

Sex Education in the United States

HISTORY OF SEX EDUCATION IN THE U.S.

The primary goal of sexuality education is the promotion of sexual health (NGTF, 1996). In 1975, the World Health Organization offered this definition of sexual health:

Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love. Fundamental to this concept are the right to sexual information and the right to pleasure. ... [T]he concept of sexual health includes three basic elements:

1. *a capacity to enjoy and control sexual and reproductive behavior in accordance with a social and personal ethic*
2. *freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationship*
3. *freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions*

Thus the notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counseling and care related to procreation or sexuality transmitted diseases (WHO, 1975).

WHO's early definition is at the core of our understanding of sexual health today and is a departure from prevailing notions about sexual health — and sex education — that predominated in

the 19th and early 20th centuries. Until the 1960s and '70s, the goals of social hygiene and moral purity activists eclipsed broader sexual health concerns in the public health arena. Their narrow goals were to prevent sexually transmitted infection, stamp out masturbation and prostitution, and limit sexual expression to marriage (Elia, 2009).

From the 1960s on, support for sex education in schools gained widespread support. However, beginning in the 1980s, a debate began in the United States between a more comprehensive approach to sex education, which provided information about sexual health — including information about contraception — and abstinence-only programs. Education about sex and sexuality in U.S. schools progressed in these two divergent directions. One was based on the belief that medically accurate and comprehensive information about sexual health would *decrease* risk-taking behaviors among young people. The other was based on the erroneous belief that medically accurate, comprehensive information would *increase* risk-taking behaviors among young people. There is now significant evidence that a comprehensive approach to sex education that demonstrates a number of key characteristics has been able to promote sexual health among young people by reducing sexual risk-taking behavior. The abstinence-only approach has not (Kantor et al, 2008).

MEDICALLY-ACCURATE, COMPREHENSIVE SEXUALITY EDUCATION IN U.S. SCHOOLS

In 1964, Dr. Mary Calderone, medical director for Planned Parenthood Federation of America, founded the Sexuality Information and Education Council of the United States (SIECUS) out of her concern that young people and adults lacked accurate information about sex, sexuality, and sexual health (SIECUS, 2011a).

In 1990, SIECUS convened the National Guidelines Task Force, a panel of experts that constructed a framework within which local communities could design effective curricula and/or evaluate existing programs. The resulting *Guidelines for Comprehensive Sexuality Education — Kindergarten–12th Grade* was first published in 1991. Subsequent editions were published in 1996 and 2004 (NGTF, 2004). The *Guidelines* identified the role of sexuality education in promoting sexual health:

It should assist young people in developing a positive view of sexuality, provide them with information they need to take care of their sexual health, and help them acquire skills to make decisions now and in the future.

According to the National Guidelines Task Force, sexuality education promotes sexual health in four ways:

- It provides accurate information about human sexuality, including growth and development, anatomy, physiology, human reproduction, pregnancy, childbirth, parenthood, family life, sexual orientation, gender identity, sexual response, masturbation, contraception, abortion, sexual abuse, HIV/AIDS, and other sexually transmitted infections.
- It helps young people develop healthy attitudes, values, and insights about human sexuality by exploring their community's attitudes, their family's values, and their own critical thinking skills so that they can understand their obligations and responsibilities to their families and society.
- It helps young people develop communication, decision-making, assertiveness, and peer-refusal skills so they are prepared to create reciprocal, caring, non-coercive, and mutually satisfying intimacies and relationships when they are adults.
- It encourages young people to make responsible choices about sexual relationships by practicing abstinence, postponing sexual intercourse, resisting

unwanted and early sexual intercourse, and using contraception and safer sex when they do become sexually active (NGTF, 2004).

With the publication of the *Guidelines*, SIECUS also convened the National Coalition to Support Sexuality Education. The coalition now has 140 member organizations that include the American Medical Association, the American Public Health Association, the American Psychiatric Association, the American Psychological Association, the National Urban League, and the YWCA of the U.S.A (NCSSE, 2008).

Since publication of the *Guidelines*, a large number of sex education programs have been developed, implemented, and evaluated in order to understand which approaches to sex education have the most success in helping move young people toward sexual health. In November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy published *Emerging Answers*, Douglas Kirby's summary of the findings of 115 studies conducted during the previous six years to measure the impact of sex education programs. Of the 48 comprehensive sexuality education curricula he evaluated, he identified programs that

- helped teens delay first intercourse
- helped sexually active teens reduce the frequency of sex
- helped teens reduce the number of sex partners
- helped teens increase their use of condoms
- helped increase teens' use of other contraceptives
- helped sexually active teens reduce their sexual risk through changes in their behavior

Other curricula — abstinence-only programs described in more detail later — were not effective in any of these ways (Kirby, 2007, 102).

Kirby has identified 17 characteristics of effective curriculum-based programs based on his meta-analyses. He sorted these characteristics into three categories.

Characteristics of Effective Pregnancy and HIV/AIDS Prevention Programs

THE PROCESS OF DEVELOPING THE CURRICULUM	THE CONTENTS OF THE CURRICULUM ITSELF	THE PROCESS OF IMPLEMENTING THE CURRICULUM
<p>1. Involved multiple people with expertise in theory, research, and sex and STD/HIV education to develop the curriculum.</p> <p>2. Assessed relevant needs and assets of the target group.</p> <p>3. Used a logic model approach that specified the health goals, the types of behavior affecting those goals, the risk and protective factors affecting those types of behavior, and activities to change those risk and protective factors.</p> <p>4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space, and supplies).</p> <p>5. Pilot-tested the program.</p>	<p>CURRICULUM GOALS AND OBJECTIVES</p> <p>6. Focused on clear health goals—the prevention of STD/HIV, pregnancy, or both.</p> <p>7. Focused narrowly on specific types of behavior leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these types of behavior, and addressed situations that might lead to them and how to avoid them.</p> <p>8. Addressed sexual psychosocial risk and protective factors that affect sexual behavior (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy) and changed them.</p> <p>ACTIVITES AND TEACHING METHDOLOGIES</p> <p>9. Created a safe social environment for young people to participate.</p> <p>10. Included multiple activities to change each of the targeted risk and protective factors.</p> <p>11. Employed instructionally sound teaching methods that actively involved participants, that helped them personalize the information, and that were designed to change the targeted risk and protective factors.</p> <p>12. Employed activities, instructional methods, and behavioral messages that were appropriate to the teens' culture, developmental age, and sexual experience.</p> <p>13. Covered topics in a logical sequence.</p>	<p>14. Secured at least minimal support from appropriate authorities, such as departments of health, school districts, or community organizations.</p> <p>15. Selected educators with desired characteristics (whenever possible), trained them, and provided monitoring, supervision, and support.</p> <p>16. If needed, implemented activities to recruit and retain teens and overcome barriers to their involvement (e.g., publicized the program, offered food, or obtained consent).</p> <p>17. Implemented virtually all activities with reasonable fidelity.</p>

Research has shown that when comprehensive programs include these 17 characteristics, they positively affect adolescent sexual behavior.

Research has also shown that it is possible for such programs to delay sexual debut and increase the use of condoms and other forms of birth control among adolescents. Further, the research is clear that programs that stress abstinence, as well as the use of protection by those who are sexually active, do not send mixed messages. They have, in fact, a positive impact on young people's sexual behavior — delaying initiation of sex and increasing condom and contraceptive use. This strong evidence suggested that some comprehensive sex education programs should be widely replicated (Kirby, 2008).

In 2009, recognizing that evidence-based sex education programs were effective in promoting sexual health among teenagers, the Obama administration transferred funds from the Community-based Abstinence Education Program and budgeted \$114.5 million to support evidence-based sex education programs across the

country. The bulk of the funds — \$75 million — was set aside for replicating evidence-based programs that have been shown to reduce teen pregnancy and its underlying or associated risk factors. The balance was set aside for developing promising strategies, technical assistance, evaluation, outreach, and program support (Boonstra, 2010). This was the first time federal monies were appropriated for more comprehensive sex education programs (SIECUS 2011).

The U.S. Department of Health & Human Services has identified 28 evidence-based curricula that are effective at preventing teen pregnancies, reducing sexually transmitted infections, or reducing rates of associated sexual risk behaviors — sexual activity and number of partners — as well as increasing contraceptive use. These curricula are used in community-based organizations (CBOs), elementary schools, middle schools, high schools, and youth detention facilities.

Here is a list of evidence-based curricula that are currently eligible for replication with this funding.

Program Name	Settings
1. Aban Aya Youth Project	Middle schools
2. Adult Identity Mentoring (Project AIM)	Middle schools
3. All4You!	Alternative high schools
4. Assisting in Rehabilitating Kids (ARK)	Substance use treatment facilities
5. Be Proud! Be Responsible!	Middle schools, high schools, or CBOs
6. Be Proud! Be Responsible! Be Protective!	Middle schools, high schools, or CBOs
7. Becoming a Responsible Team (BART)	Middle schools, high schools, or CBOs
8. Children's Aid Society (CAS) — Carrera Programs	CBOs
9. ¡Cuídate!	Middle schools, high schools, or CBOs
10. Draw the Line/Respect the Line	Middle schools
11. FOCUS	CBOs or clinics
12. Horizons	CBOs or clinics
13. It's Your Game: Keep it Real	Middle schools
14. Making a Difference!	Middle schools or CBOs
15. Making Proud Choices!	Middle schools or CBOs
16. Project TALC	CBOs
17. Promoting Health Among Teens! Abstinence-Only Intervention (formerly known as 'Promoting Health Among Teens!')	Middle schools or CBOs
18. Promoting Health Among Teens! Comprehensive Abstinence and Safer Sex Intervention (formerly known as 'Comprehensive Abstinence and Safer Sex Intervention!')	Middle schools or CBOs
19. Raising Healthy Children (formerly known as the Seattle Social	

Development Project)	Middle schools or CBOs
20. Reducing the Risk	High schools
21. Rikers Health Advocacy Program (RHAP)	CBOs or youth detention facilities
22. Safer Sex	CBOs or clinics
23. SiHLE	CBOs or clinics
24. Sexual Health and Adolescent Risk Prevention (SHARP) (formerly known as HIV Risk Reduction Among Detained Adolescents)	Youth detention facilities
25. Sisters Saving Sisters	CBOs or clinics
26. Teen Health Project	CBOs
27. Teen Outreach Program	Middle schools, high schools, or CBOs
28. What Could You Do?	High schools, CBOS, or clinics

For updates to this list, go to <http://www.hhs.gov/ash/oah/oah-initiatives/tpp/programs.html> (DHHS, 2011).

In January 2012, a consortium of organizations — the Future of Sex Education Initiative (FoSE) — published its *National Sexuality Education Standards — Core Content and Skills, K–12*. Led by Advocates for Youth, Answer, and SIECUS, FoSE included the American Association of Health Education, the American School Health Association, the National Education Association — Health Information Network, and the Society of State Leaders of Health and Physical Education. The *Standards* are designed to address the inconsistent implementation of sex education nationwide and the limited time allocated to teaching the topic. The goal of the *Standards* is to “provide clear, consistent and straightforward guidance on the essential minimum, core content for sexuality education that is age-appropriate for students in grades K–12. FoSE recommendations are designed to

- *Outline what, based on research and extensive professional expertise, are the minimum, essential content and skills for sexuality education K–12 given student needs, limited teacher preparation and typically available time and resources.*
- *Assist schools in designing and delivering sexuality education K–12 that is planned, sequential and part of a comprehensive school health education approach.*
- *Provide a clear rationale for teaching sexuality education content and skills at different grade levels that is evidence-informed, age-appropriate, and theory-driven.*
- *Support schools in improving academic performance by addressing a content area that is both highly relevant to students and directly related to high school graduation rates.*

- *Present sexual development as a normal, natural, healthy part of human development that should be a part of every health education curriculum.*
- *Offer clear, concise recommendations for school personnel on what is age-appropriate to teach students at different grade levels.*
- *Translate an emerging body of research related to school-based sexuality education so that it can be put into practice in the classroom (FoSE, 2012).*

ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS IN U.S. SCHOOLS

In 1981, Congress passed the Adolescent Family Life Act (AFLA), also known as the “chastity law.” It funded educational programs to “promote self-discipline and other prudent approaches” to adolescent sex, or “chastity education.” Federal funds were granted to abstinence-only programs that were developed by churches and religious conservatives nationwide.

The American Civil Liberties Union (ACLU) challenged AFLA in court, calling it a Trojan horse that smuggled the doctrines of the Christian Right — particularly its opposition to abortion — to public-school children at public expense — in violation of the principle of separation of church and state (Heins, 2001; Levin-Epstein, 1998; Pardini, 1998; Schemo, 2000).

Twelve years later, the U.S. Supreme Court held that federally funded programs must delete direct references to religion. Such programs could no longer, for example, suggest that students take Christ on a date as chaperone. By that time, however, some of the biggest federal grant

recipients, including Sex Respect and Teen-Aid, had already had success in getting schools to adopt their programs.

In 1996, Congress attached a provision to welfare legislation that established a federal program to exclusively fund abstinence-only programs (NCAC, 2001). Since the inception of the abstinence-only movement, more than \$1.5 billion has been spent on programs whose only purpose is to teach the social, psychological, and health benefits that might be gained by abstaining from sexual activity (SIECUS, 2006a; SIECUS, 2006b; "Take Back Our Rights," 2004).

The goals of abstinence-only programs were defined by government regulation in Title V. Federal funding is only available to a program that

- A. *has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;*
- B. *teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;*
- C. *teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;*
- D. *teaches that a mutually faithful, monogamous relationship in context of marriage is the expected standard of sexual activity;*
- E. *teaches that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects;*
- F. *teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;*
- G. *teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and*
- H. *teaches the importance of attaining self-sufficiency before engaging in sexual activity (Social Security Act § 510).*

Funding guidelines stipulate that abstinence-only education grant funds cannot be used to provide instruction in the use of birth control or to promote the use of such methods (Trenholm, 2007).

In the last year of his presidency, George W. Bush requested \$242 million for abstinence-only funding in his proposed FY2008 budget. The Congress signed off on \$176.83. The total amount of federal and state tax dollars spent on abstinence-only

programs during the Bush administration exceeded \$1.75 billion (nomoremoney.org, 20011; SIECUS, 2006b).

Between 2004 and 2008, five authoritative reports, including Kirby's, have shown that abstinence programs do not help young people to delay the onset of sexual intercourse, do not help them reduce risk-taking behaviors, and frequently include misinformation. Here is a summary of these reports and studies:

I. Waxman Report

In December 2004, Rep. Henry Waxman released a report on 13 abstinence-only programs — *The Content of Federally Funded Abstinence-Only Education Programs*. The report found that abstinence-until-marriage programs were often inaccurate and sometimes dishonest:

- Eleven of the 13 curricula contained errors and distortions.
- The curricula contained false and misleading information about the effectiveness of contraception, HIV prevention, and condoms.
- The curricula contained false and misleading information about the risks of abortion.
- The curricula blurred religious belief with science.
- The curricula treated stereotypes about girls and boys as scientific fact. The stereotypes
 - undermine girls' achievements
 - promote the myth that girls are weak and need protection
 - reinforce sexual aggressiveness among men
- The curricula contained false and misleading information about the risks of sexual activity, including information about cervical cancer prevention, HIV risk behaviors, chlamydia, and mental health.
- The curricula contained scientific errors (Waxman, 2004).

In October 2006, the Government Accounting Office (GAO) released a report supporting Rep. Waxman. This report found that most of the abstinence-only programs funded by the U.S. Department of Health and Human Services (HHS) were not reviewed for scientific accuracy before funding *and* implementation (GAO, 2006a). The GAO also sent a letter to the Secretary of Health and Human Services recommending that "HHS reexamine its position and adopt measures to ensure that, where applicable, abstinence education materials comply [with section 317P(c)(2) of the Public Health Service

Act].” Section 317P(c)(2) requires that education materials designed to address sexually transmitted infections contain medically accurate information about the effectiveness or lack of effectiveness of condoms in preventing sexually transmitted infection (GAO, 2006b).

II. Trenholm Study

In 2007, Christopher Trenholm published his study for Mathematica Policy Research, Inc. Trenholm evaluated four Title V, Section 510, A–H, abstinence programs. His evaluation was based on data collected from teens four to six years after study enrollment. The four programs were

- My Choice, My Future! (Powhatan, VA)
- Recapturing the Vision (Miami, FL)
- Families United to Prevent Teen Pregnancy (Milwaukee, WI)
- Teens in Control (Clarksdale, MS)

The evaluation found that all four programs were ineffective in helping young people to change their behavior.

- No program helped teens abstain from sex any longer than other teens.
- No program helped raise the age of first intercourse.
- No program helped reduce the number of teens’ sex partners.
- No program helped teens protect themselves at first intercourse.
- No program helped teens use less marijuana and alcohol.
- And teens in these abstinence-only programs were less likely than other teens to believe that condoms reduce the risk of infection (Trenholm, 2007).

III. United Nations Programme on HIV/AIDS & the World Health Organization

On August 4, 2007, the *British Medical Journal* published a UNAIDS / WHO evaluation of 13 abstinence-only programs for HIV prevention in “high-income countries.”

The evaluation found that abstinence-only programs that aim to prevent HIV infection are ineffective:

- No program helped raise the age of first intercourse.
- No program helped reduce the number of sex partners.

- No program helped reduce the amount of intercourse.
- No program helped improve the use of condoms among sexually active teens (Underhill, 2007).

IV. Kirby Summary — *Emerging Answers*

In November 2007, The National Campaign to Prevent Teen and Unplanned Pregnancy published *Emerging Answers*, Douglas Kirby’s summary of the findings of 115 studies conducted during the previous six years to measure the impact of sexuality education programs. Of the 56 curriculum-based programs evaluated, 48 were comprehensive sexuality education curricula described above. The other eight were abstinence-only curricula. The reason that there were so few was that very few abstinence-only programs had been rigorously evaluated.

The study found that all the rigorously evaluated abstinence-only programs were ineffective:

- No program helped raise the age of first intercourse.
- No program helped teens postpone having sex.
- No program helped sexually-active teens become sexually abstinent.
- No program helped reduce the number of teens’ sex partners.
- No program helped improve the use of condoms or other contraceptives among sexually active teens (Kirby, 2007).

V. Kirby Review

In 2008, Douglas Kirby reviewed 56 studies to compare the impact of abstinence-only and comprehensive sex education curricula. In his comparison, Kirby found little evidence to warrant widespread replication of abstinence-only programs (Kirby, 2008).

These and other studies showed that the increased dominance of abstinence-only programs from 1995 to 2002 left an increasing proportion of teenagers without formal instruction about birth control (Duberstein, et al, 2006). In September 2005, SIECUS and Advocates for Youth filed a challenge to the federal government funding of inaccurate and ineffective abstinence-only-until-marriage programs and called upon the Administration of Children and Families (ACF) and HHS to immediately cease sponsorship of programs that fail to provide medically accurate, complete

sexual health information (SIECUS / Advocates for Youth, 2005).

In 2006, the Society for Adolescent Medicine (SAM) developed a position paper that concluded that “Abstinence only, as a basis for health policy and programs should be abandoned.” The seven positions taken by the SAM and endorsed by the American College Health Association included

- support for abstinence as a healthy choice for adolescents
- recommendation that promotion of abstinence occur within programs that provide complete and accurate information about sexual health
- recommendation for individualized counseling about abstinence and sexual risk reduction
- promotion of social and cultural sensitivity to sexually-active and LGBTQ youth
- elimination of censorship of sexual health information
- adoption of evidence-based programs that are evaluated with rigorous research methods
- recognition that federal law and guidelines were ethically flawed and interfere with fundamental human rights (Santelli, et al., 2006).

The American Public Health Association also called for repealing funding for abstinence-only programs (APHA, 2006). By 2008, 21 states required medical or scientific accuracy in the provision of sexuality or HIV/AIDS education — although many did not define exactly what that meant (Santelli, 2008).

In the past few years, a few abstinence-only programs have been shown to be somewhat effective. One program for inner-city African-American students in the sixth and seventh grades may have had an important role in preventing early adolescent sexual involvement. This program, however, did not meet federal, A–H guidelines for abstinence-only programs, was not moralist nor critical of condoms and other elements associated with risk-reduction interventions for sexually-active adolescents (Jermmott et al., 2010).

Despite wide-ranging attempts to defund abstinence-only-until-marriage programs over the last 20 years, \$50 million in federal funds were again set aside for such programs in 2010 (Boonstra, 2010).

SEXUALITY EDUCATION IN THE U.S. TODAY

According to the CDC, more than 95 percent of all teenagers in U.S. schools, churches, community centers, or other places, receive some “formal” sexuality education before they turn 18. More than 80 percent received information about sexually transmitted infections and “how to say no to sex.” But only 70 percent of girls and 62 percent of boys 15–19 years old receive information about birth control (Martinez, 2010). And only about a third of girls and half of boys receive information about birth control *before* they first have intercourse (Guttmacher, 2011a).

The lack of information about birth control is due in large part to the fact that one out of four teenagers in the U.S. attends abstinence-only programs that do not provide information about birth control (Guttmacher, 2011a). One study found that among teens aged 18–19, more than 40 percent say they know little or nothing about condoms and 75 percent say they know little or nothing about the pill (Kaye, 2009).

Three decades of national polling has shown that the vast majority of Americans, especially American parents, have long supported comprehensive, medically accurate sexuality education (Harper, 1981). During this time, the overwhelming majority of Americans have wanted their children to receive sex education that includes a variety of subjects, including communications and coping skills, the emotional aspects of sexual relationships, sexually transmitted infection, HIV/AIDS, how to use contraception (85 percent) and condoms (84 percent), sexual orientation (76 percent), abortion (79 percent), and the consequences of becoming sexually active (94 percent) (KFF, 2000). Only 36 percent of Americans have supported abstinence-only educational programs (Bleakley et al., 2006), and 56 percent of Americans have not believed that abstinence-only programs prevent sexually transmitted infections or unintended pregnancies (Research!America and APHA, 2004).

Today, 90 percent of U.S. parents believe that sex education programs in high school should cover topics such as sexually transmitted infections including HIV, healthy relationships, birth control, and abstinence. Seventy-five percent of parents believe that sex education programs *in middle school* should cover the same topics. These findings suggest that the overwhelming majority of parents do not support abstinence-only programs (PPFA/CLAFH, 2011).

Additional studies have shown that parental opinions regarding sexuality education are similar between states that teach comprehensive sexuality education and states that mandate abstinence-only programs.

- A 2006 survey of parents in North Carolina — a state that mandates abstinence-only education — found that 91 percent of parents support sexuality education in the schools, with 89 percent supporting comprehensive sexuality education — including discussions of sexual orientation, oral sex, and anal sex (Ito et al., 2006).
- A 2007 survey of California parents found that regardless of educational attainment, political or religious affiliation, or place of residence, nearly 90 percent believe their children should have comprehensive sex education in the classroom (Mangaliman, 2007).
- A 2011 study of parents in Harris County, Texas — the third most populous county in the U.S. — found that a majority support sex education in middle school that would include abstinence messages as well as medically accurate information and instruction on the use of condoms and other kinds of contraception. Despite the desires of parents, however, nearly three out of four Texas school districts implement abstinence-only programs that have no evidence of effectiveness (Texas Freedom Network, 2011; Tortolero, 2011).
- A recent study in Mississippi showed that 92 percent of Mississippi parents support abstinence-plus sex education in schools. In this state — with the highest teen pregnancy and gonorrhea rates in the country — the overwhelming majority of parents want to move from abstinence-only programs to abstinence-plus curricula that include information about birth control, relationships, and sexually transmitted infections (McKee, 2011).

Despite widespread public support, particularly from parents, only 20 states mandate sex education and HIV education, only 18 states mandate the provision of information about birth control, only 12 states mandate instruction about sexual orientation, and only 13 states mandate that instruction in sex education and HIV education be medically accurate (Guttmacher, 2011b).

While the majority of programs used in American schools today are abstinence-based and abstinence-only programs, with the support of federal funding, states are moving away from failed

abstinence-only programs to more comprehensive approaches (SIECUS, 2011b).

It is estimated that *only* five percent of America's schoolchildren are taught comprehensive sexuality education that encompasses the holistic approach to sexuality — education that addresses the biological, psychological, socio-cultural, and spiritual dimensions of sexuality. And *only* 10 percent of all American school districts have a sexuality education policy that includes contraception and safer sex in addition to abstinence (Guttmacher Institute, 1999; NGTF, 1996; NGTF, 2004; PPFA/CALFH, 2011).

Decisions are made at the state and local level about which specific sex education programs are offered in U.S. schools, but the federal government influences programs in local schools and communities by offering some grant support for school-based efforts. This is how the Obama administration and the U.S. Congress may have ushered in a new era of sex education in the U.S. through the Appropriations Act of 2010 and federal health care legislation, which eliminated two-thirds of federal funding for ineffective abstinence-only programs and provided nearly \$190 million in funds for evidence-based teen pregnancy-prevention programs and more comprehensive approaches to sex education (SEICUS, 2011b).

SEX EDUCATION WORLDWIDE

Comprehensive sex education is increasingly recognized worldwide as a human right. International organizations such as the World Health Organization, UNESCO, the Joint United Nations Programme on HIV/AIDS, and the International Conference on Population and Development recognize that sex education is an obligation of government and that it must be evidence-based and must not be biased, ideologically motivated, or censored (CRR, 2008).

THE ROLE OF PARENTS AS THE PRIMARY SEXUALITY EDUCATORS OF THEIR CHILDREN

Parents are a critical influence on their children's sexual health. Research shows that teens who report having good conversations with their parents about sex have stronger relationships with their parents and are more likely to delay sex, have fewer partners, and are more likely to use condoms and other birth control methods when they do have sex (Martino et al., 2008). This is why Planned Parenthood and other advocates of comprehensive sex education believe that parents are and ought to

be their children's primary sexuality educators (NGTF, 2004).

An overwhelming majority of parents (82 percent) are talking with their kids about issues related to sexuality, but they aren't always tackling the hard issues. A 2011 nationally representative study of 1,100 parents of 10- to 18-year-olds, found that parents are talking to their kids about a wide range of sexuality-related topics, including relationships (92 percent) and their own values about when sex should or should not take place (87 percent) (PPFA/CLAFH, 2011).

However, fewer parents are talking with their kids about tougher, more complicated topics. Only 74 percent are talking about how to say no to sex, and while 94 percent believe they are influential in whether or not their child uses condoms or other forms of birth control, only 60 percent are *talking* with their children *about* birth control (PPFA /CLAFH, 2011).

Parents are very concerned about keeping their kids safe and healthy through adolescence. Nine out of 10 parents are very concerned about making sure their child stays safe and healthy and that he or she does well in school. Eight out of 10 are very concerned about making sure their child doesn't use drugs or alcohol and that their child is involved in healthy relationships with peers and anyone they might date. Seven out of 10 want to make sure that their child doesn't become pregnant or get a sexually transmitted infection. Fathers are taking nearly as active a role in these conversations as mothers, and fathers are equally as concerned as mothers that their children receive adequate, effective in-school sex education. Seventy-eight percent of fathers have spoken with their kids about topics related to sexuality, compared to 88 percent of mothers (PPFA/CALFH, 2011).

Studies have shown that parents have a greater impact on the sexual health of their children when family conversations about sex and sexuality are ongoing. The American Academy of Pediatrics suggests that parents have open, honest, reciprocal, and repeated conversations with their children about sexuality beginning early in their children's lives. Repeated conversations allow parents to reinforce and build on what they want to teach their children. They also give children the chance to ask questions that help them understand and put into practice the lessons about sex and sexuality that their parents have taught them (Martino, 2008).

Some sex education programs incorporate homework assignments to complete with parents.

Parents who have and take the opportunity to involve themselves in parent/child sex education homework activities further enrich their relationships with their young teenagers, lead them to delay having sexual intercourse, and reduce their children's risk for unintended pregnancy and sexually transmitted infection (Blake et al., 2008). Most parents look to schools to help them educate their kids about sex and sexuality. A recent national poll showed that 90 percent of today's parents support high-school sex education programs that cover topics such as sexually transmitted infections, including HIV, healthy relationships, birth control and abstinence. And 75 percent of parents support similar programs in middle school (PPFA / CLAFH, 2011).

PLANNED PARENTHOOD'S ROLE IN SEX EDUCATION

Planned Parenthood is the largest, most trusted provider of sex education in the U.S. In 2010, Planned Parenthood affiliate education departments provided sex education to more than one million participants. The majority — 78 percent — were teenagers or young adults. They included 695,000 young people ages six to 18, more than 280,000 young adults ages 19 to 30. Fifty-three percent of participants received sex education in a school setting. Another 47 percent received it in settings such as social service agencies, religious institutions, and juvenile detention centers.

Planned Parenthood also trains 80,000 professionals, including 8,000 teachers and school staff, on how to effectively deliver sexual health messages to young people as well as adults. The other professionals trained by Planned Parenthood sex educators include college and university faculty and staff, religious leaders, medical professionals, public health workers, and other human service providers. We also train community health workers/promotoras and teen peer educators.

Planned Parenthood sex education programs incorporate proven characteristics of effective programs, such as multi-session programs. Most Planned Parenthood affiliates replicate one or more evidence-based programs. In 2010, 18 Planned Parenthood affiliates were awarded federal grants or were part of winning grants as subcontractors, totaling near \$22 million per year for five years.

Fifty-seven percent of parents say they feel only "somewhat comfortable" or "very uncomfortable" talking with their children about sex (PPFA/CLAFH). Every year, more than 9,000 parents turn to Planned Parenthood sexuality educators to learn how to

improve parent/child communication about sex and sexuality. Thousands of other parents turn to Tools for Parents at <http://www.plannedparenthood.org/parents/> for advice on talking with their children about sex and sexuality and for advice on helping their youngsters delay sexual initiation and be prepared to use condoms and contraceptives when they do decide to become sexually active.

Planned Parenthood also provides sexual health information online. plannedparenthood.org receives more than three million visits a month from people seeking sexual health information. In 2011, the website's Info for Teens page received more than one million visits, and the website's Tools for Parents section received 200,000 visits. One study shows that, of the 29 leading sexual health websites for adolescents, Info for Teens at plannedparenthood.org is the most well-rounded and useful (Whiteley, et al., 2011).

In 2010, Planned Parenthood launched a live chat/text program that

- provides access to teens and young adults when they are in moments of crisis
- takes advantage of young people's preferences for new communication methods
- enables live interaction to help lower anxiety levels which can be barriers to action and health seeking behaviors

Eighty-seven percent of the more than 50,000 visitors to date have found the service very helpful or somewhat helpful, and built-in surveys show that the chat/text experience substantively reduces the level of worry for many of our visitors.

To broaden our reach to young people and support them in their efforts to maintain their sexual health, we are currently investigating a range of interactive tools and social media experiences that will help guide young people to make responsible choices about their sexual health.

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