.

In December 2010, Congress passed the *Consolidated Appropriations Act of 2010*, which eliminated all discretionary funding for abstinence-only-until-marriage programs, including the entire CBAE grant program and the portion of AFLA that had been tied to the eight-point definition of abstinence-only-until-marriage programs. This bill marked the first time since 1981 that abstinence-only-until-marriage programs did not receive dedicated federal funding.

Created in 1981 under the Reagan Administration, AFLA was established to promote “chastity” and “self-discipline,” in addition to providing comprehensive support services to pregnant and parenting teens and their families. Since its inception, the prevention portion of AFLA, which was explicitly tied to the more stringent eight-point definition of “abstinence education” found in the Title V abstinence-only-until-marriage program in 1997, has received more than \$200 million. While the smallest and least restrictive of the three funding streams, it helped build the infrastructure for abstinence-only-until-marriage programs across the country. The CBAE grant program was created under the approving eye of the George W. Bush Administration to be the most restrictive of the three funding streams and eventually became the largest. By the end of the program, Congress had spent nearly three quarters of a billion dollars on CBAE grantees. While Fiscal Year 2009 grantees have two years from their grant date to spend out their funds, the elimination of the CBAE program has wielded a significant blow to the abstinence-only-until-marriage industry.

While AFLA and CBAE were actively eliminated by Congress, the Title V abstinence-only-until-marriage program was allowed to expire. This program was originally authorized for five years, 1998–2002. After years of continuing resolutions extending the program, it was officially reauthorized in July 2008 but only for a 12-month extension. When that year was up on June 30, 2009, Congress deliberately took no action, thereby allowing the program to expire. The Title V abstinence-only-until-marriage program did receive \$50 million in federal funds for Fiscal Year 2009 (the year covered by this edition of the profiles); however, due to the expiration, three months prior to the end of the federal fiscal year, the states that did accept the funding received three quarters of the total funding allocated for the full fiscal year.

At the first publication of the *State Profiles*, only three states were out of the Title V abstinence-only-until-marriage program. By the time the program expired in June 2009, nearly half the states had rejected

funding for this unsuccessful program. Of the states that refused the money at the time of the program's end, over 80 percent did so based on the strong research and evaluations showing that abstinence-only-until-marriage programs are incredibly ineffective. These principled rejections came from diverse parts of the country and were not unique to any one political party affiliation.

Unfortunately, since its expiration, there have been several attempts by conservative lawmakers to revive the Title V abstinence-only-until-marriage program. Much to advocates dismay, they were ultimately successful in resurrecting the program in late-fall 2009 when conservatives in the U.S. Congress, led by Senator Orin Hatch (R-UT), managed to insert funding for the Title V abstinence-only-until-marriage program in Senate health care reform legislation (the *Patient Protection and Affordable Care Act*) and the language remained in the final legislation signed by President Barack Obama. This extension equals another \$250 million for failed abstinence-only-until-marriage programs over the next five years (2010–2014).

How this program went from being left on the scrap heap to being included in the most ambitious and progressive social legislation in decades should baffle anyone who believes in putting science- and evidence-based decision making ahead of cheap political gimmicks. The Title V abstinence-only-until-marriage program was never about public health or even about pregnancy prevention—the creators of the program were clear, it “was intended to align Congress with the social tradition...that sex should be confined to married couples.”¹⁵ As such, it had absolutely no place as part of legislation dedicated to improving the health of our nation.

At the time of the writing of the Fiscal Year 2009 Edition of the *SIECUS State Profiles*, ACF has yet to issue a Request for Applications to the states and it is therefore unclear how the guidance issued by the Obama administration will read and how many states will reject the funding for Fiscal Year 2010. Regardless of the guidance issued, the Title V abstinence-only-until-marriage program will continue to require states to provide a match of three state dollars for every four federal dollars received. Recognizing the evidence and the severe fiscal and budget crises in nearly every state across the country, advocates across the country are working diligently to get the states to reject this flawed funding. The rejection of these funds will continue to be a strong statement that many states need funding for programs that work and not money for a failed experiment that had already run its course and should have been left for dead.

In all truth, abstinence-only-until-marriage programs were being taught in public schools long before the influx of federal money turned the mom and pop abstinence-only-until-marriage organizations into a billion dollar industry and they will be around once that federal money completely dries up. This industry is remarkably adaptable and will continue to re-market and re-brand its merchandise to fit the popular thinking and the available federal funding for teen pregnancy prevention and sex education. It has done it before—by taking away blatantly religious message (like the suggestion that young people take Jesus Christ on their dates for protection) and ridiculous medical misinformation (like the idea that young people who have had sex should wash their genitals with Lysol to prevent STDs)—and it's doing it again. Today, as the industry scrambles to stay relevant it has begun describing its programs as “holistic” and even comprehensive. But if you really delve past their marketing, into what these programs are saying to students, nothing has changed. They are the same fear- and shame- based programs they have always been.

FEDERAL FUNDING FOR TEEN PREGNANCY PREVENTION AND COMPREHENSIVE SEX EDUCATION

Over the past three decades, as the federal government was spending over \$1.5 billion on abstinence-only-until-marriage programs, an overwhelming body of evidence continued to build proving more comprehensive approaches to sex education effective. The federal government finally began heeding the evidence and the urgings of the nation's leading medical and public health organizations, parents, and advocates, and dedicated funding for more comprehensive approaches to sex education through two separate funding streams—the President's Teen Pregnancy Prevention Initiative and the Personal Responsibility Education Program—totaling nearly \$190 million.

President's Teen Pregnancy Prevention Initiative

When President Obama signed the *Consolidated Appropriations Act of 2010* in December 2009, it included \$114.5 million for the President's Teen Pregnancy Prevention Initiative (TPPI). \$110 million of this was designated for competitive contracts and grants to public and private entities for the purpose of funding medically accurate and age-appropriate programs that reduce unintended teen pregnancy.¹⁶ At least \$75 million is slated for replicating effective, evidence-based programs that have been proven to “reduce teenage pregnancy [and] behavioral risk factors underlying teenage pregnancy,” and at least \$25 million for testing additional models and innovative strategies. The remaining \$4.5 million is provided for program evaluation, including longitudinal evaluations, of teenage pregnancy prevention approaches. These funds are being administered by the newly established Office of Adolescent Health (OAH), which is coordinating with ACF and the CDC on implementing the initiative. OAH has already released three Funding Opportunity Announcements—Tier 1 for evidence-based programs, Tier 2 for innovative approaches, and Tier 3 for community-wide approaches—and grants will be awarded by September 30, 2010. Given the number of applications OAH has received, it is clear that public health agencies, community-based organizations, and public schools across the country are hungry for funding to implement effective and innovative comprehensive programs.

While a significant departure from the CBAE program of the Bush Administration, the White House, unfortunately, focused the funding solely on teen pregnancy prevention, and did not explicitly address the equally important health issues of STDs, including HIV, or require discussion of both abstinence and contraception, as so many advocates were urging them to do. With limited resources, the Obama administration and Congress missed an opportunity to provide true, comprehensive sex education that promotes healthy behaviors and relationships for all young people, including lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, and addresses the inter-related health needs of adolescents, including the prevention of unintended pregnancy, HIV, other STDs, as well as healthy relationships, and other topics. It is worthwhile to note that OAH worked with Mathematica Policy Research to create a list of evidence-based programs for use by Tier 1 grantees. Of the 28 programs on the list, the vast majority are STD- and HIV-prevention programs that grantees will be required to replicate with fidelity, yet applicants are still required to walk through a teen pregnancy prevention door in order to apply for program funds.

Given that over half of young people have had sexual intercourse by the age of 18 and are at risk of both unintended pregnancy and STDs, including HIV, in order to strategically and systemically provide young people with all the information and services they need to make responsible decisions about their sexual health, the President's TPPI must be broadened to focus on implementing efficient and effective comprehensive sexuality education programs, insofar as they address the delay of sexual initiation and the use of condoms and other forms of contraception for the prevention of unintended pregnancy, HIV, and other STDs. Without this comprehensive requirement on the TPPI, many advocates are concerned that previous CBAE grantees will be wolves donning their best sheep clothing, presenting themselves as holistic and focused on evidence-based programming when in reality they are the same purveyors of fear- and shame-based misinformation they have always been.

For Fiscal Year 2010, the first year of funding for the program, the President's Teen Pregnancy Prevention Initiative received \$114.5 million. The President requested an increase of \$19.2 million in his Fiscal Year 2011 budget request, for a total of \$133.7 million.

Personal Responsibility Education Program

Following months of negotiations and partisan bickering, President Obama signed health care reform legislation, the *Patient Protection and Affordable Care Act* (P.L. 111-148), into law on March 23, 2010. While the law unfortunately included the Title V abstinence-only-until-marriage program, it also created the Personal Responsibility Education Program (PREP), which will offer individual states grants for comprehensive sex education programs that provide young people with complete, medically accurate, and age-appropriate sex education in order to help them reduce their risk of unintended pregnancy, HIV/AIDS, and other STDs. Programs funded by PREP are also required to foster development of life skills so that young people can

make informed decisions and lead safe and healthy lives. The program was offered as an amendment to the Senate health care reform legislation by Senator Max Baucus (D-MT).

The program totals \$75 million per year in mandatory funding for the period 2010–2014 and, with just over \$55 million of it dedicated to state grants, it will go a long way toward creating the infrastructure necessary to institutionalize comprehensive sex education in states across the country. Recognizing that not all states will follow the evidence and act in the best interest of young people by applying for PREP funding, drafters of the legislation included a provision that allows funding to trickle into the state even if the state government does not apply. If a state does not submit an application for Fiscal Years 2010 or 2011, it will become ineligible to apply for funding, and the Secretary of HHS will be able to award three-year grants to community-based and faith-based organizations and local entities in that state using the allotted funds for Fiscal Years 2012–2014. Drafters of the legislation were also careful to define key terms in the legislation—such as “age appropriate” and “medically accurate and complete”—with the hope that programs funded under this legislation would not fall prey to the same misinformation and misuse of taxpayer dollars as federally funded abstinence-only-until-marriage programs. PREP also includes much needed funding dedicated to tribes and tribal organizations, research and evaluation, and innovative approaches (which has been combined with the Tier 2 funding from the President’s Teen Pregnancy Prevention Initiative).

At the time of this writing, with the exception of the \$10 million for innovative approaches, ACF, which is tasked with administering the program, has yet to release guidance or Requests for Applications for the remaining PREP funding. PREP funds are required to be allocated before the end of the federal government’s Fiscal Year, which occurs on September 30, 2010. In our tradition of “following the money,” SIECUS will include all federal funding grantees under both the President’s Teen Pregnancy Prevention Initiative and PREP in the Fiscal Year 2010 Edition of the *SIECUS State Profiles*.

ADVANCES IN THE STATES: BEST PRACTICES AND MODEL POLICIES

While shifts at the national level have been significant, states across the country continue to lead the way in advancing policy and implementation of more comprehensive approaches to sex education. In the past year states and communities have created and passed a number of model policies and programs that can serve as best practices to be replicated by others across the country. We have seen states reject failed abstinence-only-until-marriage policies that we saw proliferate during the Bush administration in favor of more comprehensive sex education and pass requirements that states only apply for the more comprehensive pots of federal funding. Some have also been pushing the boundaries of what a state or community can accomplish in their efforts to implement comprehensive sexuality education in public schools, even, in some cases, in unsupportive climates.

Best Practices through Coordinated Efforts

Oregon continues to be a leader in the field of sexuality education and, in the last year, demonstrated the progress a state can achieve through concrete collaboration among all relevant players in sexual and public health and education. In 2008, the Oregon Department of Human Services released the *Oregon Youth Sexual Health Plan*, a strategic action plan to holistically address sexual health for youth. The *Plan* was created by the Teen Pregnancy Prevention/Sexual Health Partnership (TPP/SHP), a statewide coalition made up of employees of the state departments of health and education, county health departments, and teen pregnancy prevention, HIV/AIDS prevention, and adolescent sexual health organizations.¹⁷ It goes beyond the “disaster prevention” focus of many public health policies, advocating for policies that recognize the intersecting social issues contributing to negative sexual health outcomes among young people, and calls for mandatory comprehensive sexuality education in schools. In May 2009, the Oregon State government made this a reality by passing legislation requiring that comprehensive, age-appropriate, and medically accurate sexuality education be taught in all public elementary and secondary schools as an integral part of the health education curriculum.¹⁸ The Oregon State Board of Education then bolstered the legislative effort by approving revisions to the Human Sexuality Education administrative rule, further strengthening the state’s comprehensive sex education policy and aligning the state’s education standards with the updated state law.

On the other side of the country, the District of Columbia worked on a similar strategy. Prompted by the HIV/AIDS rate in Washington, DC—at least three percent of District residents have HIV or AIDS, a total that far surpasses the one percent threshold that constitutes a “generalized and severe” epidemic—the Mayor, the Office of the State Superintendent, and the District’s State Board of Education developed health standards for public schools that included HIV/AIDS-prevention education.¹⁹ Working in collaboration with local youth and HIV/AIDS organizations, public health officials, and national sexual and reproductive health organizations, the government created health standards that outline concepts and skills that students should gain in grades Pre-K–12 and include comprehensive sexuality education as a core content area. These standards were adapted from a number of sources, including the *Indiana Academic Standards for Health Education*, the *New Jersey Health Frameworks*, and the *SIECUS Guidelines for Comprehensive Sexuality Education*. Since the passage of the standards, District administrators and teachers have worked with the DC Healthy Youth coalition, a local coalition of youth development, sex education, teen pregnancy, and HIV/AIDS prevention education advocates, to implement three existing HIV/AIDS and sex education curricula in the schools.²⁰

Ideally other states and communities will build on these best practices and take action long before they have an HIV/AIDS rate similar to that of Washington, DC.

Model Policies in Unfavorable Climates

Cleveland, Ohio not only provides another example of what the coordination of relevant players, and a strong Mayor, can accomplish but also reveals another trend—even in states with less-than-favorable political climates or policies on the books (such as those that mirror federal definitions of abstinence-only-until-marriage programs), communities are passing model policies and implementing comprehensive sex education in public schools. Ohio does not require schools to teach sexuality education; however, each school district’s board of education is required to establish a health curriculum that closely mirrors the federal definition of “abstinence education.” Despite this, when the Cleveland Metropolitan School District (CMSD) adopted a district-wide Comprehensive Health Plan in 2002, outlining critical objectives for improving the health and well-being of “the District’s students, families, and staff,” it included four overarching goals related to responsible sexual behavior that take a comprehensive line.²¹ In accordance with these goals, and with the support of a public/private partnership, CMSD developed a Responsible Sexual Behavior Initiative for grades K–12 that was first implemented in schools during the 2006–2007 school year, using modified versions of four evidence-based curricula and promising models. The program is currently in its third year of implementation and evaluation of the program continues.

Similarly, though Florida state law requires an abstinence-only-until-marriage approach, a growing number of Florida school districts are revising their health education policies to eliminate such requirements and implement more comprehensive sex education. Bucking the discriminatory nonsense coming from the state capitol, at least six school districts have adopted more comprehensive sex education policies since 2007, and more are continuing to move in this direction. Likewise, in Pennsylvania a state that has received over \$8 million in direct federal earmarks for abstinence-only-until-marriage programs since 2004, the Pittsburgh Public Schools School Board overturned its abstinence-only-until-marriage policy and adopted a new, comprehensive sexuality education policy for grades K-12.²²

Updated Education Standards

As an untested subject, in many states sexuality education falls out of the scope of typical education content standards. Some states and localities, however, recognize that just like math or English, for example, health and sex education is a necessity if students are going to achieve the highest academic success possible. To ensure that this topic is taught successfully, these states have begun adopting or revising content standards. New Jersey, a leader in comprehensive sexuality education, recently revised its content standards. The *2009 New Jersey Core Curriculum Content Standards* establish “21st-century” knowledge, skills, concepts, “global perspectives,” and technology expectations for students in pre-school through grade 12. The standards address nine education content areas, including Comprehensive Health and Physical Education, which

includes families, relationships, gender, puberty, human sexuality, pregnancy, parenting, STD and HIV/AIDS prevention, risk behaviors, and risk-reduction.²³

South Carolina also updated its content standards in 2009 and based them off the revised *National Health Education Standards* developed by the Division of Adolescent and School Health at the CDC. The *2009 South Carolina Academic Standards for Health and Safety Education* serve as a framework for the development of locally produced curricula and includes a content area titled “Growth, Development, and Sexual Health and Responsibility.” The standards include “performance indicators” that address a variety of sexuality education topics, including growth and development, puberty, families, healthy relationships, abstinence, and “strategies” for the prevention of STDs, HIV/AIDS, and unintended pregnancy.

In addition, in December 2008, the Colorado State Board of Education voted to develop the state’s first-ever health education standards. The revised standards, the *Comprehensive Health and Physical Education Standards*, establish learning expectations for grades K–8 and high school. Standards related to human sexuality set grade-level expectations for students’ abilities to use decision-making skills and make healthy decisions about relationships and sexual health.

Legislative Advances

Several states across the country also saw varying degrees of success in the legislative arena. Some states passed model legislation requiring sexuality education to be comprehensive, if taught. For example, in July 2009, Hawaii enacted legislation, after the legislature overrode the Governor’s veto, that requires groups that receive state funding for sex education to provide instruction that is medically accurate and age-appropriate and teaches facts about abstinence, as well as contraception, for the prevention of unintended pregnancy and STDs, including HIV. Wisconsin passed its *Healthy Youth Act* in February 2010, which requires school districts that offer instruction on human sexuality to provide medically accurate, age-appropriate, comprehensive sexuality education that addresses the benefits of abstinence, the benefits and proper use of contraceptives and barrier methods, and other topics such as positive youth development and healthy relationships. In addition, the bill also amends current statute to require the state to apply for federal funds to be used for evidence-based teen pregnancy prevention programs.

In North Carolina, advocates worked to pass legislation that expands the requirements for human sexuality instruction provided in public schools and amends the state’s former abstinence-only-until-marriage policy to provide young people with a more comprehensive approach to sex education. In passing the *Healthy Youth Act*, which was signed by the Governor in June 2009, North Carolina made a significant advance in its fight for comprehensive sexuality education. While the program remains part of a larger reproductive health education curriculum that retains the abstinence-only-until-marriage focus, the new law requires all school systems to offer information to students in seventh, eighth, and ninth grade about the use of contraceptives for pregnancy and STD prevention. The new law will go into effect for the 2010–2011 school year.

Advocates in Florida worked with the legislature to introduce the *Healthy Teens Act*, which recognizes that, in order to be competitive for the new federal funding coming down the pike, the state must invest in effective models for pregnancy and disease prevention. In this vein, the bill requires any school that receives state funding and offers sex education programs to provide comprehensive, medically accurate, and age-appropriate information. Pennsylvania, Kentucky, and Louisiana, as well as Hawaii and Wisconsin, went one step further in their respective pieces of comprehensive sex education legislation, including language that would require funding allocated for sex education to support medically accurate, evidence-based, and comprehensive programs. Finally, Washington State was even more specific, passing legislation, signed by the Governor in April 2009, which prohibits the state from seeking federal abstinence-only-until-marriage funds. The bill requires state agencies to apply only for sexual health education funding for programs that are medically and scientifically accurate, including, but not limited to, programs on abstinence, the prevention of STDs, and the prevention of unintended pregnancies.

CONCLUSION

We are witnessing a fundamental paradigm shift in Washington, DC and in states and communities across the country when it comes to our nation's approach to sex education; but we need to continue to push the boundaries and break new ground, looking for new opportunities to advance comprehensive sex education, such as the National HIV/AIDS Strategy and education reform efforts. And, as progress comes, we have seen the actions and rhetoric of the abstinence-only-until-marriage industry get more anxious and wily. Despite the fact that abstinence-only-until-marriage programs are ineffective and violate mainstream American values by censoring information, misinforming students, and leaving young people at risk, they continue to prosper in some areas, particularly in the South. These extreme voices continue to call for taxpayer dollars and, make no mistake, will do whatever they can to continue to wreak havoc. We must remain vigilant in our efforts to provide young people with the information and knowledge they need to be safe and healthy, and give them the tools and skills they need to empower themselves to success.

In continuing to learn from, and strategize with, each other, building off best practices and models of success, we will triumph. We have not yet reached our ultimate goal of comprehensive age- and culturally appropriate, evidence-based sex education for all school-age youth, but we have shown that we are on the right track and our strategies are working; and if the Obama administration continues to be serious about science and evidence, eschewing the ideological advances of a desperate minority, then abstinence-only-until-marriage programs can be truly eliminated and comprehensive approaches to sex education allowed to flourish.

¹ Preventive Health Amendments of 1992, Public Law 102-531

² *Ibid.*

³ Danice K. Eaton, et al., "Youth Risk Behavior Surveillance—United States, 2009," *Surveillance Summaries, Morbidity and Mortality Weekly Report* 59.SS-5 (4 June 2010), accessed 14 June 2010, <<http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>>, Table 62.

⁴ *Ibid.*, Table 64.

⁵ Danice K. Easton, et al., "Youth Risk Behavior Surveillance—2009."

⁶ Joyce A. Martin, et al., "Births: Final Data for 2006," *National Vital Statistics Reports*, vol. 56, number 6 (Hyattsville, MD: Centers for Disease Control and Prevention, 7 January 2009), accessed 5 March 2010, <http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf>, Table B.

⁷ Lawrence B. Finer, et al., "Disparities in rates of unintended pregnancy in the United States, 1994 and 2001," *Perspectives on Sexual and Reproductive Health* 2006; 38(2):90–96, accessed 13 June 2008, <<http://www.guttmacher.org/ppubs/psrh/full/3809006.pdf>>.

⁸ Lawrence B. Finer, *Unintended pregnancy among U.S. adolescents: accounting for sexual activity* (New York: Guttmacher Institute, 2010), accessed 17 May 2010, <<http://www.guttmacher.org/pubs/journals/JAH-Unintended-pregnancy.pdf>>, 4; *see also*, Figure 2.

⁹ Guttmacher Institute, "Following Decade-Long Decline, U.S. Teen Pregnancy Rate Increases as Both Births and Abortions Rise," Press Release, 26 January 2010, accessed 13 June 2010, <<http://www.guttmacher.org/media/nr/2010/01/26/index.html>>.

¹⁰ Heather Boonstra, "Winning Campaign: California's Concerted Effort to Reduce Its Teen Pregnancy Rate," *Guttmacher Policy Review*, Spring 2010, Volume 13, Number 2, accessed 14 June 2010, <<http://www.guttmacher.org/pubs/gpr/13/2/gpr130218.html>>.

¹¹ Hillard Weinstock et al., "Sexually transmitted diseases among American youth: incidence and prevalence estimates," 2000, *Perspectives on Sexual and Reproductive Health*, 2004, 36(1):6–10.

¹² "Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis among Female Adolescents in the United States: Data from the National Health and Nutritional Examination Survey (NHANES) 2003–2004, Centers for Disease Control and Prevention, 2008 National STD Conference, Chicago, IL, accessed 13 June 2010, <<http://cdc.confex.com/cdc/std2008/webprogram/paper14888.html>>.

¹³ *HIV/AIDS Surveillance Report, 2006*, (Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2008); 18:11.

¹⁴ "Estimated Percentage of New HIV Infections by Race/Ethnicity, Sex and Age—United States, 2006," Centers for Disease Control and Prevention, accessed 15 June 2010, <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/incidence/slides/HIV-Incidence_10.ppt>.

¹⁵ Ron Haskins and Carol Statuto Bevan, "Abstinence education under welfare reform," *Children and Youth Services Review*, 1997, 19(5/6):465–484.

¹⁶ Consolidated Appropriations Act, 2010, Pub. L. No. 111–117, 123 Stat. 3253, accessed 8 June 2010, <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ117.111.pdf>.

¹⁷ Oregon Youth Sexual Health Plan, (Salem, OR: Oregon Department of Human Services, 2008), accessed 19 April 2010, <<http://www.oregon.gov/DHS/children/teens/tpp/yhsp-021109.pdf>>, 8.

¹⁸ See SIECUS' June 2009 Policy update, "New Sex Ed Laws Pass in Oregon and North Carolina," Ore. Rev. Stat. § 336.455.

¹⁹ Phone conversation between Morgan Marshall and Adam Tenner, executive director of Metro TeenAIDS, 7 April 2010.

²⁰ *Health Education Standards*, (Washington, DC: DC Office of the State Superintendent of Education, August 2008), accessed 15 April 2010, <<http://dcps.dc.gov/DCPS/Files/downloads/TEACHING%20&%20LEARNING/Learning%20Standards%202009/DCPS-HEALTH910-STANDARDS.pdf>>; *Ibid.*

²¹ *Status of Implementation of the Comprehensive Health Plan: A Report Card*, (Cleveland, Ohio: Cleveland Municipal School District, 2006), accessed 3 May 2010, <<http://www.communitysolutions.com/images/upload/resources/CompHealthReportCard06.pdf>>, 2.

²² School District of Pittsburgh, School Board Policy No. 135, Comprehensive Sexuality Education, adopted 24 February 2009, accessed 5 May 2010, <http://www.pps.k12.pa.us/pps/lib/pps/ComprehensiveSexualityEducation%202_2_.pdf>, 1.

²³ 2009 *New Jersey Core Curriculum Content Standards*, (Trenton, NJ: New Jersey Department of Education, 2009), accessed 20 May 2010, <<http://www.njcccs.org/Worldclassstandards.aspx>>.