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Effective Sex Education

The Facts

Each year, U.S. teens experience as many as 850,000 pregnancies, and youth under age 25 experience about 9.1 million sexually transmitted infections (STIs).[1,2] By age 18, 70 percent of U.S. females and 62 percent of U.S. males have initiated vaginal sex.[3] Comprehensive sex education is effective at assisting young people to make healthy decisions about sex and to adopt healthy sexual behaviors.[4,5,6,7] No abstinence-only-until-marriage program has been shown to help teens delay the initiation of sex or to protect themselves when they do initiate sex.[8,9,10,11] Yet, the U.S. government has spent over one billion dollars supporting abstinence-only-until-marriage programs.[12] Although the U.S. government ignores it, adolescents have a fundamental human right to accurate and comprehensive sexual health information.[8,11]

Comprehensive Sex Education Is Effective, Does Not Promote Sexual Risks.

- Research has identified highly effective sex education and HIV prevention programs that affect multiple behaviors and/or achieve positive health impacts. Behavioral outcomes have included delaying the initiation of sex as well as reducing the frequency of sex, the number of new partners, and the incidence of unprotected sex, and/or increasing the use of condoms and contraception among sexually active participants.[4,5,6,7] Long-term impacts have included lower STI and/or pregnancy rates.[4,5,6,7]
- No highly effective sex education or HIV prevention education program is eligible for federal funding because mandates prohibit educating youth about the benefits of condoms and contraception.[13]
- Evaluations of comprehensive sex education and HIV/STI prevention programs show that they *do* ***not*** increase rates of sexual initiation, *do not* lower the age at which youth initiate sex, and ***do not*** increase the frequency of sex or the number of sex partners among sexually active youth.[4,5,6,7,14,15]
- Between 1991 and 2004, the U.S. teen birth rate fell from 62 to 41 births per 1,000 female teens.[16,17] Some experts attribute 75 percent of the decline to increased contraceptive use and 25 percent to delayed initiation of sex.[18] Others credit increased contraceptive use and delayed initiation of sex about equally.[19] Regardless, contraceptive use has been critical to reducing teenage pregnancy.

Abstinence-Only Programs Are Dangerous, Ineffective, and Inaccurate.

- The Society for Adolescent Medicine recently declared that "abstinence-only programs threaten fundamental human rights to health, information, and life."[8,11]
- According to Columbia University researchers, virginity pledge programs increase pledge-takers' risk for STIs and pregnancy. The study concluded that 88 percent of pledge-takers initiated sex prior to marriage even though some delayed sex for a while. Rates of STIs among pledge-takers and non-pledgers were similar, even though pledge-takers initiated sex later. Pledge-takers were less likely to seek STI testing and less likely to use contraception when they did have sex.[20,21]
- Evaluations of the effectiveness of state-funded abstinence-only-until-marriage programs found no delay in first sex. In fact, of six evaluations that assessed short-term changes in behavior, three found no changes, two found *increased* sexual activity from pre- to post-test, and one showed mixed results. Five evaluations looked for but found *no* long-term impact in reducing teens' sexual activity.[9]
- Analysis of data from the Youth Risk Behavior surveys found that sexual activity among high school youth declined significantly from 1991 to 1997, prior to large-scale funding of abstinence-only-until-marriage programs, but changed little from 1999 to 2003, with federal funding of such programs.[22]
- Analysis of federally funded abstinence-only curricula found that over 80 percent of curricula supported by the U.S. Department of Health & Human Services contained false, misleading, or distorted information about reproductive health. Specifically, they conveyed:
  - False information about the effectiveness of contraceptives;
  - False information about the risks of abortion;
  - Religious beliefs as scientific fact;
  - Stereotypes about boys and girls as scientific fact; and
  - Medical and scientific errors of fact.[23]

Medical Organizations, Parents, and the Public Support Comprehensive Sex Education.

- The American Academy of Pediatrics, American College of Obstetricians & Gynecologists, American Medical Association, American Public Health Association, Institute of Medicine, and Society for Adolescent Medicine, among others, support comprehensive sex education, including education about *both* abstinence *and also* contraception and condoms.[1,10,11,24,25]
- In one study, most American adults supported sex education that includes information about both abstinence and also contraception and condoms. In fact, 89 percent believed that it is important for young people to have information about contraception and prevention of STIs and that sex education should focus on how to avoid unintended pregnancy and STIs, including HIV.[26]
- In another recent survey, 94 percent of adults and 93 percent of parents said that sex education should cover contraception. Only 15 percent of Americans wanted abstinence-only education taught in the classroom.[27]

Characteristics of Effective Sex Education

Experts have identified critical characteristics of highly effective sex education and HIV/STI prevention education programs. Such programs:

1. Offer age- and culturally appropriate sexual health information in a safe environment for participants;
2. Are developed in cooperation with members of the target community, especially young people;
3. Assist youth to clarify their individual, family, and community values;
4. Assist youth to develop skills in communication, refusal, and negotiation;
5. Provide medically accurate information about both abstinence and also contraception, including condoms;
6. Have clear goals for preventing HIV, other STIs, and/or teen pregnancy;
7. Focus on specific health behaviors related to the goals, with clear messages about these behaviors;
8. Address psychosocial risk and protective factors with activities to change each targeted risk and to promote each protective factor;
9. Respect community values and respond to community needs;
10. Rely on participatory teaching methods, implemented by trained educators and using all the activities as designed.[4.,5,6,7,10,14,]

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