

Sex Education in the U.S.: Policy and Politics

According to a recent Kaiser Family Foundation study, nine out of ten (89%) of the nation's nearly 20 million public secondary school students will take sex education at least once between the 7th and 12th grades.¹ Yet what students learn can vary widely.

Across the nation, states have passed a patchwork of sex education laws, ranging from general mandates that the subject be taught to more specific guidelines regarding topics or messages to be included. The AIDS epidemic led a number of states to pass specific requirements to provide some form of education about the prevention of HIV/AIDS in particular and/or sexually transmitted diseases (STDs) in general. Because most state laws governing these topics are fairly broad, the specific content of the curriculum is often left to local school districts or individual schools.

The federal government's involvement in sex education has primarily been to provide funding for education programs – a role that has grown in recent years. As part of its response to the HIV/AIDS epidemic, the budget for the Centers for Disease Control and Prevention (CDC) has included funding for HIV education since 1988. In 1996, as part of its broad welfare reform package, Congress made significant federal funds available over a five-year period to promote abstinence-only messages through community-based and in-school programs.

In the coming year, federal, state, and local lawmakers will look at education spending in a new context of shrinking budgets. Congress is expected to debate whether to reauthorize funding for several abstinence-only programs, and the outcomes of this federal discussion will likely influence further state and local action on sex education.

This issue brief examines the federal, state, and local policies that guide approaches to sex education today. It also examines recent research into community-level experiences and practices, as well as emerging evidence about the effectiveness of different types of sex education curricula.

Approaches to Sex Education

Comprehensive or "Abstinence Plus"

Comprehensive curricula include information about both abstinence and contraception. Sometimes a comprehensive curriculum may be referred to as "abstinence plus" because it teaches abstinence as the preferred choice. Advocates of comprehensive sex education argue that while young people should be taught to remain abstinent until they are emotionally and physically ready for sex, information about

birth control and disease prevention is essential for those who are sexually active.²

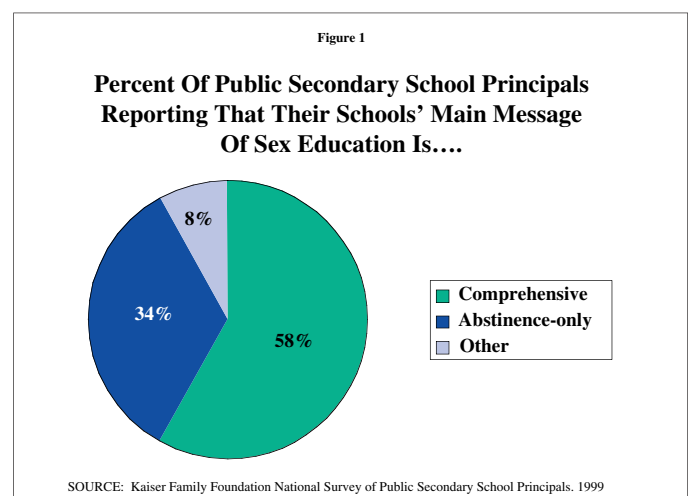
Abstinence-only

Abstinence-only sex education teaches abstinence until marriage as the only option for teenagers. Proponents of abstinence-only education argue against any discussion or education about contraception and safer sex, asserting that this sends young people a mixed message that contradicts the absolute prescription of abstinence – thus encouraging sexual activity.³

While the particulars of what is taught may vary, sex education is often described as presenting either an "abstinence-only" or "comprehensive" message. According to national surveys, most Americans support a more comprehensive approach to sex education: 81 percent say schools should both teach abstinence and give teens enough information to help them prevent unplanned pregnancies and the spread of STDs if they do decide to have sex; 18 percent support teaching only abstinence until marriage.⁴

Sex Education in Practice

A nationwide survey of principals, conducted by the Kaiser Family Foundation in 1999, found that some form of sex education is taught in the vast majority of public secondary schools (95%).⁵ Most principals – 58 percent – describe their sex education curriculum as comprehensive, that is "young people should wait to have sex but if they do not they should use birth control and practice safer sex." A third (34%) say their school's main message is abstinence-only, that is "young people should only have sex when they are married" (Figure 1).



According to the 2000 Federal School Health Education Profiles study, the median percentage of schools offering required health education courses to students in grades 6 to 12 was 91 percent. Among these schools, a large percentage said that they tried to increase knowledge of HIV (96%) and pregnancy prevention (84%).⁶

Federal Policy

HIV/AIDS Education

In response to the public health threat presented by the AIDS epidemic, the Centers for Disease Control and Prevention (CDC) has provided funding and technical assistance specifically for HIV education since 1988.⁷ In 2000, the CDC budgeted approximately \$47 million for in-school HIV education, which is just one piece of its larger prevention efforts. In-school HIV education funds are directed toward strengthening national efforts for coordinated school health education, training 180,000 teachers annually in effective strategies for HIV/STD education, as well as supporting HIV education for youth in 48 states, U.S. territories, the District of Columbia, and 18 major cities.⁸ Ohio and Utah are the only states that do not accept HIV education funding from the CDC.

Most of the CDC funding for in-school HIV education goes toward the education of students in high schools or middle schools, although some money goes toward HIV education efforts aimed at college students and at-risk youth who are not in schools. Most of the recipients are state and local education agencies, although other national organizations receive funds as well. Programs and schools that receive the CDC funding must agree to have their curriculum reviewed by a committee which is supposed to follow the Guidelines for Effective School Health Education to Prevent the Spread of AIDS, which recommend a comprehensive curriculum.⁹

Abstinence-only Education

Federal support for abstinence-only education efforts began in 1981 with passage of the Adolescent Family Life Act (AFLA), whose primary stated goal is to prevent premarital teen pregnancy by establishing “family-centered” programs to “promote chastity and self discipline.”¹⁰ It also seeks to promote adoption as the preferred option for pregnant teens and to provide support services for adolescents who are pregnant or parenting. In AFLA’s first year, Congress authorized \$11 million to be spent, in part, on promoting abstinence. Since then, the program has been refunded annually at between \$6 and \$18 million,¹¹ with last year’s appropriation providing \$12 million for the effort.¹²

A much more substantial amount of funding for abstinence-only education was allocated in 1996 under the auspices of the Personal Responsibility and Work Opportunity Reconciliation Act, welfare reform legislation best known for the sweeping revisions it made to public assistance programs (including replacing the Aid to Families with Dependent Children—AFDC—with a new program, Temporary Assistance to Needy Families, TANF).

The omnibus bill, which amended portions of Title V of the Social Security Act, provided \$250 million in federal funds to the states allocated over a five-year period (fiscal year 1998 through fiscal year 2002) to support abstinence-only programs, for both teens and unmarried adults.

To qualify for Title V money, states must match every four dollars in federal funds with three dollars of state money, thus directing as much as \$437.5 million to abstinence-only programs by the time the initial funding cycle ended in the fall of 2002. The legislation also provides a detailed definition of what federally funded programs are expected to teach (Table 1).

In 2000, Congress approved a separate abstinence-only “set-aside” for community organizations as part of the maternal and child health block grants. These “Special Projects of Regional and National Significance Community-Based Abstinence Education” (SPRANS) initially received \$40 million in earmarked funds over a two-year period.¹³ Under SPRANS, grants are awarded directly by a federal agency, not by governors or state agencies; it also does not require that local funds match federal donations, thus potentially allowing greater access to the funds.

Congress is expected to renew funding for all three of the current federal abstinence-only initiatives during the fiscal year 2003 appropriations process, particularly given President Bush’s strong support of these programs. In fact, abstinence-only advocates have urged the President to hold to his promise to provide as much federal funding for abstinence programs as is provided to family planning programs that serve adolescents, which some estimate received \$135 million in fiscal year 2001.¹⁴

Table 1
Definition of “Abstinence”

Under federal law, abstinence funds are available only to those programs that teach:

- Abstinence has social, psychological, and health benefits
- Unmarried, school-age children are expected to abstain from sex
- Abstinence is the only certain way to prevent out-of-wedlock pregnancy and sexually transmitted diseases
- A mutually faithful and monogamous married relationship is the standard for sexual activity
- Sexual activity outside marriage is likely to have harmful psychological and physical effects
- Out-of-wedlock childbearing is likely to harm a child, the parents, and society
- How to reject sexual advances and how alcohol and drug use increases vulnerability to them
- The importance of attaining self-sufficiency before engaging in sex

Source: Section 510 (b), Title V of Social Security Act.

State Policy

Despite these federal efforts, education policy is mostly decentralized. And, since states may have multiple policies governing the teaching of sex education, the overall policy picture is fairly complex. For example, states that require that sex education be taught may vary considerably in terms of what, if any, curriculum they specify. Meanwhile, a state that has no specific policy on sex education may still “recommend” that educators take a particular course of action or even specify that a school district opting to offer sex education adhere to a particular curriculum.

Even within an individual state, there may be differing policies governing mandates for education about contraception or abstinence and instruction on HIV/AIDS and other STDs. In fact, more states require schools to offer specific HIV or STD education than general sex education. It is also common for states to have different requirements for students in different grade levels. These policy distinctions among and within states are often lost in the larger debate about sex education. As of September 2002, 22 states require that students receive sex education and 39 require HIV/STD instruction:¹⁵

- Twenty-two (22) states require schools to provide both sex education as well as instruction on HIV/STDs (AK, DE, FL, GA, HI, IL, IA, KS, KY, ME, MD, MN, NV, NJ, NC, RI, SC, TN, UT, VT, WV, WY).
- Seventeen (17) states require instruction about HIV/STDs, but not sex education (AL, CA, CT, ID, IN, MI, MS, NH, NM, NY, ND, OH, OK, OR, PA, WA, WI).
- One state requires sex education, but not STD instruction (ME).

Specific requirements about what should be taught are also on the books in a number of states. Thirty (30) states require local school districts that offer sex education to teach about abstinence: Eight require that it be covered (CT, DE, FL, GA, KY, MI, VT, VA) and twenty-two require that it be stressed (AL, AZ, AK, CA, HI, IL, IN, LA, MD, ME, MS, MO, NC, NJ, OK, OR, RI, SC, TN, TX, UT, WV). In addition, thirteen of these states require local school districts that do offer sex education to cover information about contraception (AL, CA, DE, HI, MD, MO, NJ, OR, RI, SC, VT, VA, WV), but no state requires that birth control information be emphasized.

Thirty-four states (34) give parents some choice as to whether or not their children can receive sex education or STD instruction (AL, AZ, CA, CT, FL, GA, ID, IL, IA, KS, LA, MD, MA, ME, MI, MN, MS, MO, MT, NJ, NY, NC, OK, OR, PA, RI, SC, TN, TX, VT, VA, WA, WV, WI).¹⁶ Most of these states give parents the option of withdrawing their children from the courses. Three of these states (AZ, NV, UT) say that parents must actively consent before the instruction begins, while one of these (AZ) has an opt-out policy for STD education while requiring parental consent for sex education. Of the states with “opt-out” policies, five require that it be due to a family’s religious or moral beliefs.

Local Policy

Even when state policy on sex education exists, significant latitude and oversight is left to local school districts.¹⁷ A national survey of school superintendents, conducted in 1998 by the Alan Guttmacher Institute (AGI), found that more than two-thirds (69%) of U.S. school districts have a policy to teach sex education.¹⁸ The remaining 31 percent leave the decisions about whether to teach such curriculum to individual schools. However, a disproportionate number of students reside in the districts with policies to teach sex education.

Among districts with a policy, 14 percent report that their policy takes a “comprehensive” approach, teaching abstinence as one possible option for adolescents; 51 percent promote “abstinence-plus,” that is abstinence as the preferred option but allowing discussion of contraception as effective in protecting against pregnancy and disease; and the remaining third (35%) have an “abstinence-only” policy.

When asked to name the single most important factor influencing district policy, an average of 48 percent of superintendents cite state directives. Special committees and school boards were named as influential about equally often (18% and 17%, respectively).

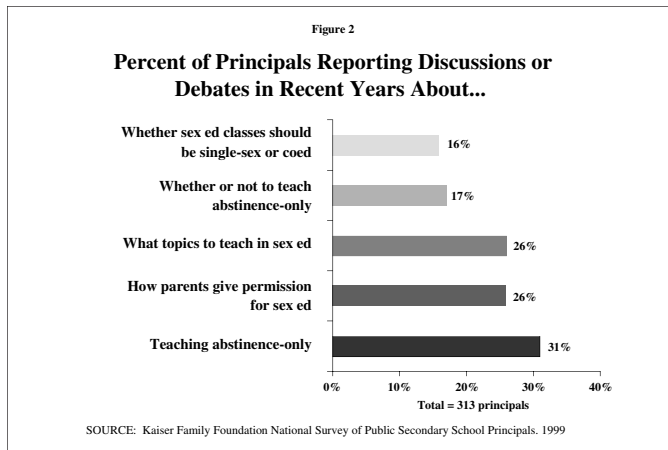
Similarly, the large majority of public secondary school principals (88%) in the 1999 Kaiser Family Foundation study report that school districts and local governments have at least “some influence” on their schools’ sex education curricula.¹⁹ Seventy percent (70%) report that state government has at least “some influence,” and 31 percent report that the federal government’s abstinence-only funds had at least “some influence” at the time the survey was conducted. Principals also note that the content of sex education in public secondary schools is subject to at least some local or state guidelines (85%), including four in 10 principals (43%) who term the guidelines as “strict.”

When a specific topic is not taught in sex education, principals often cite a school or district “policy.” For example, the leading reason given by principals for not covering abortion and sexual orientation was a school or district “policy,” followed closely by actual or perceived pressure from the community.

Community Involvement

Beyond government policy and public officials, principals report that several other groups are involved in deciding what is covered in their schools’ sex education curricula. More than half of principals (57%) say teachers are “very involved” and one in four (23%) say parents are as equally involved. Other members of the community (15%) and religious leaders (11%) are less frequently named.

One in two (48%) principals say there have been recent “discussions or debates at the PTA, school board, or other public meetings” on some aspect of sex education, from what to teach to how parents give permission. However, most (58%) report no change in curriculum as a result. The highly publicized issue of whether to teach an abstinence-only curriculum was the most commonly named specific topic, but was a subject of discussion in fewer than one third (31%) of schools. Debate over abstinence-only curriculum was equally likely to have occurred in schools with a comprehensive curriculum as in those that emphasized abstinence as the only option (Figure 2).



Evaluating Effectiveness

Congress has approved \$6 million for a national evaluation of abstinence efforts funded under the 1996 welfare law.²⁰ Additionally, within the first two years of the federal program, at least 39 states indicated that they had plans to conduct some form of evaluation of their own efforts, using a portion of the funds they were receiving from the federal government.²¹

The federally funded effort – a rigorous, large-scale study of abstinence-only programs in five states (FL, MS, SC, VA, WI) – is now underway.²² Researchers will examine the types of programs that have emerged in response to the Title V funds and requirements and measure the impact of different curricula and program models on different behaviors and outcomes among students who participate in them. Behaviors and outcomes of interest would include whether students have sex, their exposure to STDs, and rates of adolescent pregnancies and births. The due date for this evaluation is 2005, and interim findings are being released periodically before that final report is completed.

In the meantime other work is underway to examine the impact of different sex education approaches. Many public and private groups have weighed in on the debate over what type of sex education is most effective.

The Office of the Surgeon General released a “Call to Action to Promote Sexual Health and Responsible Sexual Behavior” in

June 2001 that noted that “more research is clearly needed” on abstinence-only programs, but that research on programs that cover both abstinence and contraceptive methods “gives strong support to the conclusion that providing information about contraception does not increase adolescent sexual activity, either by hastening the onset of sexual intercourse, increasing the frequency of sexual intercourse, or increasing the number of sexual partners.” The report encourages education that “assure[s] awareness of optimal protection from sexually transmitted diseases and unintended pregnancy for those who are sexually active, while also stressing that there are no infallible methods of protection, except abstinence, and that condoms cannot protect against some forms of STDs.”²³

In May 2001, The National Campaign to Prevent Teen Pregnancy released a report analyzing “impact evaluations” of more than 100 adolescent pregnancy prevention programs (both abstinence-only and comprehensive).²⁴ This research, which was cited in the Surgeon General’s report, found that sex education programs can assist in preventing teen pregnancy, and noted that comprehensive programs that promote abstinence and provide information about contraceptive methods do not increase the frequency of sex or number of sex partners among adolescents – nor do they lower the age at which teenagers first have intercourse. At the same time, the analysis found, when adolescents do become sexually active, such programs can apparently increase the likelihood that they will use contraception.

The National Campaign selected eight programs that demonstrated a high evidence of success. Five were specific sex education programs; two were “service learning” programs that are meant to address what are considered “nonsexual antecedents” of teen pregnancy (such as detachment from school); and one was a general program that offered sex education as part of a larger package of social services. The most effective program, The Children’s Aid Society-Carrera Program, was also the most comprehensive, with sex education as one of many components, including individual tutoring, sports and art activities, work-related activities, and health care services. It was also an expensive program, costing up to \$4,000 per student.

In its review of the research literature, the report found only three published evaluations of abstinence-only programs that it considered rigorous enough to be included in the analysis. None of these three evaluations found either an overall impact on sexual behavior or an effect on contraceptive use among the sexually active students in their programs. As a result, the report concludes that there is still not enough evidence available to assess the effectiveness of abstinence-only education programs.

Additional copies of this publication (#3224-02) are available on the Kaiser Family Foundation website at www.kff.org.

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