
Report on Abstinence-Only-Until-Marriage Programs in Ohio

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EXECUTIVE SUMMARY

This report investigates the nature and impact of abstinence-only-until-marriage programming in the state of Ohio and was initiated as a result of concerns raised at the national level regarding the implications of abstinence-only-until-marriage curricula. Such scrutiny is warranted because Ohio ranks 4th in the nation in tax dollars expended for abstinence education; because these curricula are now implemented in at least 84 of Ohio's 88 counties; because rates of teen pregnancy and STD in Ohio remain high; and because \$455,000 of state tax dollars are scheduled to be allocated toward abstinence-only-until-marriage education. Significant federal and state funding increases, when considered with the actual rate of sexual activity and the emerging research on outcomes associated with abstinence-only-until-marriage programs, warrant a critical examination of funded programs, their scientific accuracy, and the messages they convey to youth.

In fiscal year 2005, the federal government will spend about \$186 million on abstinence-only-until-marriage programs—more than twice as much as it spent in 2001. Currently, abstinence-only-until-marriage programs are taught in about one third of US schools, reaching approximately 8 million students. However, in 2003 nationally, 44% of students in grades 9-12 report that they have experienced sexual intercourse and nearly 20% of female teens who have had sexual intercourse become pregnant each year. In Ohio, 42% of students report having engaged in sexual intercourse (42.7% of females, 40.4% of males). Of Ohio students that are sexually active, 40% report not using a condom at last sexual intercourse and 74% report not using oral contraceptives.¹ Though abstinence-only-until-marriage is described by these programs as the expected norm, nationally 88% of women reporting sexual activity relate their first voluntary intercourse prior to marriage, including 95% of women aged 20-24 years and 98.5% of women younger than 20 years.²

This report reviews the abstinence-only-until-marriage curricula and supplementary programs utilized by a variety of publicly-funded organizations in Ohio. The two critical questions regarding these curricula involve the effectiveness of such programs; and the accuracy and nature of the content. Because research investigation into the comparative effectiveness of abstinence-only-until-marriage curricula is still ongoing, this report examines this issue briefly, then focuses primarily on the content of the curricula.

It is important to acknowledge that an abstinence orientation to sexual education has been convincingly demonstrated to delay onset of sexual intercourse. It is equally important to recognize that concerns about “mixed messages” offered regarding inclusion of a strong abstinence message in the same educational program that includes information about condom use and contraception appear unfounded.³ “Abstinence plus” programs that offer both of these features have strong scientific support for delaying the onset of intercourse, decreasing teen pregnancy, and decreasing the rate of STD.⁴ There is less investigation of abstinence-only-until-marriage programs available for evaluation. Recent evidence however indicates that though abstinence-only-until-marriage programs may delay the onset of sexual activity, participants experience no decrease in rates of sexually transmitted

¹ Youth Risk Behavior Surveillance—United States 2003, Morbidity and Mortality Weekly, www.cdc.gov

² Abma JC, et al. Fertility, Family Planning, and Women's Health: New Data from the 1995 National Survey of Family Growth. Vital and Health Statistics, 23(19). Washington DC: National Center for Health Statistics

³ Stammers, TG. Abstinence Under Fire, *Postgraduate Medical Journal* 2003;79:365-366

⁴ Fortenberry, JD. The limits of abstinence-only in preventing sexually transmitted infections. *Journal of Adolescent Health*, 36 (2005) 269-270

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diseases; are less likely to use condoms when they initiate sex; are less likely to seek testing for STDs; and more likely to participate in sexual behaviors other than vaginal intercourse, such as oral and anal sex, presumably in an effort to maintain “virginity”.⁵

The issue is not only the general effectiveness of the abstinence-only-until-marriage approach, but the accuracy and veracity of Ohio’s abstinence-only-until-marriage programs. Critical problems are identified with a number of Ohio programs, with material evaluated that contains false and misleading information regarding sexual health and wellness. This report concludes that the Ohio abstinence-only-until-marriage curricula:

- Contain false information about contraceptives
- Contain false information about abortion
- Misrepresent religious convictions as scientific fact
- Perpetuate destructive, inaccurate gender stereotypes
- Do not portray the risks related to sexual activity in a scientifically accurate manner
- Disregard the needs of the youth at risk for STD and pregnancy
- Do not provide information for Lesbian, Gay, Bisexual, Transgender (LGBT) populations
- Stand in contrast to the desire of the majority of parents, who want children to receive education about both abstinence *and* about prevention of pregnancy and sexually transmitted disease
- May be taught by instructors that are not trained as health educators.

The issue is not whether sexual education should include a strong abstinence message, but whether the restrictive, narrowly defined abstinence-only-until-marriage approach represents the most effective way to communicate this key message. As such this report recommends that Ohio sexual education programming:

- Revise the content requirements of abstinence-only-until-marriage curricula to address the educational needs of all youth
- Provide information on contraception and protection from sexually transmitted infections for youth who are not abstinent
- Implement third-party scientific review of abstinence-only-until-marriage curricula
- Establish standards of competence for Ohio abstinence-only-until-marriage instructors
- Offer parents a more prominent role in determining the nature of sexual education received by their children.
- Offer more resources for LGBT youth

⁵ Bruckner H, Bearman P. After the promise: the STD consequences of adolescent virginity pledges. *Journal of Adolescent Health* 36 (2005) 271-278

Introduction

With the introduction Adolescent Family Life Act (AFLA), signed into law in 1981 during the Reagan presidency, the federal government for the first time began to invest in small scale local programs intended to prevent teen pregnancy through advocating for sexual “chastity and self discipline” among teens. Twenty years and more than 1 billion dollars later,⁶ this small social experiment has resulted in 3 distinct federal funding streams for what has now evolved into “abstinence-only-until-marriage” sexual education movement. Funding accelerated in 1996 during the Clinton presidency with the passage of the abstinence-only-until-marriage initiative (Section 510(b) of Title V) of the Social Security Reform Act.

The 1990’s have been described as the “What Works?” era, with an increased sense of accountability for public health programming in recognition of the increasing stock of knowledge regarding program effectiveness, and the decreasing availability of funds to support community health. Programs addressing prevention of substance abuse, violence, tobacco use, and underage drinking were often (and understandably) restricted in approach to using “programs that work”. In contrast, growth in abstinence-only-until-marriage funding has occurred despite a relative lack of scrutiny and evidence supporting its comparative effectiveness. Simultaneously, the nature the content of abstinence-only-until-marriage curriculum have raised concerns regarding the likelihood of stigma and disenfranchisement of students who do not share the religious, cultural, and ideologically narrow message proffered by these programs.⁷

School-based sexual health education can be categorized into three groups:

- Comprehensive sexual education
- Abstinence-only-until-marriage education
- Abstinence-plus education

Comprehensive Sexual Education

Comprehensive sexual education (sometimes referred to as “safer sex” education) represents the descriptor for virtually all school-based programming prior to the introduction of abstinence-only-until-marriage programs. “The primary goal of sexuality education is the promotion of adult sexual health. It assists children in understanding a positive view of sexuality, provides them with information and skills about taking care of their sexual health, and helps them acquire skills to make their decisions now and in the future. They are based on four primary goals: [information; attitudes, values, and insights; relationships and interpersonal skills; and responsibility].”⁸ Comprehensive sexual education was never intended to supplant family values, but rather to provide adolescents with the tools to integrate these values into their daily lives.

Comprehensive sexual education programs are often blamed by abstinence-only-until-marriage advocates for the increase in sexual activity from 1960 to 1990, disregarding concurrent cultural changes resulting from the “sexual revolution,” with a constant stream of mixed messages presented to teens from their own parents, corporate America, the entertainment industry, and the

⁶ Ed Bradley, *The Pledge*. 60 Minutes Transcript May 22, 2005

⁷ Waxman, H. Content of Federally Funded Abstinence-Only Programs, WWW.DEMOCRATS.REFORM.HOUSE.GOV

⁸ Sexuality Information and Education Council of the United States, www.siecus.org

advertising industry. While studies indicate that comprehensive sexual education was not responsible for the increase in sexual behavior, it must be acknowledged that it also did nothing to *decrease* teen sexual behavior. Historically, comprehensive sexual education programs did not emphasize or promote abstinence, but included it only as one choice in a spectrum of options that teens could make. Comprehensive sexual educational programs advocate that teens should not experience unwanted pregnancy and sexually transmitted disease. In contrast, abstinence oriented programming advocates that teens should not have sex. Comprehensive sexual education programs have tended to ignore the need to provide permission to teens preferring to choose abstinence to make this choice in a supported, socially acceptable manner.

Comprehensive sexual education programs are based on core values that include:⁹

- Every individual has dignity and self worth
- Sexual relationships should never be coercive or exploitive
- All sexual decisions have consequences
- Every person has the right and obligation to make responsible sexual choices

Abstinence-Only-Until-Marriage Sexual Education

Funded **abstinence-only-until-marriage education** programs are subject to regulations detailed below regarding the nature of what must and must not be included. In general, these programs include discussion of values, character building, and refusal skills. These programs focus, “wholly on encouraging teenagers not to have sex, providing a rationale for this lifestyle choice, and equipping them with skills such as assertiveness and self esteem to fulfill this goal.”¹⁰ They argue that sex outside of marriage is inappropriate or immoral and that abstinence is the only 100% effective way to prevent unwanted teen pregnancy or sexually transmitted diseases. As such, virginity, abstinence, or chastity pledges are a prominent component of these programs. Abstinence-only-until-marriage education programs express concern that offering information about sex, contraception and sexually transmitted diseases can encourage sexual activity among teens, a concern disputed by objective scientific evidence in existing research.¹¹

Abstinence-only-until-marriage programs, “Attempt to use fear and shame as a deterrent to sexual activity. Provide nothing for students who choose to remain sexually active. Frequently place the responsibility for sexual behavior on the female only. Omit vital health information. And often contains sexist, racist and/or heterosexist stereotypes.”¹² Instruction about health benefits of contraception or condom use is specifically prohibited in federally funded abstinence-only-until-marriage programs. These programs tend to ignore the needs of teens that are already sexually active; who have already been pregnant or given birth; who initially conform to abstinence messages, but later become sexually active; or for whom marriage is not likely or not possible, such as gay or lesbian students. An Ohio constitutional amendment prohibits same-sex marriage. These educational programs also emphasize offering sexually active teens a second chance for abstinence, and assert that they also serve at-risk populations.

⁹ Alford, S. What’s Wrong with Federal Abstinence Only Until Marriage Reuirements? Advocates for Youth, www.advocatesforyouth.org

¹⁰ Stammers, TG. Abstinence Under Fire, *Postgraduate Medical Journal* 2003;79:365-366

¹¹ Kirby, D. Emerging Answers: Research Findings on programs to prevent teen pregnancy, National Campaign to Prevent Teen Pregnancy, May, 2001

¹² HIV Prevention and the Place of Abstinence, National AIDS Trust Discussion Paper, nat.org.uk, June 23, 2004

Abstinence-only-until marriage programs:

- Promote abstinence from sexual activity
- Do not acknowledge that many teens will become sexually active
- Do not teach about contraception or condom use, except in the context of the failure of these methods
- Avoid discussion of abortion
- Avoid definition of “sexual activity,” concerned that mentioning topics such as masturbation, mutual masturbation, oral sex or anal sex would represent a guide to sexual activity
- Teach about sexually transmitted diseases and HIV/AIDS only as a reason to avoid sexual activity

Abstinence Plus Sexual Education Programs

Abstinence plus sexual education programs (inaccurately equated with comprehensive sexual education by some), “present the same message that abstinence is the safest form of protection against pregnancy and sexually transmitted infections but also provide information and advice on contraception.”¹³ These programs represent an evolution of comprehensive sexual education programs to include lessons learned from abstinence-only-until marriage programs about the importance and validity of offering teens a strong abstinence message. Such programs acknowledge that, “the vivid national dialogue about the content of sexually transmitted infection prevention messages for adolescents has helped create a social environment in which abstinence, until an older age or until marriage, is a relevant choice.”¹⁴ Abstinence plus programs acknowledge the central fact that more than 40% of students are or will become sexually active, and that “...absolutist approaches to STI prevention, whatever their moral, religious, or philosophic origins, incompletely serve those at risk.”¹⁵

Abstinence plus programs are criticized by abstinence-only-until marriage advocates for offering a dual message,¹⁶ despite evidence from research that teens have the capability to comprehend a hierarchy of risk, rather than requiring unconditionally extreme viewpoints in order to benefit. To the point, as discussed further below, in peer reviewed research publications, abstinence plus programs demonstrate the capacity to both delay the onset of sexual intercourse and decrease the incidence of teen pregnancy and sexually transmitted disease.

Abstinence plus sexual education programs:¹⁷

- Promote abstinence from sexual activity
- Acknowledge that many teens will become sexually active
- Teach about health benefits and risks of contraception or condom use
- Include discussion about abortion, STDs, and HIV/AIDS

¹³ Stammers, TG. Abstinence Under Fire, *Postgraduate Medical Journal* 2003;79:365-366

¹⁴ Fortenberry, JD. The limits of abstinence-only in preventing sexually transmitted infections. *Journal of Adolescent Health*, 36 (2005) 269-270

¹⁵ Ibid

¹⁶ Federal funding information, National Coalition for Abstinence Education, www.SexRespect.com

¹⁷ Collins C, Alagiri P, Summers T, Morin SF. Abstinence Only vs. Comprehensive Sex Education, AIDS Research Institute, University of California, San Francisco, Policy Monograph Series, 2002

II. HISTORY OF ABSTINENCE FUNDING IN OHIO

In fiscal year 2004, Ohio received \$8,086,793 for abstinence-only-until-marriage programs, bringing the total to approximately \$32 million since 1999. The three major federal funding sources are Title V of the Social Security Act, Special Projects of Regional and National Significance (SPRANS), and the Adolescent Family Life Act (AFLA). Projects funded by each of these grant sources are governed by the same basic rules and regulations, based on the 1996 abstinence-only-until-marriage initiative: Section 510(b) of Title V of the Social Security Reform Act (P.L. 104-193), often referred to as “Title V.”

Section 510 of this legislation specifically states that a funded abstinence education program must:

1. Have as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
2. Teach abstinence from sexual activity outside marriage as the expected standard for all school age children;
3. Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
4. Teach that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
5. Teach that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
6. Teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
7. Teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
8. Teach the importance of attaining self-sufficiency before engaging in sexual activity.¹⁸

Title V funding requires that for every four federal dollars, a 20% match must be provided for abstinence-only education programs. The state match can be made by general revenue, grant recipients, or private donations. In 2004, Ohio received \$1,676,074 in Title V funding and matched the federal dollars with \$500,000 of state revenue, which funded 13 grants to organizations. Ohio ranks 4th in the Nation in expenditure of tax dollars on abstinence-only-until-marriage programs, behind New York, Florida, and Texas.

The SPRANS-CBAE (Community Based Abstinence Education) program (P.L. 106-554) began in FY 2001 and has already distributed over \$140 million directly to over 200 abstinence-only-until-marriage programs throughout the country. This funding stream was created to avoid state-government complications and is administered by the U.S. Department of Health and Human Services. In 2004, Ohio received \$5,660,719 in SPRANS funding, which funded 10 grants to state agencies.

The Adolescent Family Life Act (AFLA) was enacted in 1981 as Title XX of the Public Health Service Act (P.L. 97-35) and is administered by the U.S. Office of Population Affairs. It funds both prevention programs and programs that provide medical and social services to pregnant or

¹⁸ http://www.idph.state.ia.us/hpcdp/abstinence_education.asp

parenting teens. From 1981 to 1996, it was the only federal program that focused directly on the issues of adolescent sexuality, pregnancy and parenting. Since 1997, all AFLA funded prevention projects have been abstinence-only-until-marriage programs conforming to Title V regulations. In FY 2004, AFLA was appropriated a total of \$13 million for abstinence programs. In 2004, the three Ohio AFLA grantees received a combined total of \$750,000. Both SPRANS and AFLA are direct federal grants that bypass state and local government.

The total Ohio abstinence funding in 2004 included \$1,676,074 in Title V funds, \$500,000 in Ohio general revenue funds, \$5,660,719 in SPRANS funding, and \$750,000 in AFLA funding, for a total of \$8,586,793. On the federal level, for FY2005, the funding for abstinence education totals \$186 million: \$50 million for Title V abstinence-only education block grant; \$31 million for AFLA prevention projects which all follow abstinence-only-until-marriage curricula; \$100 million for SPRANS abstinence-only-until-marriage program; and \$4.5 million for SPRANS evaluation.¹⁹

III. METHODOLOGY

Funding for abstinence-only-until-marriage education allows these programs to be offered in numerous schools and federally funded institutions throughout the state of Ohio. With such significant funding and wide-spread programming, the abstinence-only-until-marriage curricula and grant recipients in Ohio should be reviewed to ensure accurate information is provided in a format that is most effective in order to avoid inefficiency in government spending and achieve valuable public health service delivery. To date, such a comprehensive review has not occurred. With limited dollars available for funding public health initiatives, and with rates of teen pregnancy and STD that remain unacceptably high, there is a priority on using funds in a manner that maximizes the capacity to positively influence teen behavior.

This report initially reviews evidence in the scientific literature examining the comparative effectiveness of different approaches to human sexual education. While research cannot make judgments about social values, it can evaluate the influence of these curricula on teen sexual behavior. Because investigation of program effectiveness is incomplete and ongoing, this report emphasizes review of the accuracy and nature of the messages communicated in curricula used by various schools and organizations that implement federally funded abstinence-only-until-marriage education programs in Ohio. It examines the missions, staff, staff credentials, and other aspects of the organizations receiving grant funding, and how they influence educational content. It also considers the grant proposals submitted by such organizations and their organizational background information that is available in the public domain.

¹⁹ Carmen Solomon-Fears, *Reducing Teen Pregnancy: Adolescent Family Life and Abstinence Education Programs*, CRS, December 10, 2004, p. 5.

IV. FINDINGS

A. Comparative Effectiveness of Abstinence-Only-Until-Marriage Programs

1. Abstinence-Only-Until-Marriage Programs²⁰

Evidence now exists that demonstrates that an abstinence approach, specifically virginity pledging, can delay the onset of sexual intercourse on average from 6 to 18 months. For certain small subgroups, vaginal intercourse may be delayed up to 5 years. Such virginity pledges had been taken by an estimated 2.2 million adolescents as of 1995, or 12% of all adolescents. Because the context in which the virginity pledge was taken had a profound effect on its effectiveness, debate remains about the generalizability of these findings. The pledge appears to work best when it is made in the context of supportive group activities where identification with the abstinence movement can be supported and nurtured.

Despite these promising findings, there is a disappointing lack of peer reviewed evidence supporting abstinence-only-until-marriage programming. Though there are a large number of programs currently in Ohio, few have undergone evaluation of the effectiveness of their approach. Many abstinence-only-until-marriage advocates acknowledge this concern, with the creation of a standardized evaluation questionnaire reported as planned for the fall of 2005.

Regardless of the success in delaying the onset of intercourse it is important to note that 88% of virginity pledgers who report sexual activity become sexually active before marriage. In addition, concerning evidence has recently been published documenting that regardless of the delay in onset of intercourse, those who have taken the virginity pledge have equal rates of sexually transmitted disease. Possible explanations offered include that pledgers are less likely to use condoms when they initiate sex; less likely to seek testing for STDs; and more likely to participate in sexual behaviors other than vaginal intercourse, such as oral and anal sex, presumably in an effort to maintain “virginity”.

2. Abstinence-Plus Programs²¹

The pertinent question is not only whether abstinence-only-until-marriage programs work successfully, but whether they work more successfully than abstinence plus programs. In fact there is far more published evaluation of sexual education and HIV prevention programming, generally taking an abstinence plus approach. “A large body of evaluation research clearly shows that sex and HIV education programs included in this review do not increase sexual activity—they do not hasten the onset of sex, and do not increase the number of sexual partners. To the contrary, some sex and HIV prevention programs delay the onset of sex, reduce the frequency of sex, or reduce the number of sexual partners.” Seminal program studies include *Reducing the Risk, Safer Choices, Becoming a Responsible Teen, Making a Difference*, and *Healthy Oakland Teens*. In addition, several youth development programs with positive effects on abstinence and sexual behaviors include *Teen Outreach Program, Reach for Health Community Youth Service Learning*, and *Children’s Aid Society—Carrera Program*. In one of the few studies directly

²⁰ Bruckner H, Bearman P. After the promise: the STD consequences of adolescent virginity pledges. *Journal of Adolescent Health* 36 (2005) 271-278

²¹ Emerging Answers: Research Findings on programs to prevent teen pregnancy, Kirby, D. National Campaign to Prevent Teen Pregnancy, May, 2001

comparing an abstinence plus program and a safer sex (comprehensive sex education program), results showed greater decrease in frequency of sex, increased condom use, and decreased frequency of unprotected sex over time. The abstinence plus component showed delayed initiation of sex and increased condom use.²² An abstinence plus program garnering worldwide attention is described as the Ugandan “ABC” program—**A**bstain, **B**e faithful, or wear a **C**ondom.²³ This program has contributed to a 54% decline in HIV infection among pregnant women, from 21.1% in 1991 to 9.7% in 1998. While these prevalent rates remain tragic and are much higher than experienced in Western countries, there may be important lessons to be learned from this experience. The success of the Ugandan program has been described as “...big A, big B, and little C,” implying that the promotion of abstinence and monogamy have been far more important to program success than the promotion of condom use.²⁴ It is important to note that in neglecting the reality of sexually active teens, an opportunity is lost to promote monogamy as a risk reduction strategy among this high risk group of American teens. Since marriage is not an option for LGBT teens, promotion of abstinence until adulthood and monogamy for those who are sexually active seems to represent a strategy that has an opportunity for success.

B. Ohio Abstinence Programs, Curricula, and Target Populations Available for Review

1. **Curriculum Overview**: This listing represents program content and curricula of Title V programs²⁵ for which information was readily available, based on information requests to the Ohio Department of Health. The starred curricula represent those that are available for research. They are widely used throughout the state of Ohio and across the nation making it extremely important to point out the misconceptions as they are noted. The grant recipients that are referred to and analyzed in this report each use one or more of the curricula that contain questionable information. Much of the information found in these curricula contains false and misleading material. There are far more organizations and curricula that are used statewide; this chart gives examples of the type of information that is being conveyed to young people in abstinence-only-until-marriage in Ohio and across the United States.

²² Abstinence and safer sex HIV risk reduction interventions for African American adolescents: a randomized controlled clinical trial. *JAMA*, May 20, 1998, 279(19): 1529-1526

²³ Stoneburner R, Low-Beer D. Population level HIV declines and behavioral risk avoidance in Uganda. *Science*, 304(5671) April 30, 2004

²⁴ Stammers, TG. Abstinence Under Fire, *Postgraduate Medical Journal* 2003;79:365-366

²⁵ <http://www.odh.ohio.gov/odhprograms/aeduc/abttitlev.pdf>

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Curricula and supplementary programs used by abstinence-only-until-marriage programs in Ohio in FY 2003:

PROGRAM	CURRICULA/PROGRAMS USED OR RECOMMENDED	TARGET POPULATION
<i>Abstinence Educator's Network</i>	3,7,8,9,10,11,12,17,18,19,22,25,27,28	Students 12-18 years of age and adult mentors
<i>Abstinence the Better Choice, Inc.</i>	5,22	Students 10-18 years of age
<i>Catholic Social Services</i>	13	Students 12-18 years of age
<i>Clark County Combined Health District</i>	5,6,7,8,14,20,22,23	Students 12-18 years of age, and girls aged 1-15 who are at higher risk for teen pregnancy
<i>Directions for Youth and Families</i>	4,21	Students 12-18 years of age
<i>Healthy Visions</i>	31	Students 10-18 years of age
<i>Huron County General Health District</i>	3,22	Students 11-14 years of age (primarily), and some students 15-18 years of age
<i>Mansfield Ontario Richland County Health Department</i>	24	Students 10-18 years of age and adult mentors
<i>Miami County General Health District</i>	7,8,11,12,24	Students 12-19 years of age, 10-11 year olds taking part in asset-building, and adult mentors
<i>Pregnancy Decision Health Center</i>	9,12,15,22,26,27,	Students 12-18 years of age and adult mentors
<i>Pregnancy Resource Center</i>	22	Students 11-16 years of age and adult mentors
<i>Reach</i>	19	Students 12-18 years of age
<i>RIDGE Project</i>	3,7,8,29,30	Students 11-18 years of age and adult mentors
<i>St. Vincent Mercy Medical Center</i>	1,7,8,12	Students 12-18 years of age, primarily high-risk students
<i>Teenage Pregnancy and Prevention</i>	22,24	Students 10-18 years of age
<i>Zanesville-Muskingham County Health Department</i>	5,22	Students 10-17 years of age

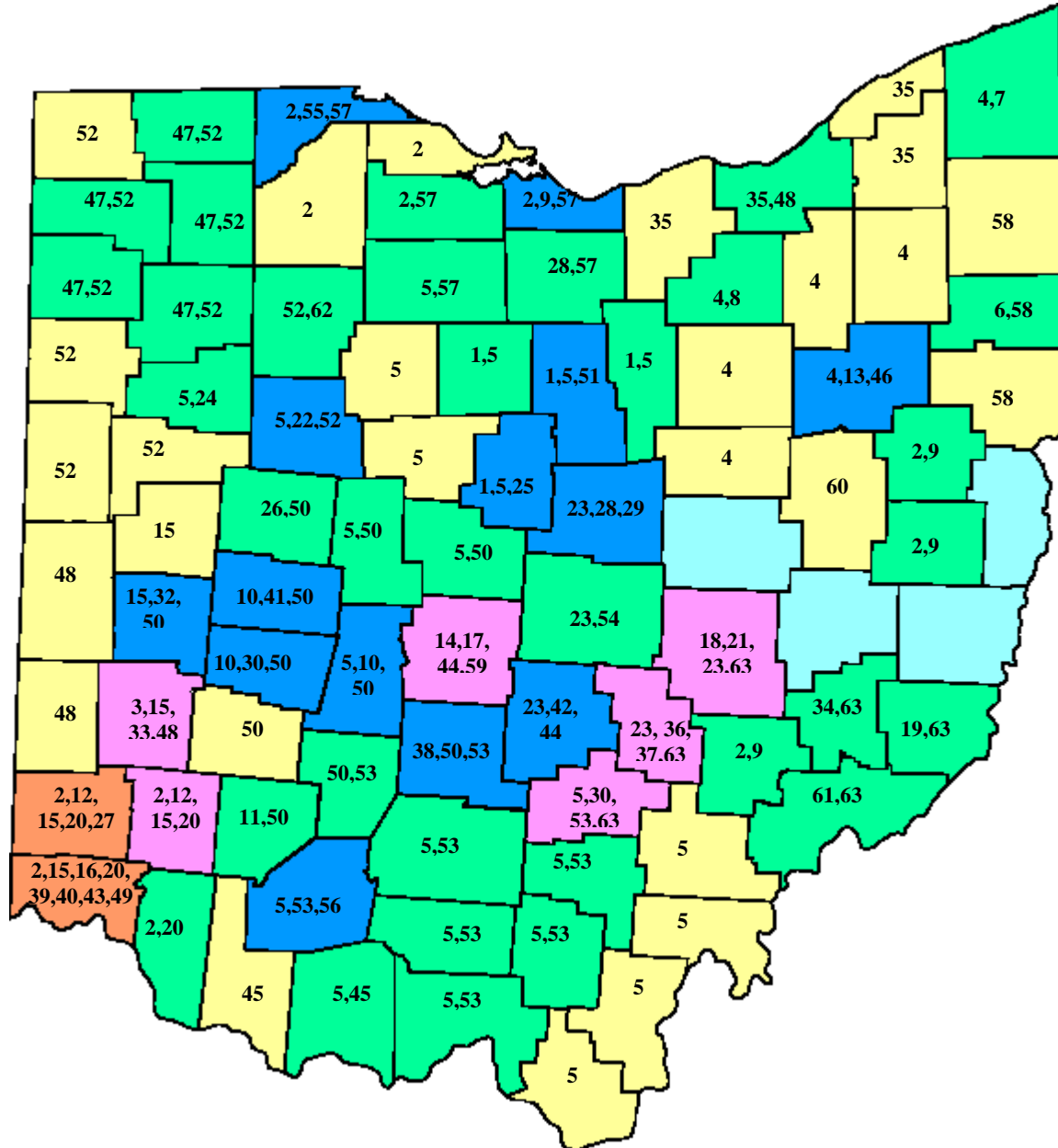
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|---|--|
| 1. Abstinence Only, Send a Clear Message | 18. M.A.P. (Making Abstinence Possible) |
| 2. Abstinence, the Better Choice | 19. Me, My World, My Future*- Teen Aid |
| 3. A.C. Green's Game Plan*- Project Reality | 20. No Apologies*- Focus on the Family |
| 4. Baby Think it Over | 21. Project Self |
| 5. C.A.T.S. (Concerned About Teen Sexuality) | 22. R.S.V.P. (Responsible Social Values Program) |
| 6. Character Counts | 23. Sex and Character*- Foundation for Thought and Ethics |
| 7. Choosing the Best LIFE*- Choosing the Best | 24. Sex Can Wait*- ETR Associates |
| 8. Choosing the Best PATH*- Choosing the Best | 25. Sex Respect*- Respect, Inc. |
| 9. Facing Reality | 26. SEX: When, Where, Why and What is the Truth |
| 10. Facts and Reasons*- Northwest Family Services | 27. Sexual Health Today |
| 11. Friends First Mentoring Program*- Friends First | 28. Sexuality and Commitment |
| 12. Game Plan | 29. True Love Waits*- LifeWay Christian Resources |
| 13. GROW-Fest | 30. W.A.I.T. (Why Am I Tempted) Training*- Abstinence and Relationship Training Center |
| 14. H2O (Help to Others) | 31. Why Abstinence |
| 15. Healthy Choices Abstinence Program | |
| 16. Helping Teens Choose Abstinence (for parents) | |
| 17. I'm In Charge* | |

*Curricula that was available for review

◆Information not available for review

Abstinence Education Service Providers by County

Below is a map of Abstinence Education Service Providers receiving Title V, SPRANS, and AFLA federal funding²⁶. Four counties (Jefferson, Belmont, Guernsey, and Coshocton) currently have no provider contact information. Provision sites are mapped according to their mailing address, not necessarily the communities they serve. Provision sites often serve more than one community.



Legend		
 No Contact Information	 One Service Site	 Two Service Sites
 Three Service Sites	 Four Service Sites	 Five or more Service Sites

²⁶ <http://www.odh.ohio.gov/odhprograms/aeduc/abprovdr.pdf>

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1. Abstinence & Absolutes, Assoc. (*Ashland, Crawford, Morrow, and Richland County*)
2. Abstinence Educators' Network, Inc. (*Butler, Carroll, Clermont, Erie, Hamilton, Harrison, Lucas, Ottawa, Morgan, Sandusky, Warren, and Wood County*)
3. Abstinence Resource Center (*Montgomery County*)
4. Abstinence the Better Choice, Inc. (*Ashtabula, Holmes, Medina, Portage, Stark, Summit, and Wayne County*)
5. ATM Education (*Adams, Allen, Ashland, Athens, Crawford, Delaware, Gallia, Hardin, Highland, Hocking, Jackson, Lawrence, Madison, Marion, Meigs, Morrow, Pike, Richland, Ross, Scioto, Seneca, Union, Vinton, and Wyandot County*)
6. Care Net of Mahoning Valley (*Mahoning County*)
7. Catholic Charities of Ashtabula County (*Ashtabula County*)
8. Catholic Charity Service (*Medina County*)
9. Central Ohio AEN (*Carroll, Erie, Harrison, and Morgan County*)
10. Clark County Combined Health District (*Champaign, Clark, and Madison County*)
11. Clinton County Women's Center (*Clinton County*)
12. Community Pregnancy Center (*Butler and Warren County*)
13. Community Services of Stark County, Inc. (*Stark County*)
14. Directions for Youth & Families (*Franklin County*)
15. Elizabeth's New Life Center (*Butler, Hamilton, Miami, Montgomery, Shelby, and Warren County*)
16. 4-CHARIS (*Hamilton County*)
17. Frontline Youth Communications (*Franklin County*)
18. Genesis HealthSource (*Muskingum County*)
19. Guernsey-Monroe-Noble Tri-County CAC (*Monroe County*)
20. Healthy Visions (*Butler, Clermont, Hamilton, and Warren County*)
21. Heartbeat Family Center (*Muskingum County*)
22. Heartbeat of Hardin County (*Hardin County*)
23. Heartbeats of Licking County (*Fairfield, Knox, Licking, Muskingum, and Perry County*)
24. Heartbeats of Lima (*Allen County*)
25. Heartbeats of Morrow County (*Morrow County*)
26. Hi Point Women's Center (*Logan County*)
27. Hope House (*Butler County*)
28. Huron County General Health District (*Huron and Knox County*)
29. Knox County Health Department (*Knox County*)
30. Logan-Hocking County Health Department (*Hocking County*)
31. Mercy Parent Infant Center (*Clark County*)
32. Miami County General Health District (*Miami County*)
33. Miami Valley Women's Center (*Montgomery County*)
34. Noble County Health Department (*Noble County*)
35. Operation Keepsake (*Cuyahoga, Geauga, Lake, and Lorain County*)
36. Perry County Health Department (*Perry County*)
37. Perry County Right to Life (*Perry County*)
38. Pickaway Pregnancy Center (*Pickaway County*)
39. Pregnancy Care of Cincinnati (*Hamilton County*)
40. Pregnancy Center East (*Hamilton County*)
41. Pregnancy Center of Champaign County (*Champaign County*)
42. Pregnancy Center of Fairfield County (*Fairfield County*)
43. Pregnancy Center West (*Hamilton County*)
44. Pregnancy Decision Health Center (*Fairfield and Franklin County*)
45. Pregnancy Resource Center (*Adams and Brown County*)
46. Pregnancy Support Center of Stark County (*Stark County*)
47. Project Respect (*Defiance, Fulton, Henry, Paulding, and Putnam County*)
48. REACH (*Cuyahoga, Darke, Montgomery, and Preble County*)
49. Reachout Pregnancy Center (*Hamilton County*)
50. Real Life...A Matter of Choices (*Champaign, Clark, Clinton, Delaware, Fayette, Greene, Logan, Madison, Miami, Pickaway, and Union County*)
51. Richland County Youth and Family (*Richland County*)
52. The RIDGE Project, Inc. (*Auglaize, Fulton, Defiance, Hancock, Hardin, Henry, Mercer, Paulding, Putnam, Van Wert, and Williams County*)
53. Ross County Health District (*Fayette, Highland, Hocking, Jackson, Pickaway, Pike, Ross, Scioto, and Vinton County*)
54. RSVP of Licking County (*Licking County*)
55. RSVP of Toledo (*Lucas County*)
56. Southern Ohio Pregnancy Center (*Highland County*)
57. St. Vincent Mercy Medical Center (*Erie, Huron, Lucas, Sandusky, and Seneca County*)
58. Teen Straight Talk (*Columbiana, Mahoning, and Trumbull County*)
59. Truth Lies Youth Talks (*Franklin County*)
60. Tuscarawas County Council for Church and Community (*Tuscarawas County*)
61. Washington County Children's Services (*Washington County*)
62. Women's Resource Center of Hancock County (*Hancock County*)
63. Zanesville-Muskingum County Health Department (*Hocking, Monroe, Muskingum, Noble, Perry, and Washington County*)

2. Ohio Curricula Contains Inaccurate Information About Contraceptives.

Proper contraceptive use, and the benefits thereof, is not addressed in abstinence-only-until-marriage curricula. In fact, the opposite occurs: contraceptives are portrayed as ineffective in preventing pregnancy and STDs, and are mentioned only to convey a negative message about birth control and HIV/STD risk reduction, and to provide another reason to avoid remain abstinent until marriage.

Condoms are a primary target in abstinence-only-until-marriage curricula, and the rate at which condoms fail to prevent pregnancy is often depicted as exponentially higher than the well-documented scientific evidence. *Choosing the Best PATH*, for example, claims that condoms are ineffective in preventing pregnancy 15% of the time during the first year of use, and concludes that “This means that over a period of five years, there could be a 50% chance or higher of getting pregnant with condoms used as a birth control method.”²⁷ According to *Contraceptive Technology*, “1st year effectiveness rate in preventing pregnancy among typical condom users is 86%”; however, this number does not increase as the curriculum suggests.²⁸ Rather, *Studies in Family Planning* states, “Condoms are 98% effective in preventing pregnancy when used consistently and correctly.”²⁹

Many abstinence-only-until-marriage curricula contradict scientific studies and overstate the possibility that a condom may slip off or break.³⁰ *Me, My World, My Future* compares condoms to a game of Russian Roulette, implying that not only is there a high failure rate, but that condom use can also lead to death.³¹ *Sex Respect* is more explicit yet, stating that teens who have sex before marriage should “be prepared to die.” However, an authoritative study conducted by *Consumer Reports* states, “With correct use, a condom will break as little as two percent of the time, authorities believe, and will slip off as little as one percent of the time.”³²

In emphasizing the failure rate of contraceptives, abstinence-only-until-marriage curricula programs are exploiting the well-established discrepancy between “typical use” and “perfect use” of these tools. There is, unquestionably a difference between use in all contraceptive users, and in “perfect” users. Ironically, in emphasizing only the failure rate and not how to improve the successful use of contraceptives, programs may contribute to this divide. This strategy is especially troubling since abstinence-only-until-marriage programs do not also acknowledge the discrepancy between typical and perfect use of the abstinence pledge. While conclusive research is not available, since 88% of virginity pledgers relate having sex before marriage, it is likely that virginity pledges slip off or are broken more often than condoms.

²⁷ *Choosing the Best*, Leaders Guide, p.22.

²⁸ R.A. Hatcher, et al. *Contraceptive Technology* 17th revised edition, New York: Ardent Media, Inc. 1998, p.328.

²⁹ J. Trusesel, et al. *Contraceptive Failure in the United States: An Update*, Studies in Family Planning, Jan./Feb. 1990, vol. 21 no. 1, p. 52.

³⁰ *Choosing the Best PATH*, Leader Guide, p.18.

³¹ *Me, My World, My Future*, revised HIV material, p. 258.

³² “Condoms Get Better.” *Consumer Reports*, June 1999, p.46.

Some abstinence-only-until-marriage curricula also infer that sex, and even contraceptives themselves are responsible for poor mental health among youth. The teacher's manual accompanying *Sex Respect* states, "Contraception, technology's despairing answer to adolescent sexual activity, has intensified the loneliness, frustration, and emptiness of our young people."³³ While evidence supports an association between depression and sexual activity, it is scientifically inaccurate to assert that contraceptives or sex *cause* depression. Depression may be just as likely to cause teens to initiate sexual activity. Other curricula infer that the use of contraceptives is a sign of immaturity, low self-confidence and control, a broken heart, and unhealthy relationships. In fact, research shows that among sexually active teens, rates of depression, anxiety, and low self esteem are higher among females who do not use contraception; and among those with multiple sexual partners.³⁴ Another article states, "The literature on the psychological antecedents of contraceptive behavior clearly characterize ineffective female contraceptors as being unaccepting of their own sexuality and having negative attitudes toward most matters pertaining to sex. Their attitudes and emotions include irrational fears about specific contraceptives, conflicting attitude and belief systems about birth control in general, and guilt."³⁵

It is reasonable to suggest that the teens most likely to experience mental health problems associated with sexual activity are those with the highest levels of emotional dissonance regarding their behavior, and the greatest fears related to negative outcomes. It is unknown the extent to which abstinence-only-until-marriage programs may exacerbate these concerns and make mental health problems more likely for participants who do not take and participants who later break their virginity pledge.

In addition to mischaracterizing the effectiveness of condoms, the abstinence-only-until-marriage curricula often provide inaccurate information about other contraceptive methods. For example, *Sex Respect* suggests that birth control pills, shots, and implants can affect a girl's physical state by increasing the chance for future infertility. However, the U.S. Department of Health and Human Development states, "There appears to be little risk that the use of the pill leads to sterility. In fact, because the pill protects many women from pelvic inflammatory disease, which can damage the fallopian tubes, it guards against a leading cause of infertility."³⁶ As with most prescription drugs, side-effects associated with oral contraceptives and other forms of birth control may exist, however the risks are statistically low. Therefore, the curricula misrepresent the risks with exaggerated claims that are scientifically inaccurate.

Abstinence-only-until-marriage curricula often treat contraceptives as extremely ineffective and unreliable and provide inaccurate statistics to buttress these claims. They do not subject their own method to the same standards of evaluation that they cite relating to contraceptive failure. Moreover, curricula in Ohio do not give information on what types

³³ *Sex Respect*, Teacher Manuel, p. 15.

³⁴ Not restricted to adolescents – higher anxiety and emotional immaturity found among inconsistent contraception users. Brooks GG, Butcalis MR. *Am J Obstet Gynecol.* 1976 Jan 1;124(1):85-7.

³⁵ The antecedents and prevention of unwanted pregnancy. Gerrard M, McCann L, Geis BD. *Issues Ment Health Nurs.* 1983;5(1-4):85-101

³⁶ M.B. Gardner. *Facts About Oral contraceptives*, National Institute of Child Health and Human Development.

of contraceptives are effective or how to effectively use them in order to decrease the discrepancy between typical and perfect use, thus avoiding pregnancy and STD.

3. Ohio Curricula Contain False Information about Abortion.

Abstinence-only-until-marriage curricula instructs students that abortion contributes to permanent bodily harm and is the wrong choice in response to an unplanned pregnancy. *Sex Respect* states:

If she is a young teen, pregnant for the first time, there's a chance the abortion will cause heavy damage to her reproductive organs. Heavy loss of blood, infection, and puncturing of the uterus may all lead to future pregnancy problems such as premature birth or misplaced pregnancy (in which the baby begins to develop in the fallopian tubes or in the cervix).³⁷

While hemorrhage, infection, and uterine rupture *can* occur following abortion, “Medical abortion also has evolved into a simple, safe, highly effective, and acceptable regimen.”³⁸ In fact, the likelihood of each of these complications is substantially higher in adolescents carrying a pregnancy to term than those undergoing medical abortion.

Many of the curricula also state that conception begins when the sperm and egg unite, thereby disregarding the diversity of scientific perspectives regarding when human life actually begins. Scientific and ideological debate persists over whether conception (or human life) is defined as the onset of pregnancy, marked by implantation of the blastocyst, the formation of a viable zygote; or by fertilization of the ovum by the spermatozoa.

Moreover, the curricula offers insensitive and inflated statistics on the correlation between teen parenting and the dependence on welfare, educational success and the health of the child in an effort to promote adoption. *Choosing the Best LIFE* implies that teenage mothers are irresponsible if they keep the child, predicting that “80% of unmarried teen mothers will end up on welfare,” and that “...children of teen mothers have lower birth weights, are more likely to perform poorly in school, and are at greater risk of abuse and neglect”.³⁹ While advising students on the possible outcomes resulting from teenage pregnancy may be informative, misusing statistical analysis by creating predictive percentages is not scientifically valid. These statistics reflect present conditions, not a prophesy for the fate of any individual hearing them in the classroom. Furthermore, failing to consider the impact of this information on students in the class that may be pregnant or are parents already is inappropriate and lacks compassion. This format conveys a negative view of teenage parenting that can marginalize and stigmatize pregnant teens or teen parents who may be struggling the most.

Ohio’s abstinence-only-until-marriage curricula emphasize that adoption is the most acceptable and healthy choice if pregnancy occurs, more than keeping the child, or

³⁷ *Sex Respect*, Student Workbook, p.85.

³⁸ Newhall EP, Winikoff B. Abortion with mifepristone and misoprostol: regimens, efficacy, acceptability and future directions. *Am J Obstet Gynecol* 2000;183(suppl):S44 –53.

³⁹ *Choosing the Best LIFE*, Student Workbook, p. 29.

pursuing pregnancy termination. Students are often referred exclusively to pro-life organizations for more information, which reinforces the message that abortion is always wrong. Portraying adoption in only positive light trivializes the difficult reality of the experience. While there is little data on the mental health consequences of giving a child up for adoption, there is little doubt that the experience is psychologically disturbing and may cause long term emotional trauma, potentially to both the birth mother and to the adopted child in later life. Clinical symptoms for birth parents include unresolved grief, isolation, difficulty with future relationships, and trauma. Recent research has found that some birth mothers who relinquish tend to fare comparably to those who do not relinquish on external criteria of well-being (such as high school graduation rates).⁴⁰ However, there appear to be serious long-term psychological consequences of relinquishment. In fact, "...most unmarried mothers choose to parent their child. Indeed, the percentage of premarital births being placed for adoption has declined over the past two decades. Before 1973, almost 9% of all premarital births were placed for adoption. For premarital births occurring 1973 through 1981, this percentage decreased to 4%; for births from 1982 through 1988, it decreased even further to 2%."⁴¹ Presenting only one side of a complex public health issue is disingenuous and contradicts scientific findings.

4. Ohio Curricula Misrepresents Religious Conviction as Scientific Fact.

The *True Love Waits* program is used in conjunction with some of the abstinence-only-until-marriage curricula. This campaign is sponsored by LifeWay Christian resources and focuses on obtaining virginity pledges from students as well as "following God's plan for purity".⁴² The pledge for True Love Waits states,

*Believing that true love waits, I make the commitment to God, myself, my family, my friends, my future mate, and my future children to a lifetime of purity including sexual abstinence from this day until the day I enter a biblical marriage relationship.*⁴³

Not only does this program assume that all students follow Judaism or Christianity, but it also implies that the "purity" in life can only be achieved through marriage. This campaign fails to provide comprehensive information that addresses all students of diverse religions, ethnic backgrounds and belief systems and those for whom marriage is not desirable, illegal, or may simply never occur.

In addition, some of the curricula associate chastity with religious and moral purity. The *Sex Respect* curriculum recommends that parents maintain a household that is free from pornography, sexually explicit television programming, and music that does not display a "pure way of life." Parents are asked to provide a "chaste home" for their son or daughter

⁴⁰ O'Leary Wiley M, Baden AL. Birth Parents in Adoption: Research, Practice, and Counseling Psychology. *The Counseling Psychologist*, Vol. 33, No. 1, 13-50 (2005)

⁴¹ Stolley,k.S. (1993). Statistics on Adoption in the United States. *The Future of Children: Adoption* 3(1), 26-42

⁴² http://www.lifeway.com/tlw/ldr_faq_home.asp.

⁴³ http://www.lifeway.com/tlw/tns_join_home.asp.

in order to help teens resist sexual pressures.⁴⁴ This proscription appears to not take into account the cultural diversity that is America, and the diversity of parenting approaches that can in fact support abstinence. In fact, network television, magazines, newspapers, computers, movies, and music all represent possible portals to “sexually explicit” information within the home (not to mention billboards, peer influence, popular entertainment outside of the home), illustrating that parental communication about sexuality may represent an alternative strategy for protecting children from irresponsible sexual decision making in current culture.

Concern has been raised that abstinence-only-until-marriage programs are being used as a tool to circumvent laws governing separation of church and state. On a recent 60 Minutes report on abstinence-only-until-marriage programs, Ed Bradley reported, “The White House’s position is that faith-based organizations like Silver Ring Thing can [spread the gospel of Christ and still get federal funds] as long as they give their listeners an option to hear a non-religious message in a different location... This interpretation of the law is now being challenged in court.”⁴⁵

Some curricula, such as *Sex Respect*, recommend books and movies that are religious in nature, and narrow depictions of dating as sources for more information on sexuality. In one lesson, teachers instruct students to refer to the book *I Kissed Dating Goodbye*, by Joshua Harris, to learn more about new dating practices that are arising as a result of the abstinence movement. One section of the book states,

*Like many high school relationships, our romance was premature - too much, too soon. And our struggle against sin was a losing battle. Though we never actually had sex, we were dishonoring God. We were violating each others’ purity, and our spiritual lives were stagnant as a result.*⁴⁶

The book is recommended to young people in both the private and public school settings despite the religious basis and contradictory message on dating practices. The author explicitly states that sexual intercourse never occurred, which is the definition of abstinence. Despite this compliance with abstinence, the author claims God was dishonored, a sin was committed, purity violated and spirituality destroyed. To recommend such readings is confusing, contradictory and misleading. The plurality of our culture begs a breadth of reference material with differing points of view that incorporate diversity in religions, ethnicity and healthy personal choice in order to meet the holistic public health needs of a broad spectrum of teenagers.

5. Ohio Curricula Perpetuate Destructive, Inaccurate Gender Stereotypes.

Gender stereotypes and a consistent misrepresentation of correlations as definitive causations permeate Ohio abstinence-only-until-marriage curricula. For instance, *Sex Respect* instructs students on the many examples of the differences between the male and

⁴⁴M.E. Kempner. “Keeping Our Youth ‘Scared Chaste’ SIECUS Curriculum Review: Sex Respect, A Fear-Based Abstinence-Only-Until-Marriage Curriculum for Junior High and Senior High School Students”, p. 8.

⁴⁵ Ed Bradley, *The Pledge*. 60 Minutes Transcript May 22, 2005

⁴⁶ J. Harris, *I Kissed Dating Good-bye*, p. 17.

female sex drives, which include males are seen as sexual “desirers” as a result of testosterone increase while females are sexual “desirers” only as a result of “cultural conditioning” to become sexually driven. The *Sex Respect* student workbook states,

Deep down, you know that your friend’s plunging necklines and short skirts are getting the guys to talk about her. Is that what you want? To see girls drive guys hormones when a guy is trying to see her as a friend. A guy who wants to respect girls is distracted by sexy clothes and remembers her for one thing. Is it fair that guys are turned on by their senses and women by their hearts?⁴⁷

This rhetoric implies that females are at “fault” for wearing clothing that arouses males, and that males are without capacity to control sexual thoughts and urges in the face of such provocation. It also implies that what a female wears controls how every male reacts. This viewpoint is offensive to men who are not universally aroused by all women and possess the cognitive ability to distinguish between friends, professional colleagues and potential partners. It also implicitly supports victim blaming in cases of sexual harassment and sexual violence, a dangerous theory that has been refuted by Rape Shield Laws in Ohio and throughout the country.

Gender stereotypes are also promoted in *Choosing the Best*, which uses various activities to illustrate the differences between genders regarding sex. With one dramatic, anecdotal story of a young woman’s experience with sexual intercourse, the students are led to conclude that girls have a much harder time dealing with the effects of premarital sex while boys do not feel nearly as burdened. The exercise ends with the instructor posing the question, “If Kendra respected herself, would she have given herself to Antonio without his commitment to her?”⁴⁸ By asking such a question, the instructor informs students that females lack self-respect if they choose to engage in sexual activity, but if a male engages in the same activity, his self-respect remains intact. This question also highlights the importance of the female obtaining a commitment from the male before intercourse while a male obtaining such a commitment from the female is neither necessary nor recommended.

A cartoon in the same curriculum bears the caption: “Watch what you wear. If you don’t aim to please, don’t aim to tease”.⁴⁹ What does this mean? Are women morally obligated to fulfill an implicit contract based on the perception that others may have of their choice of clothing? Clothing choices made by teens—males and females—are highly influenced by corporate marketing; represent an effort to feel good about themselves and their changing bodies; to fit in with their peers; and for many, to look more like their peers than like their parents. Females are not responsible for male sexual desire.

In fact, many of Ohio’s abstinence-only-until-marriage curricula claim that it is the women’s job to make a man feel good about his decision to abstain from sex. *Facing Reality* states,

⁴⁷ *Sex Respect*, Student Workbook, p. 12.

⁴⁸ *Choosing the Best LIFE*, Leader Guide, p. 9.

⁴⁹ *Sex Respect*, Student Workbook, p. 82.

*Although times are changing, people are dying, and futures are being ruined, guys in particular are sometimes subjected to ridicule if they choose to avoid sexual activity with those they date. How can girls make guys feel esteemed and admired for choosing the right choice?*⁵⁰

This policy of holding females responsible for their own sexual activity; the sexual desires of males; male sexual activity; and male self-esteem places an unfair burden on females and an unfair judgment on males. In 2003 Ohio females (42.7%) were more likely to be sexually active than males (40.4%); and were slightly more likely to have four or more lifetime sexual partners (female 13.0%; males 12.7%). Noting these statistics is not a condemnation of female sexual behavior, but a reflection of the current environment, in which portraying males as sexual predators and females as unwitting seductresses and unwilling victims does not reflect today's teen experience. Moreover, this perpetuation of inaccurate male and female stereotypes is destructive to both genders, and in the worst case may contribute to sexual violence, and unfulfilling sexual relationships. These attitudes should not be taught to or reinforced in teens, and are not scientifically or legally sound.

6. Ohio Curricula Contain Scientific Errors.

Discussion of STDs and other risks associated with sexual activity in Ohio's abstinence-only-until-marriage curricula is not consistently based on scientific evidence. Misleading and vague information is often used to scare youth away from premarital sexual relations. The *Choosing the Best LIFE* workbook states, "Syphilis . . . affects about 120,000 Americans each year."⁵¹ However, the yearly rate in 2004 was only 20,000, according to the CDC.⁵² *Sex Respect* also claims that "infectious syphilis rates have more than doubled among teens since the mid-1980s."⁵³ But again, the CDC reports that the rates of syphilis are actually at an all-time low and that it is possible that the disease could be wiped out entirely.⁵⁴

Another common theme in the curricula involves inaccurate information on the transmission of STDs. *Sex Respect* begins by stating, "Of all these people who transmit or catch STDs, probably none of them will be virgins."⁵⁵ While unprotected sex accounts for the vast majority of STDs, this statement ignores spread through blood transfusions, through open sores, and by oral or anal sex, activities that some teens believe still renders them virgins. It also does not offer information necessary to make students aware of the risks associated with other forms of intimate contact that can transmit STDs. Finally, this example does not acknowledge that both medicine and the public are presently conflicted regarding the evolving definitions of abstinence and virginity.

⁵⁰ *Facing Reality*, Student Manual, p. 30.

⁵¹ *Choosing the Best LIFE*, Student Workbook, p. 21.

⁵² "Common Questions About Syphilis," (Atlanta, GA: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Divisions of Sexually Transmitted Diseases, accessed online at <http://www.cdc.gov/std/Syphilis/STDFact-Syphilis.htm#common>, Feb. 18, 2004)

⁵³ *Sex Respect*, Student Workbook, p. 36.

⁵⁴ *Eliminating Syphilis from the United States*, CDC, National Center for HIV, STD, and TB Prevention, October 1999.

⁵⁵ *Sex Respect*, Student Workbook, p.52.

Sold Out 4 Me, an Ohio abstinence-only-until-marriage program promotes this confusion stating, “You lose your virginity when the penis enters the vagina (even if it’s only for a second). But, sexual purity is also a state of mind, not merely a physical act. When you think you are just “fooling around” or if you think “oral sex doesn’t count,” can you really look at yourself and say you’re being sexually abstinent? . . . Technically you may still be a virgin in your body, but in your mind and heart, you are giving a very intimate part of yourself away.”⁵⁶ In comparison, the *Medical Institute for Sexual Health*, an abstinence-only-until-marriage advocacy group relates “true abstinence includes avoiding genital contact until marriage. Some have proposed mutual masturbation and “outercourse” as healthy and safe alternatives for single people. These activities are not consistent with the abstinent lifestyle. Sexual activity, such as these, cannot only result in both pregnancy and sexually transmitted disease, but can also lead to sexual intercourse.”⁵⁷ Outercourse is also known as dry sex or grinding. These definitions are highly consistent with that of Planned Parenthood, an organization at the other end of the ideological spectrum, which states abstinence is defined as “not having sex play with a partner at all.”⁵⁸ Finally, the Ohio Department of Health describes sexual activity as, “intercourse, oral sex, or touching an erogenous zone of another for the sexual arousal of either person.”⁵⁹

A common program utilized by abstinence-only-until-marriage education programs is known as *Baby Think it Over* (BTIO). In BTIO, a student is given a simulated baby that cries, eats, and needs its diaper changed. If the simulated baby is not satisfied, it will cry and students are instructed that it is the parents’ job to walk, cradle, or feed the baby. One review stated that after the *Baby Think it Over* program, “[Teens] expressed the need for additional information in relation to prevention and dating, namely information about contraception, sexually transmitted infections, and communication in intimate relationships.”⁶⁰ Another study conducted at the University of Colorado’s Health Sciences Center found,

*Little learning about the difficulties of parenting took place during the study. On average, the 6th grade students did not find BTIO care more difficult than anticipated and the 8th grade students actually found it easier than anticipated. Finally, caring for BTIO had no effect on the intent of students to become teen parents; 13 (12%) of the 109 students wanted to be teen parents before they cared for BTIO and 16 (15%) wanted to be teen parents after they cared for the doll.*⁶¹

A number of other studies have reflected the ineffectiveness of *Baby Think it Over*, finding little statistical significance regarding changes in teen parenting attitudes before and after the program. While *Baby Think it Over* may offer a glimpse into the life of a teen parent, it

⁵⁶ *Sold Out 4 Me*, Pregnancy Support Center of Stark County, 2002-2005.

⁵⁷ *Medical Institute for Sexual Health*, www.medinstitute.org

⁵⁸ Planned Parenthood of America, www.plannedparenthood.org

⁵⁹ Ohio Department of Health, www.ODH.gov

⁶⁰ J. E. Barnett and C. S. Hurst, “Do Adolescents Take ‘Baby Think it Over’ Seriously?,” *Adolescence* 39.153 (Spring 2004): 65-75.

⁶¹ J. Kralewski and C. Stevens-Simon, “Does Mothering a Doll Change Teens’ Thoughts About Pregnancy?,” *Pediatrics* 105.3: e30. <http://pediatrics.aappublications.org/cgi/content/full/105/3/e30>.

is apparent that both youth *and* parents need more effective, accurate and comprehensive educational content.

Perhaps the most outdated and inaccurate component of many abstinence-only-until-marriage curricula regards AIDS and HIV. *Sex Respect* describes HIV as a lentivirus, or slow-moving virus, “That can be in your body from six months to ten years without being detected, either by a test or by physical symptoms”.⁶² However, the CDC states, “Most detectible HIV antibodies are present within two to eight weeks. 97% will develop antibodies within the first three months, and in a few very rare cases it can take up to six months.”⁶³

While explaining the various ways in which HIV is transmitted, some curricula state that transmission can occur through tears and open mouth kissing. This is false and inaccurate information.⁶⁴ Similarly, *Sex Respect* chooses to focus on open mouth kissing to imply that it is highly likely for HIV to be transmitted through saliva, which is not possible.⁶⁵

Sex Respect includes a passage in the student workbook that states,

*Research and common sense tell us the best ways to avoid AIDS are: Remain a virgin until marriage. If you marry, marry a virgin. Remain faithful to your spouse. Avoid homosexual behavior. Avoid the use of intravenous drugs. Do not marry someone who uses (or has used) intravenous drugs.*⁶⁶

Much of this statement gives accurate information on how to avoid HIV transmission. However, homosexuality, in and of itself, is not a risk factor for HIV transmission. Lack of barrier protection and multiple sexual partners represent risks in both hetero and homosexual intercourse.

C. The Impact of Ohio Abstinence-Only-Until-Marriage Programs on Youth at Risk for STDs and Pregnancy

The Centers for Disease Control describes lesbian, gay, bisexual, and transgender (LGBT) youth as being at the highest risk of HIV infection among adolescents.⁶⁷ One of the greatest flaws of abstinence-only-until-marriage programs is their inherent exclusion of LGBT individuals. The Abstinence-only-until-marriage curricula are inapplicable to LGBT youth because in 2004, the Ohio State Constitution was amended to forbid marriage between same-sex partners.

⁶² *Sex Respect*, Student Workbook, p. 60.

⁶³ *How long after possible exposure should I wait to get tested for HIV?*, (Atlanta, GA, Centers for Disease Control and Prevention) accessed on line at www.cdc.gov/hiv/pubs/faq/faq9.htm on March 22, 2005.

⁶⁴ *How is HIV passed from one person to another?*, (Atlanta, GA, Centers for Disease Control and Prevention) accessed on line at <http://www.cdc.gov/hiv/pubs/faq/faq16.htm> on March 22, 2005.

⁶⁵ *Sex Respect*, Student Workbook, p. 52.

⁶⁶ *Sex Respect*, Student Workbook, p. 54.

⁶⁷ Centers for Disease Control and Prevention. (1997). *HIV/AIDS surveillance report: US HIV and AIDS Cases Reported Through June 1997*, Vol. 9, CDC: Atlanta, GA.

Additionally, studies indicate that those groups at highest risk lack effective prevention knowledge. A 1999 study found that although gay and bisexual youth have a better grasp of the risk of contracting HIV in comparison to heterosexual youth, they lack the skills to prevent the transmission of STDs.⁶⁸ Moreover, teenagers engaging in sexual activity need accurate information on how to protect themselves from STDs and pregnancy, which is not provided in a curriculum that exclusively defines prevention as abstention. By failing to provide comprehensive sex education, effective prevention strategies are not employed. Abstinence-only-until-marriage programs disregard the educational, public health needs of at-risk individuals.

D. Characteristics of the Ohio Abstinence-Only-Until-Marriage Grantees

Thus far in the report, effectiveness of and inaccuracies in abstinence-only-until-marriage curricula have been reviewed. Of equal importance to the *message* is the *messenger*. Many abstinence-only-until-marriage service providers are not public health organizations, but rather, ideologically oriented groups in a campaign to impose a strict understanding of religion, “purity” and morality on America’s youth. As the director of one Ohio program said, “We want to be able to develop relationships with the clients and plant the seed for spiritual growth and help them develop a relationship with Christ.” Another Ohio program director stated, “The only healthy sex is in a relationship. Otherwise, they damage their bodies and themselves emotionally because they are not ready.”⁶⁹

Too often, the programs providing abstinence-only-until-marriage messages are not promoting public health messages but a message of morality, judgment, and fear with no room for exploration, self-discovery and comprehension of individually-based parameters for sexual activity. While moral decision-making is an element of healthy sexuality; and while promotion of abstinence is rational and perhaps crucial; teenagers still need comprehensive, medically accurate information to help guide their decision-making in the context of their own families, their own lives, and their own conscience.

Parental attitudes regarding abstinence-only-until-marriage education in schools are extremely difficult to gauge. There are few better examples of the truism that “the response you receive to a question depends on how the question is asked”. On one hand, 91% of parents of high school students believe it is important to have sexuality education as part of the school curriculum and that this type of education will be helpful for their child in the future.⁷⁰ On the other hand, 91% of parents want teens to be taught that “the best choice is for sexual intercourse to be linked to love, intimacy, and commitment. These qualities are most likely to occur in a faithful marriage.”⁷¹ An NPR/Kaiser/Kennedy School poll on sex education shows that more than 90% of Americans approve of sex

⁶⁸ Mary Jane Rotheram-Borus, Ph.D., William D. Marelich, Ph.D., and Shobha Srinivasan, Ph.D. “HIV Risk Among Homosexual, Bisexual, and Heterosexual Male and Female Youths.” *Archives of Sexual Behavior*, Vol. 28, No. 2, 1999.

⁶⁹ All quotes about abstinence instructors were taken directly from the various programs’ websites.

⁷⁰ *Mobilizing Support for Sex Education: New Messages and Techniques* (p. 28, New York, NY: The Othmer Institute of Planned Parenthood of NYC, 2002.)

⁷¹ What do Parents Want Taught in Sex Education Programs? Rector RE, Pardue MG, Martin S. Background. Heritage Foundation, January 28, 2004, 1722

education in schools.⁷² Another study found 84% of Americans support comprehensive, age-appropriate, medically accurate sex education.⁷³ Meanwhile, 91% of parents want schools to teach “that adolescents should be expected to remain abstinent at least through high school.” It should be pointed out that, while this statistic is used to promote abstinence-only-until-marriage education, this is not what the programs teach, or are required by funding criteria to teach. A vast majority of parents also believe that HIV/AIDS, other STDs, contraceptives, and pregnancy issues are all important for their children to learn through comprehensive sexuality education.⁷⁴ But perhaps the most important finding, even in response to the survey sponsored abstinence-only-until-marriage program advocates, 75% of parents want teens to be taught about both abstinence and contraception.⁷⁵

E. Credentials of the Ohio Abstinence-Only-Until-Marriage Instructors

One mechanism that can help reduce presentation of inaccurate information in abstinence-only-until-marriage programs is ensuring that those delivering curricula have relevant scientific and academic credentials, or training to present information about sexuality and sexually transmitted diseases.

While no single national standard outlines the credentials that STD prevention, pregnancy, and sexuality educators should have, there are a number of sources that provide useful recommendations. The American Association of Sex Educators, Counselors, and Therapists, for example, has determined that Sexuality Educators should have, minimally, a Bachelor’s degree and 90 hours of education in the core areas of sexual and reproductive anatomy/physiology, developmental sexuality, dynamics of interpersonal relationships, gender-related issues, sexual orientation and gender identity, and health factors that may influence sexuality including illness, disability, drugs, abortion, pregnancy, contraception, fertility, HIV/AIDS, sexually transmitted infections, and safer sex practices.⁷⁶

Since presentation of sexuality curricula requires an understanding of the complex elements of health behavior and health behavior change applied to a specific topic, we believe professionals presenting such curricula should have a Bachelor’s in community health or a related field, and ideally possess a Masters in Public Health or a related field, or work under the direct supervision of an MPH graduate.

It is likely that some comprehensive sexuality educators do not meet these criteria, and it is therefore a subject for further discussion and action in the field as a whole. But in our review of Ohio programs conducting abstinence-only-until-marriage curricula, we could find no evidence of any effort to define minimum qualifications. Nor could we find

⁷² Protect Our Kids, September 2004 at www.protectourkids.com and <http://www.npr.org/templates/story/story.php?storyId=1646885>.

⁷³ Lake Snell Perry & Associates and Deardourff & Associates/The Media Company, July 2001 at http://www.plannedparenthoodsb.org/pressroom/pdf/{1FA1A2D7-DADC-49AB-A9E8-C2C13F4B6B68}_Website.pdf#search='poll%20on%20sex%20education'.

⁷⁴ *Sex Education in America*, Toplines, pp. 9-11

⁷⁵ Rector RE, Pardue MG, Martin S. Background. Heritage Foundation, January 28, 2004, 1722

⁷⁶ www.aasect.org/req.asp.

evidence of the credentials of those teaching abstinence-only-until-marriage programs. The absence of any mention of minimum educator qualifications, or discussion of the need for such qualifications, is cause for concern.

F. The Impact of Federal Requirements on the Medical Accuracy of Abstinence-Only-Until-Marriage Programs

The federal requirements of abstinence-only-until-marriage programs virtually require medically inaccurate and misleading information (Title V, Section 510). Problematic requirements include:

- Have as its *exclusive purpose* teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.
 - This requirement restricts educators from acknowledging the medically demonstrated health benefits of contraception, before or after marriage.
- Teach that abstinence from sexual activity is *the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems*.
 - Abstinence is only 100% effective at preventing out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems in perfect use conditions. In typical use conditions, abstinence pledges did not decrease the rate of STD. Programs that teach abstinence plus, forbidden by these criteria, have been proven to both delay sexual intercourse and decrease STD. In typical use then, abstinence plus programming, given current research knowledge, outperforms abstinence-only-until-marriage programs.
- Teach that a mutually faithful *monogamous* relationship in context of marriage is the *expected standard of human sexual activity*.
 - Nationally 87.8% of women report sexual activity relate their first voluntary intercourse prior to marriage, including 94.6% of women aged 20-24 years and 98.5% of women younger than 20 years. These statistics render it difficult to justify labeling abstinence-only-until-marriage the expected standard of human sexual activity. Further, in the cohort that clearly includes the parents of these children, only 15.2% of women aged 35-39 years; and 23% of women aged 40-44 years at the time of the interview waited until marriage for sex.⁷⁷ There are no individuals on earth more capable of recognizing and exposing adult hypocrisy than American teenagers. It is the responsibility of parents to guide their children to the healthiest possible future, regardless of the parents own past behavior. Smoking parents can and should advise their children not to smoke; parents who used marijuana as adolescents should still advise their children against using marijuana; parents who engaged in premarital sex can advise their children to remain abstinent, but because it is healthy, because it is the right thing to do, not because it is the inaccurately described “expected standard of human sexual activity.” Ironically, these criteria restrict the capacity of abstinence-only-until-marriage programs to promote monogamy

⁷⁷ Abma JC, et al. Fertility, Family Planning, and Women’s Health: New Data from the 1995 National Survey of Family Growth. Vital and Health Statistics, 23(19). Washington DC: National Center for Health Statistics

outside of marriage as a deterrent to harmful outcomes—a strategy demonstrated successful in other STD and HIV prevention programs.⁷⁸

- Teach that sexual activity outside of the context of marriage is *likely to have harmful psychological and physical effects*.
 - How likely must likely be to be considered likely? Likely is defined as “probable” or “a good chance of being the case or of coming about”. A recent legal definition of “likely” has been offered: “a substantial risk of causing great injury, rather than a potential risk.”⁷⁹ It is simply not medically accurate to conclude that sexual activity outside of marriage is *likely* to have harmful psychological and physical effects. One *may* conclude that it is more likely than for teens who choose abstinence, but even if true, that is not what the criteria requires. It is *not* likely or probable that sexually active teens using contraception in typical use will experience pregnancy, sexually transmitted disease, or problems of mental health. Saying that it is *likely* to coerce desired behavior is simply not necessary, as demonstrated by the successful outcomes related to abstinence plus programming.

- *...in the context of marriage...*
 - This phrase forces involved educators to exclude and stigmatize the more than 40% of students who have already become sexually active; a significant number of students who have already been pregnant or given birth; students not interested in marriage; and students prohibited by law from marriage. The needs of the students are not only ignored, but by the nature of the programming, these students are held up as immoral, lacking in self-esteem and mental health, and portrayed as individuals who are doomed to a future of poverty, disease or death.

V. RECOMMENDATIONS

Based on the findings of this report and the unmet needs of Ohio’s youth, the following recommendations are offered.

A. Revise the content requirements of abstinence-only-until-marriage curricula to address the needs of all youth

The eight governmental criteria required of abstinence-only-until-marriage programs provide no room for “abstinence-plus” teaching. The criteria restrict the capacity of programs to respond to a full range of teen needs, and virtually require medically misleading information be transmitted. To claim, as abstinence-only-until-marriage advocates do, that students can receive this information in other classes and from other

⁷⁸ Stoneburner R, Low-Beer D. Population level HIV declines and behavioral risk avoidance in Uganda. *Science*, 304(5671) April 30, 2004

⁷⁹ California Supreme Court, 2002

sources disregards the responsibility of these programs to assure a full range of knowledge and skills are communicated; disregards the scarcity of curricular time available in these days of proficiency testing; disregards the cost inefficiency of offering two parallel (yet conflicting) programs; and disregard the confusion and disenfranchisement some teens are likely to experience when receiving this conflicting information. Title V, Section 510 regulations should be changed. Revised criteria should consider recommendations from this report, and be evaluated by a diverse board of qualified professionals. School programs conducting comprehensive sexual education without an abstinence plus orientation should consider implementing this approach. The school-based sexual education debate should be reframed to investigate the most effective ways to teach abstinence and contraception in the context of the same educational program.

B. Provide information on contraception and protection from sexually transmitted disease for youth who are not abstinent

Scientific evidence continues to demonstrate that the majority of America's youth are not abstinent until marriage. While the vast majority of well-intentioned parents (91%) hope their children will remain abstinent at least until adulthood, wishing doesn't make it so. The need to provide accurate information on methods of protection for youth who are not abstinent is essential. This information can be useful at some point to *all* teens, including those who wait until adulthood or marriage to take advantage of it. Teaching about contraception and protection from STD can be functionally taught with this proviso, allowing a continued strong abstinence orientation. Scientifically-accurate instruction on contraceptives must be a part of abstinence-oriented curricula.

C. Implement a third-party scientific review of abstinence-only-until-marriage curricula

All publicly-funded sexuality curricula, not just abstinence-only-until-marriage programs, should be stringently reviewed by a panel of credentialed experts, such as public health professionals, nurses, social workers, psychologists, or epidemiologists. The review process should be multi-staged, allowing for revisions and continued evaluation. Such reviews should be regulated by government entities at the federal and local levels. It is essential that programming be evaluated not just for positive outcomes, but also to be certain that there are not associated negative outcomes. The *Precautionary Principle*, embraced by the field of public health states that: In the presence of scientific uncertainty, the burden of proof that harm will not result from the public health intervention shifts to the proponent of the intervention; requires all viable alternatives be considered; and suggests the right of the public to be involved in decision-making. Once curricula are evaluated, those identified as effective prevention programs should receive government funding.

D. Establish standards of competence for Ohio abstinence-only-until-marriage educators

Because no single national standard outlines the credentials that STD prevention, pregnancy, and sexuality educators; and because sexuality curricula require an understanding of the complex elements of health behavior and health behavior change applied to a specific topic; we support the requirement of a Bachelor's degree and 90 hours

of education in the core areas of sexual and reproductive anatomy/physiology, developmental sexuality, dynamics of interpersonal relationships, gender-related issues, sexual orientation and gender identity, and health factors that may influence sexuality including illness, disability, drugs, abortion, pregnancy, contraception, fertility, HIV/AIDS, sexually transmitted infections, and safer sex practices. Qualifications for these educators should be included as a component of the national dialogue.

E. Offer Parents a More Prominent Role in Determining the Nature of Sexual Education Received by Their Children

Apparently conflicting findings reported by investigators with advocacy roles in the national dialogue mask the true attitudes of parents. Parental attitudes and involvement should be an important component of decision-making about sexual education of teens. No interest group, however, should be allowed to drive programming to include inaccurate or misleading scientific information. While data differ significantly between studies done by different advocacy groups, the single consistent finding is that 75% to 91% of parents want their children taught about both abstinence and contraception.

F. Offer More Resources for LGBT Youth

Publicly-funded abstinence-only-until-marriage programs in Ohio should adopt a more inclusive curricula and address the needs of LGBT youth in all programming and curricula. In Ohio, “abstinence-only-until-marriage” presents an option not legally available to LGBT persons. At minimum, all abstinence-only-until-marriage programs should discuss long-term partnerships and monogamy among LGBT people, and be prepared to make referrals to community-based organizations that can meet the needs of LGBT youth.

VI. CONCLUSION

The number of federally funded abstinence-only-until-marriage programs in the state of Ohio has increased dramatically since 2001. This report concludes that curricula implemented in schools throughout the state contain misleading and false information, scientific errors, and substantial inaccuracies regarding gender stereotypes, STDs, and contraception. Evidence that an abstinence orientation in sexual education delays the onset of sexual intercourse argues for the inclusion of an abstinence component for all programming. Concerns regarding inclusion of a strong abstinence message in the same program that also offers contraceptive information appear unfounded. The organizations using these curricula exclude various high-risk youth populations, do not represent the views of the majority of parents, and often do not have the credentials necessary to teach sexuality education. Rigorous evaluation of all sexual education programming is warranted to assure the health and safety of our children through decrease in the rates of adolescent sexual activity, teen pregnancy, and STD.

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