

Financing Ignorance: A Report on Abstinence-Only-Until-Marriage Funding in New York

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Executive Summary

The past 25 years have witnessed an alarming trend in public health and social policy: since 1981, more than \$1 billion has been funneled into abstinence-only-until-marriage programs taught in classrooms and communities nationwide. These programs, too often students' only formal sex education, restrict the information that may be provided to young people to the message that abstinence—until marriage—is the exclusive method to prevent pregnancy and sexually transmitted infections (STIs). Moreover, the information they provide—at taxpayer expense—is often medically unsound, biased regarding issues of race, gender and sexuality, and/or religious in nature.

Education and public health experts agree that abstinence-only-until-marriage programming is ineffective in reducing teen sexual activity and teen pregnancy. Students are provided with limited—and often inaccurate—information, leaving them unprepared to make healthy and responsible decisions about their sexual activity. By contrast, comprehensive sexuality education teaches students safe and effective ways, including abstinence, hormonal birth control and barrier methods, to protect themselves from pregnancy and STIs. Such programs have proven to be effective in providing teens with the necessary skills and information to make healthy decisions about their sexual activity, and have been recommended by the nation's leading medical experts.

New York is currently the third largest recipient of federal funding for abstinence-only-until-marriage programs, behind only Texas and Florida. In fiscal year 2006, New York accepted more than \$10 million in federal funding—matched by nearly \$4 million in state funds—for dozens of such programs. For all the money

dedicated to under-educating children about sexuality and sexual health, not one single dollar is dedicated to comprehensive, medically sound sexuality education in New York. This discrepancy leaves young people frighteningly uninformed, and fails to address New York State's alarming rates of teen pregnancy and STIs, including HIV/AIDS. Young New Yorkers must be provided with access to medically accurate, comprehensive and age-appropriate information to enable them to make healthy decisions and help end our state's growing public health crisis.

In preparing this report, the Reproductive Rights Project of the New York Civil Liberties Union conducted an extensive study of the abstinence-only-until-marriage programs in New York State that received federal funding through the year 2006. More than 33,000 pages of state and federal documents reviewed by the NYCLU, representing 39 funded programs, revealed that:

- Abstinence-only-until-marriage curricula used across the state contain serious medical inaccuracies and employ fear-based teaching methods:
 - ▶ Curricula used by 22 grantees inflate rates of STIs and HIV/AIDS and exaggerate the failure rates of condoms in preventing STIs, HIV/AIDS and pregnancy.
 - ▶ These same curricula rely on scare-tactics, presenting a list of dire consequences of pre-marital sexual activity; one curriculum includes in this list: “heartbreak, infertility, loneliness, cervical cancer, [and] poverty.”
 - ▶ Curricula used by seven programs contain falsehoods regarding abortion, telling students, for example, that an abortion could significantly endanger a

young woman’s ability to have children in the future. Five programs partnered with crisis pregnancy centers, organizations that frequently promote inaccurate and biased views about abortion.

- The same curricula demonstrate serious bias:
 - ▶ Gender stereotypes regarding the different “natures” of girls and boys with respect to sexuality and relationships are presented as immutable, scientific facts.
 - ▶ Lesbian/gay/bisexual/transgender youth are either completely ignored or demonized as “unnatural.”
- At least 19 of the funded programs focused a significant amount of programming on after school recreational activities with no direct relation to sex education.
- Instructors were not required to have special training or expertise as educators.
- Programs were not evaluated, or even required to evaluate themselves.
- Religious groups received more than half (53 percent) of this government funding without adequate safeguards against proselytizing, and religious content was included in some of the programming.

Since conducting its review, the NYCLU has learned that as of October 2007, New York State has cancelled all existing contracts awarded under Title V, one of the principal federal funding streams for abstinence-only-until-marriage programs, although it has not officially rejected the funds. This move signals an important step in the right direction, but it does not go far enough. New York State can no longer afford to deprive school children of essential sex educa-

tion. This report recommends that the following steps be taken:

- Comprehensive sexuality education should be funded at both the state and federal levels:
 - ▶ The New York State Legislature should pass the “Healthy Teens Act.”
 - ▶ Congress should enact the Responsible Education About Life (REAL) Act.
- New York should amend the State Education Law to include a requirement that all students receive comprehensive, scientifically accurate, age-appropriate sexuality education in New York State public schools.
 - ▶ This should include—but not be limited to—an abstinence message.
 - ▶ “Medically accurate” should be defined to ensure that programs are objective and scientifically accurate.
 - ▶ The commissioners of the Departments of Health and Education should be empowered to promulgate regulations providing guidance on formation of curricula, teacher training and monitoring and evaluation of programming.
- Funding for abstinence-only-until-marriage programs should be stopped:
 - ▶ Congress should cease all funding for abstinence-only-until-marriage programs.
 - ▶ New York should join a growing number of states explicitly rejecting federal abstinence-only-until-marriage restricted funding. ■

I. Introduction

A. What Are Abstinence-Only-Until-Marriage Programs?

Abstinence-only-until-marriage programs teach abstinence as the exclusive means of preventing pregnancy and transmission of sexually transmitted infections (STIs). They prohibit teaching young people about other methods of prevention, such as condoms or birth control.¹ In addition, they include strong ideological messages and value judgments about sexual activity, many of which have their roots in religious precepts—for example, that sexual activity is only acceptable within the confines of heterosexual marriage.

The federal government defines “abstinence education” as a program that “has as its exclusive purpose teaching the social, psychological and health gains to be realized by abstaining from sexual activity[,] teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity[, and] teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.”

The official federal definition of “abstinence education” is 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 monoga-

mous relationship in the context of marriage is the expected standard of human sexual activity;

- (E) teaches that sexual activity outside of 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.²

These eight criteria must currently be included in all abstinence-only-until-marriage programs that receive federal funding.³

In addition, some abstinence-only-until-marriage programs go beyond merely omitting critical information. Critics and medical experts have pointed out that many of the abstinence-only-until-marriage curricula contain medical and scientific inaccuracies—for example, exaggerating the failure rate of condoms and the incidence of STIs, and misrepresenting the risks of sexual activity.⁴ Others contain overt anti-choice messages, gender stereotyping and “are . . . insensitive to sexually active and sexually abused teenagers, as well as to gay, lesbian, bisexual, transgender, questioning and intersexed youth.”⁵ Many abstinence-only-until-marriage programs attempt to discourage sexual activity by instilling feelings of fear,

shame and guilt.⁶ Such programs, often referred to as “fear-based,” stigmatize those who engage in any sexual activity outside the confines of a heterosexual marriage by portraying them as morally flawed, and cautioning that they will suffer psychological damage as a result.

By contrast, comprehensive sexuality education programs contain messages of abstinence, but also include practical information on family

Comprehensive sexuality education programs contain messages of abstinence, family planning and STI prevention so that teens have the information they need to make healthy, responsible life decisions.

planning and STI prevention so that teens have the information they need to make healthy, responsible life decisions. According to the Sexuality Information and Education Council of the United States (SIECUS):⁷

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.⁸

Sometimes referred to as “abstinence-plus sex education,” comprehensive sexuality education is based on these sound public health principles and is recommended by all of the nation’s leading medical and public health organizations.⁹

Virtually all school-based programming prior to the introduction of abstinence-only-until-marriage programs in the early 1980s was based on a comprehensive sexuality education model.¹⁰ However, over the past 25 years, abstinence-only-until-marriage programs have gained increasing prominence,¹¹ and currently receive

the only dedicated funds at both the federal and New York State level.

B. Twenty-five Years of Abstinence-Only-Until-Marriage Funding in New York and the Country

During the past 25 years, the federal government has increased funding for abstinence-only-until-marriage programs. Since 1981, more than \$1 billion has been spent on such programs.¹² Abstinence-only-until-marriage is currently funded through three principal sources: the Adolescent Family Life Act (AFLA),¹³ section 510(b) of the Social Security Act (Title V)¹⁴ and Community-Based Abstinence Education (CBAE).¹⁵

1. Adolescent Family Life Act

Originally sponsored by U.S. Senators Jeremiah Denton (R-AL) and Orrin Hatch (R-UT), AFLA was introduced to “promote self-discipline and other prudent approaches to the problem of adolescent premarital sexual relations, including adolescent pregnancy,”¹⁶ and to combat teen pregnancy with the “develop[ment] of strong family values.”¹⁷ Since Fiscal Year (FY) 1997, AFLA funds have been explicitly tied to the eight-point definition of abstinence-only-until-marriage education.

Since 1981, more than \$1 billion has been spent on abstinence-only-until-marriage programs.

According to SIECUS, AFLA has received more than \$125 million since its inception. For FY 2008, President Bush has proposed maintaining AFLA’s funding at \$13 million.¹⁸

2. Section 510 of the Social Security Act (Title V)

The 1996 Temporary Assistance for Needy Families Act (TANF), also known as the “welfare reform” law, added Title V, Section 510(b) to the Social Security Act to establish new funding to states for abstinence-only-until-

marriage programs. Under Title V, the U.S. Department of Health and Human Services allocates \$50 million in federal funds each year to the states. States accepting this money must match every four federal dollars with three state-raised dollars and distribute the funds to schools, health departments or non-governmental organizations.¹⁹ Title V introduced the eight-point definition of abstinence programming which all “abstinence education” programs must currently follow.

Significantly, the FY 2007 Title V program announcement lists its target population as “adolescents and/or adults within the 12- through 29-year-old age range,”²⁰ signaling that the goal is to reach not just teens, but all unmarried adults younger than 30. Originally authorized for five years (1998-2002), Title V has been repeatedly extended; the most recent extension is due to expire at the end of September 2007.²¹

The goal of Title V abstinence-only programs is to reach not just teens, but all unmarried adults younger than 30.

3. Community-Based Abstinence Education (CBAE)

In October 2000, the federal government created a third funding stream to support abstinence-only-until-marriage programs. Originally known as Special Projects of Regional and National Significance-Community-Based Abstinence Education (SPRANS-CBAE), the funding was administered by the Maternal and Child Health Bureau (MCHB) in the Department of Health and Human Services directly to state and local organizations. In 2005, the Administration for Children and Families began distributing the funding,²² a move that took oversight out of the hands of public health professionals.²³ The funds, now known as CBAE, are administered by the federal government directly to local groups, bypassing state public health and education agencies.²⁴

Funding for CBAE began in FY 2001 at \$20 million. By FY 2007, CBAE increased more than 450 percent to \$113 million. The president has proposed increasing this funding stream to \$141 million for FY 2008.

C. Abstinence-Only-Until-Marriage Programs: A Failed Experiment

Despite their popularity with policy makers, extensive research shows that abstinence-only-until-marriage programs do not lower rates of teen sexual activity, STIs (including HIV/AIDS) or teen pregnancy.²⁵ In 2006, the *Journal of Adolescent Health* published a comprehensive survey of all peer-reviewed, and some non-peer-reviewed, studies of abstinence-only-until-marriage programs and concluded that such programs are not effective in changing teens’ sexual behaviors.²⁶ A 2007 study mandated by Congress²⁷ reached the same conclusion, finding that:

- None of the individual programs had statistically significant impacts on the rate of sexual abstinence.²⁸
- Programs did not affect the age at which sexually experienced youth first engaged in sexual intercourse.²⁹
- There was no difference between students who had attended Title V-funded abstinence-only-until-marriage programs (“abstinence group”) and students who received “only the usual services available in the absence of these programs” (“control group”) in the number of sexual partners with whom they had sex.³⁰
- There was no difference between abstinence and control group youth regarding condom usage.³¹
- There was no difference between abstinence and control group youth in their expectations

to abstain from sex until marriage.³²

- Programs had no impact on the number of reported pregnancies, births or STIs.³³

This mounting data has led to a consensus within the medical and scientific communities, including the American Medical Association, the American Public Health Association, the American Psychological Association, the American Academy of Pediatrics and the Society for Adolescent Medicine, that the abstinence-only-until-marriage model is ineffective.³⁴ As the American Public Health Association’s policy states, “Sexually experienced teens need access to complete and medically accurate information about condoms and contraception, their legal rights to health care, and ways to access reproductive health services. [Abstinence-only] programs do not address these needs.”³⁵

Mounting data has led to a consensus within the medical and scientific communities that the abstinence-only-until-marriage model is ineffective.

D. Comprehensive Sexuality Education: An Effective Means of Prevention

By contrast, comprehensive sexuality education programs have been shown to be effective in helping those teens who are sexually active make healthy choices and protect themselves from unintended pregnancy and STIs.³⁶ Studies have shown that comprehensive sexuality education programs “do not hasten the onset of sex, increase the frequency of sex, [or] increase the number of sexual partners.”³⁷ On the contrary, they have shown a significant impact on increasing abstinence and delaying sexual activity, reducing risky sexual behaviors, increasing condom and contraception use and significantly decreasing teen pregnancy among participants.³⁸ Programs that did show effective

results “talked explicitly about sex, condom use, and contraception use.”³⁹ In addition, particular comprehensive sexuality education curricula have been evaluated by experts including the American College of Obstetricians and Gynecologists and Advocates for Youth and found to be effective in reducing rates of sexual activity, pregnancy, STIs and HIV/AIDS relative to controls.⁴⁰

A substantial majority of New York voters (77%) supported medically-accurate, age-appropriate sex education in public schools.

State and national surveys have shown that an overwhelming majority of Americans support comprehensive sexuality education.⁴¹ In a recent national survey, 82 percent of United State residents 18 or older supported “abstinence-plus” education, which was described as a project that encourages abstinence, but also teaches other methods of STI and pregnancy prevention.⁴² In a 2006 New York State survey, a substantial majority of voters (77 percent) supported medically-accurate, age-appropriate sex education in public schools.⁴³ This was true across every demographic group, including Republicans and those who oppose legal abortion. Eighty-eight percent of voters agreed that New York students should receive information on contraception and STI prevention.⁴⁴

This strong support is due in part to a recognition that the goals of abstinence-only-until-marriage education sharply conflict with the realities of American life. Few Americans wait until marriage to have sex, and most initiate sexual intercourse during their adolescent years.⁴⁵ Americans are marrying later, and many never marry at all.⁴⁶ Furthermore, LGBT individuals are prohibited by law from marrying in 49 states, making the use of abstinence-only-until-marriage curricula marginalizing and harmful to LGBT youth. Public health experts, parents and the majority of the public agree that comprehensive sexuality edu-

cation is the most sensible and effective approach to reducing teen pregnancy and STIs.

E. Abstinence-Only: The View from New York State

1. Funding for Abstinence + No Comprehensive Sex Ed Mandate = Abstinence-Only

In FY 2006, New York received a total of \$10,664,612 in federal abstinence-only-until-marriage funds—the third largest pool of abstinence-only dollars in the country (after Texas and Florida), and the second largest pool of Title V dollars (after Texas).⁴⁷ New York matched its Title V dollars with \$3,980,000 in state funds and in-kind services.⁴⁸ The New York State Department of Health (DOH) is responsible for distributing these funds to sub-grantees

In FY 2006, New York received a total of \$10,664,612—the third largest pool of abstinence-only dollars in the country.

throughout the state. In FY 2006, DOH distributed Title V funding to 36 faith-, school- and community-based programs. Five of these programs also received

direct federal funding. Nine additional programs received federal-only dollars through CBAE and/or AFLA.

Yet New York State does not dedicate a single dollar toward teaching comprehensive sexuality education. Nor does the state require that sex-ed be taught in New York schools. Although New York law mandates the teaching of health education, including information regarding prevention of HIV/AIDS, it does not include sexuality education among the topics that must be covered.⁴⁹ While there is doubtless some overlap, comprehensive sexuality education is not the same as HIV/AIDS education. For example, the latter generally only covers information regarding condoms in the context of preventing transmission of HIV/AIDS, and does not cover con-

traception. And because comprehensive sexuality education is neither funded nor required, the decision whether to include it is left up to individual schools. The exclusive funding for abstinence-only-until-marriage programming makes it all but certain that comprehensive sexuality education will fall by the wayside.

2. New York Critically Needs a More Effective Solution

The need for an effective approach to prevention and sexual health is particularly pressing in New York State. Thirty-nine percent of female high school students and 45 percent of male high school students in New York State report that they have had sexual intercourse.⁵⁰ In New York City, the figures are higher, at 43 percent and 52 percent, respectively.⁵¹ And statistics from the Centers for Disease Control and Prevention show that many New York teens are having sex with more partners—and earlier—than teens in the rest of the country.⁵²

As of 2000, New York State had the 14th highest teen pregnancy rate in the United States.⁵³ In 2004, the rate of teen pregnancies statewide was 61.9 out of every 1,000 women, accounting for more than 39,000 pregnancies.⁵⁴ In New York City, the rate was even higher, with 23,135 teen pregnancies, or a rate of 96 pregnancies per 1,000 women.⁵⁵ With 58 percent of teen pregnancies in New York State ending in abortion, the state ranked second in its abortion rate among those aged 15-19.⁵⁶

New York State also has the highest rates of HIV/AIDS in the country—nearly 18 percent of American adults and teens with HIV live in New York,⁵⁷ and the CDC has warned that youth are persistently at risk for infection.⁵⁸ Of the 1,268

39% of female high school students and 45% of male high school students in New York State report that they have had sexual intercourse.

teens in the United States aged 13-19 diagnosed with HIV in 2005,⁵⁹ more than 10 percent (136 teenagers) lived in New York City.⁶⁰ In addition,

18% of all American adults and teens with HIV live in New York.

a surprising increase in cases of syphilis has recently been reported in New York City, suggesting that riskier sexual practices are on the rise.⁶¹ In addressing these critical issues, New York can no longer afford to provide funding for

programs that utilize methods shown to be ineffective at reducing the risk behaviors that lead to teen pregnancy and STI/HIV transmission. ■

II. Methodology

The NYCLU issued requests to the New York State Department of Health and the federal Department of Health and Human Services pursuant to the federal Freedom of Information Act (FOIA)⁶² and the New York State Freedom of Information Law (FOIL)⁶³ for all documents and records pertaining to abstinence-only-until-marriage funding in New York State under Title V of the Social Security Act, CBAE and AFLA.⁶⁴ The NYCLU sought these documents for the 43 grantees reported by SIECUS to be in receipt of funds in New York State in FY 2004-2005,⁶⁵ as well as for any other grantees receiving such funds.

The NYCLU received more than 30,000 pages of documents from New York State and an additional 3,000 pages of documents from the federal government, representing 39 of the 43 grantees reported by SIECUS to have received funding.⁶⁶ NYCLU staff and interns reviewed and prepared summaries of each of the programs that received funding. Reviewers used an instrument that focused on:

- Stated goals and activities of program
- Dollar-amount of grant by year
- Number of children reached per year
- Curriculum used
- Relationship to public schools
- Other groups in the community serving as partners or supporters
- Internal and external evaluation methods
- Use of biased or medically inaccurate content
- Use of religious programming or content

This report represents a synthesis and analysis of the findings in those summaries. It focuses primarily on FY 2005, the most recent year for which full documentation was provided. However, it also references some relevant activities and curricula employed at various times

between 1998 and 2006, the range of years for which documents were provided. To control for the effect of having multiple reviewers involved, all factual assertions regarding the programs specifically cited in this report were verified by a different reviewer for accuracy.

A few limitations of the analysis bear mention. First, due to factors such as missing documents and inconsistencies within the documents, measures that should have been easily quantified were not. The documents produced sometimes did not include grant letters or amounts, so the amount of funds received was deduced from the grant proposal itself or from previous grant amounts (these were typically identical from year to year). The number of young people served by a given program was sometimes difficult to determine because grantees sometimes cited one figure in their quarterly reports and an entirely different figure in other documents, such as renewal applications or “work plan implementation worksheets.”

Similarly, many programs did not list a particular curriculum that they employed, or listed several different curricula, sometimes within the same grant proposal. Because the New York State Department of Health does not keep copies of the curricula or educational materials used, these were not produced in response to our FOIL requests and could not be reviewed.⁶⁷ Where particular curricula or family of curricula⁶⁸ were identified in proposals or reports as a component of a program, our reviewers relied on existing analyses of the contents of those curricula performed by other organizations and experts, including SIECUS, the U.S. House of Representatives Committee on Government Reform (in a report prepared for Representative Henry Waxman) and the Public Health Division at Case Western Reserve University School of Medicine.⁶⁹ ■

III. Findings

Our analysis found that abstinence-only-until-marriage funds have been used in New York State to support a significant number of programs using curricula that contain medical and scientific inaccuracies, rely on exaggeration and fear and contain a strong anti-abortion position. Several curricula also contain gender stereotypes or bias against LGBT youth. On the opposite end of the spectrum, many other programs used the funds for after-school activities with no clear sexuality education component. Programs were inadequately monitored or evaluated for effectiveness in achieving their stated goals of preventing teen pregnancy or STIs. And 53 percent of the funds (at least \$6,090,740 in FY 2005) were used by religious organizations without adequate monitoring.

A. Programs Funded in New York Used Educational Materials that Contain Medical Inaccuracies, Rely on Exaggeration and Fear, and Resort to Scare Tactics Regarding Abortion

Our document review revealed that although a handful of abstinence-only-until-marriage programs in New York developed their own educational mate-

rials, the majority use commercially available curricula. These curricula have been analyzed by SIECUS, the Waxman Report and the Public Health Division at Case Western Reserve University School of Medicine, and most have been found to contain serious flaws, including medical inaccuracies, exaggeration, scare-tactics and falsehoods regarding abortion. Four of these flawed curricula were reportedly used in New York State in 2004-2005: *Sex Respect*,⁷⁰ *Choosing the Best*,⁷¹ *WAIT Training*⁷² and the Project Reality family of products.⁷³ [See Figure A.] Fifty-three percent of programs in New York State reported that they used or planned to use at least one of these four curricula during the time period reviewed. In FY 2005, nearly \$7.5 million, a full 64 percent of New York’s abstinence-only-until-marriage funds, went to financing programs that used at least one of these flawed curricula. [See Figures B & C.]

In FY 2005, nearly \$7.5 million went to financing programs that used at least one of four curricula found by SIECUS or others to contain serious flaws.

1. Curricula Included Medical and Scientific Inaccuracies

Abstinence-only-until-marriage curricula that were used in New York State consistently “misrepresent the effectiveness of condoms in preventing STIs, HIV/AIDS and pregnancy.”⁷⁴ In several curricula, if condoms are mentioned at all, it is only to discuss their failure rate, which is greatly exaggerated. The incidence and prevalence of STIs are inflated and important information about testing and treatment is omitted.

For example, *Choosing the Best*, reported to have been used by seven grantees⁷⁵ across New

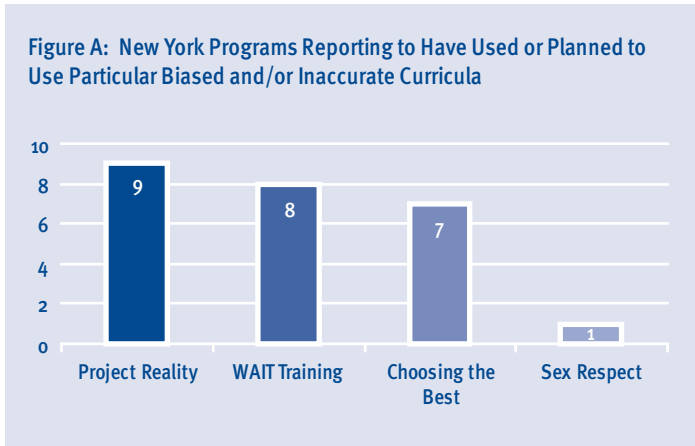


Figure B: Programs Receiving Abstinence-Only-Until-Marriage Funding Reporting in FY 2005 That They Used or Planned to Use Biased and/or Inaccurate Curricula

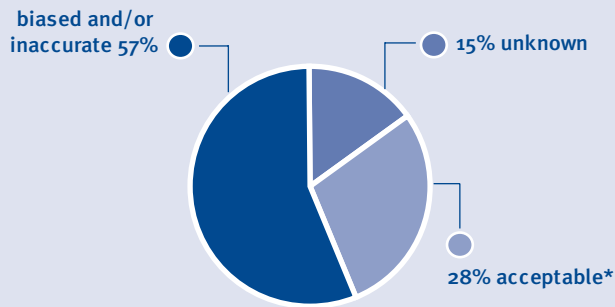
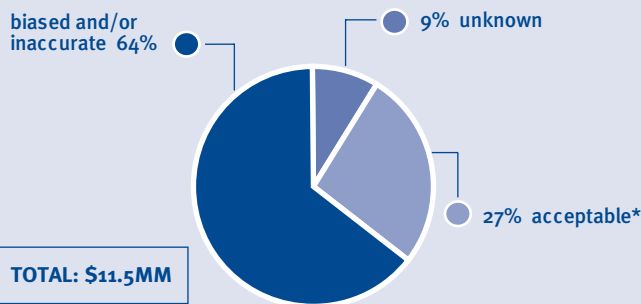


Figure C: Abstinence-Only-Until-Marriage Funding Awarded in FY 2005 to Programs Reporting That They Used or Planned to Use Biased and/or Inaccurate Curricula



* Acceptable curricula are curricula that SIECUS and others have evaluated as effective, and not including biased or fear-based content.

York State, includes scientifically inaccurate statements about the prevalence of certain STIs and the effectiveness of condoms in preventing STIs. Its materials claim that “syphilis . . . affects about 120,000 Americans each year.”⁷⁶ However, according to the CDC, there were 32,000 reported cases of syphilis in 2002.⁷⁷ *Choosing the Best* materials claim that condoms are ineffective in preventing pregnancy 15 percent of the time during the first year of use, and then conclude that, “This means that over a period of five years, there could be a 50 percent chance or higher of getting pregnant with condoms used as a birth control method.”⁷⁸ The logic used to determine a 50 percent risk of getting pregnant is flawed. The risk

remains the same from year to year and does not increase over time. Further, the first year effectiveness rate among typical condom users is 86 percent, and the 14 percent failure rate is largely due to incorrect or inconsistent use, not innate ineffectiveness of the method.⁷⁹ According to *Studies in Family Planning*, “Condoms are 98 percent effective in preventing pregnancy when used consistently and correctly.”⁸⁰ Ironically, emphasizing the failure rate of condoms without providing teens with information on how to use them may contribute to these failure rates.⁸¹

Curricula produced by **Project Reality**, reported to have been used by nine New York State grantees,⁸² contain similarly misleading statements. Its materials claim, “If condoms were effective against [sexually transmitted diseases (STDs)⁸³], the increase in condom usage would correlate to a decrease in STDs overall—which is not the case. Rather, as condom usage has increased, so have rates of STDs.”⁸⁴ Again, this is a misrepresentation of medical facts. The incidence of syphilis and gonorrhea, for example, had dropped significantly in the 15 years prior to the curriculum’s publication.⁸⁵ The CDC has established that condoms reduce the risk of chlamydia, syphilis, gonorrhea and HIV infection, and that there is a relationship between condom use and lower rates of cervical cancer caused by the human papillomavirus (HPV).⁸⁶

Emphasizing the failure rate of condoms without providing teens with information on how to use them may contribute to their failure rate.

2. Curricula Relied on “Fear-Based” Content

The exaggeration and scientific inaccuracies are part of a pattern of relying on horror stories about the consequences of sex, without providing students with critical information about prevention. **Sex Respect**, reported to have been used by one grantee,⁸⁷ is perhaps the worst

offender. It suggests that “the first step in prevention of damage to the human soul is sexual abstinence until marriage”, and that “America [has] 20 years worth of crippled relationships to show for its experimentation with unleashed sexual activity.”⁸⁸ According to the *Sex Respect Teacher’s Manual*,

These are simply natural consequences. For example, if you eat spoiled food, you will get sick. If you jump from a tall building, you will be hurt or killed. If you spend more money than you make, your enslavement to debt affects you and those whom you love. If you have sex outside of marriage, there are consequences for you, your partner and society.⁸⁹

Sex Respect goes on to dedicate half of a page to the suggestion that “French” kissing can transmit HIV.⁹⁰ Its materials warn that birth control pills, shots and implants increase the chance of future infertility, when, in fact, numerous scientific studies show that the risk is extremely low.⁹¹

The *Sex Respect* curriculum is not alone in this regard. A ***Facing Reality*** parent/teacher guide (part of the Project Reality family of curricula) contains the following list of consequences of premarital sexual activity:

Pregnancy, fear of pregnancy, AIDS, guilt, herpes, disappointing parents, Chlamydia, inability to concentrate on school, syphilis, embarrassment, abortion, shotgun wedding, gonorrhea, selfishness, pelvic inflammatory disease, heartbreak, infertility, loneliness, cervical cancer, poverty, loss of self-esteem, loss of reputation, being used, suicide, substance abuse, melancholy, loss of faith . . . various other sexually transmitted diseases, aggressions toward women, ectopic pregnancy, sexual violence, loss of sense of responsibility toward others, loss of honesty, jealousy, depression, death.⁹²

Wait Training, reported as having been used by eight New York State grantees,⁹³ warns that “Teens are emotionally wounded due to broken hearts and emotions that result when they get

involved with sexual activity. Premature, non-committed [sic] sex is physically, emotionally, and socially detrimental to teenagers.”⁹⁴

These assertions of the emotional dangers of pre-marital sex are exaggerated. There is no support for the suggestion that most sexually active teens suffer emotional harm; in fact, a recent study concludes that “the mental health of most adolescents is simply not affected by first sex.”⁹⁵ Although studies have shown an association between early sexual debut and depression, no causal relationship has ever been established. These studies caution that it is just as likely that some teens become sexually active because they are depressed, rather than vice versa.⁹⁶

3. Curricula Resorted to Scare-Tactics Regarding Abortion

Sex Respect materials also contain scare tactics about the supposed dangers of abortion:

[If a young woman is] 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).⁹⁷

The ***Choosing the Best LIFE*** teachers’ guide directs the instructor to ask: “What are the possible consequences of choosing to have an abortion?” Suggested answers include, “[f]eelings of regret, shame, sadness, guilt; physical complications for girl; continued feelings of shame, sadness, regret; death of fetus.”⁹⁸

The implication that abortion poses serious physical or psychological risks is simply untrue. Abortion is one of the safest medical procedures available and has an extremely low complication rate.⁹⁹ Studies have failed to substantiate a causal relationship between

abortion and any of these supposed psychological effects recited in these curricula.¹⁰⁰

The inaccurate and politically charged assertions made by these curricula suggest a strong bias against abortion. Indeed, several of the abstinence-only-until marriage grantees in New York listed as community partners anti-abortion “crisis pregnancy centers”—organizations whose purpose is to persuade pregnant women not to have abortions, often through deceptive and manipulative tactics.¹⁰¹ Catholic Charities of Chemung and Schuylers listed the Southern Tier Pregnancy Resource Center, a cri-

Southern Tier Pregnancy Resource Center, a “crisis pregnancy center” that overstates the risk of abortion, mischaracterizes emergency contraception as an abortion and perpetuates the false claim that abortion increases the risk of breast cancer, received more than \$90,000 a year.

sis pregnancy center, as a sub-contractee receiving more than \$90,000 a year. On its website, the Southern Tier Pregnancy Resource Center overstates the risk of abortion, mischaracterizes emergency contraception as abortion¹⁰² and perpetuates the false claim that abortion increases the risk of breast cancer.¹⁰³ The theory of a link between abortion and breast cancer has been resoundingly rejected by the scientific community.¹⁰⁴

4. The Harmful Effects of Fear-Based Teaching

The scare tactics employed by these programs are having an impact on teens, as these comments from students included in the *Wait Training* evaluation summary prepared by Catholic Charities of Ogdensburg make clear:

- “I found out that ever sense [sic] I had this class I may never want to have sex again.”¹⁰⁵
- “I learned a lot, but it kind of scared me . . .

I’m afraid something bad will happen if I have sex.”¹⁰⁶

- “I thought they were trying to scare us out of having sex.”¹⁰⁷
- “I felt they were lying to me.”¹⁰⁸

The evidence does not support the notion that scaring young people is the most effective way to discourage them from having sex. On the contrary, by instilling feelings of shame and guilt, these fear-based messages may themselves cause psychological damage. As the director of the Adolescent Health Division of the Public Health Division at Case Western Reserve University School of Medicine recently concluded in a report commissioned to evaluate the use of abstinence-only-until-marriage funds in Ohio:

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.¹⁰⁹

Further, educational theory suggests that abstinence-only-until-marriage programs’ fear-based tactics do not work, and in fact, cause students to regard the risks of sex as exaggerated. The Extended Parallel Process Model (EPPM) explains how people react to messages of health risks. If both the perceived risk and the perceived efficacy of prevention behaviors are high, individuals are more likely to adopt prevention behaviors. However, when the perceived risk is high but the perceived efficacy of prevention behaviors is low, then individuals will dismiss the risk message as propaganda.¹¹⁰

The *Choosing the Best PATH* curriculum represents a prime example of why fear-based abstinence-only-until-marriage programs are ineffective under the EPPM model. The group leader is to provide students a list of risks of sexual activity including, “poverty,” “AIDS,” “pregnancy,” “unstable long-term commitments,” “meaningless wedding,” and “suicide.”¹¹¹ Students are then asked to circle which risks will be eliminated by using a condom during sex. The correct answer, according to the leader, is “none of the above.”¹¹² In this case, the risks listed are extensive, yet students are led to believe that there is nothing short of abstinence they can do to prevent them. Based on the EPPM, it is fair to assume that perceived efficacy of this lesson would be low, leading students receiving this information to dismiss the risks rather than take proactive preventative steps.

Attempting to influence teen sexual behavior by relying on misrepresentation and exaggeration flies in the face of central goals of our educational system—providing students with accurate factual information and promoting critical thinking.

Another example of the inadequacy of curricula based on deterrence without information on prevention is a program called *“Baby Think It Over” (BTIO)*. This program provides students with a model “baby” that cries, eats and requires diaper-changing with the purpose of showing students how difficult it is to take care of a baby, and thus presumably deter them from having sex.¹¹³ Ten grantees in New York reported that they were using or planned to use the BTIO program.¹¹⁴ Although evaluations of the effectiveness of the program have shown mixed results in some areas, studies have found that teens who had completed the BTIO program expressed a desire for information related to prevention and relationship skills.¹¹⁵ Moreover, studies have shown that the program did not

produce a statistically significant change in teens’ attitudes toward parenting or contraceptive behavior.¹¹⁶ Two studies actually found that the program led to an increase in some participants’ desire to have children as teenagers.¹¹⁷

Fear and shame based teaching also overlooks the fact that in many student populations, at least a few teens will already be pregnant or parenting. “Failing to consider the impact of this information on [those] students 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.”¹¹⁸ Moreover, such messages ignore the reality that for many teens, early sexual activity is not consensual, but is the result of sexual abuse.¹¹⁹ For such teens, being told that sex is a result of moral weakness or always results in psychological damage can add further shame and compound the harms they have already suffered from the abuse.¹²⁰

Perhaps most importantly, attempting to influence teen sexual behavior by relying on misrepresentation and exaggeration flies in the face of central goals of our educational system—providing students with accurate factual information and promoting critical thinking.

B. Programs Funded in New York Used Educational Materials Containing Gender Stereotypes and Bias Against LGBT Youth

1. Curricula Contained Gender Stereotypes

Stereotypes that reinforce traditional and limiting gender roles are pervasive in abstinence-only-until-marriage materials that were used in New York State. For example, *WAIT Training* teaches that “financial support” is one of the five “major needs of women,” and “domestic support” is one of the five “major needs of men” and offers the following advice:

“Just as a woman needs to feel a man’s devotion to her, a man has a primary need to feel a woman’s admiration. To admire a man is to

regard him with wonder, delight, and approval. A man feels admired when his unique characteristics and talents happily amaze her.”¹²¹ Marriage is described as follows: “From the start, the woman has a greater intuitive awareness of how to develop a loving relationship,”

whereas the man “does not generally have her instinctive awareness of what the relationship should be.”¹²²

One of the texts from the **Choosing the Best** family of curricula includes a lesson about a knight who saves a princess from a dragon. The princess advises the knight to kill the dragon with a noose or with poison; her suggestions leave the knight feeling “ashamed.” The lesson concludes: “Moral of the story: Occasional suggestions and assistance may be alright [sic], but too much of it will lessen a man’s confidence or even turn him away from his princess.”¹²³

Another section of this curriculum contains a cartoon with a caption cautioning girls, “Watch what you wear. If you don’t aim to please, don’t aim to tease.”¹²⁴ Given that high numbers of both young women and men are sexually active, “[p]ortraying males as sexual predators and females as unwitting seductresses and unwilling victims does not reflect today’s teen experience.”¹²⁵ As the Ohio Study observes:

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 pro vocation. It also implies that what a female wears controls how every male reacts [and] implicitly supports victim blaming in cases of sexual harassment and sexual violence[.]¹²⁶

“Watch what you wear. If you don’t aim to please, don’t aim to tease.”
—*Sex Respect*

Youth across New York State have been exposed to these outdated and misogynistic views of gender presented as scientific “fact.” Teaching such stereotyped models of gender relations in the classroom, much less in a school textbook, lends them legitimacy, and thus reinforces them in students’ minds as fixed and natural. Students who do not conform to these gendered modes of behavior are likely to feel further marginalized, and pressured to conform.

2. Curricula Used Displayed Bias Against Lesbian/Gay/Bisexual/ Transgender Youth

Abstinence-only-until-marriage curricula in use in New York at best marginalize or exclude LGBT youth; at

worst, they depict such youth as unnatural or aberrant. As a preliminary matter, of course, the exclusive emphasis on marriage as the only acceptable form of inti-

mate or sexual relationship by definition excludes the vast majority of LGBT youth, as marriage is not open to same sex partners in any state except Massachusetts. But beyond that, most curricula fail to mention LGBT issues at all.

WAIT Training’s exclusion of LGBT students is explicit, stating that, “Due to the specific nature of this prevention effort it is designed to meet the needs of heterosexual relationships.”¹²⁷ **Facing Reality** actually encourages teachers to feel comfortable passing moral judgments on LGBT populations by assuring teachers that, “in order to preserve an atmosphere of intellectual freedom, [they] should feel confident that when examining health issues and moral

The exclusive emphasis on marriage as the only acceptable form of intimate or sexual relationship by definition excludes LGBT youth, as marriage is not open to same sex partners in any state except Massachusetts.

implications of homosexual behaviors, they are not engaging in an assault on a particular person or group.”¹²⁸

Other curricula mention LGBT issues only or primarily in the context of a discussion of HIV/AIDS. For example, ***Sex Respect*** introduces its discussion of HIV/AIDS with the following statement: “AIDS . . . the STD most common among homosexuals, bisexuals and [intra-venous] drug users, has now made its way into heterosexual circles.”¹²⁹ This perpetuates the

Many of the programs funded in New York State have functioned as general after-school or youth development programs, with no clear sexuality education component.

false and dangerously stigmatizing notion that AIDS is a disease that primarily affects gay men and people with substance abuse

problems. In fact, the population with the sharpest increase in HIV infections is heterosexual women of color.¹³⁰

Sex Respect alludes to anal sex with the following statement: “There is another form of sexual activity that causes an especially high risk of HIV infection. In such activity body openings are used in ways for which they were not designed.”¹³¹ Such statements are not only unscientific and judgmental, but also betray a squeamishness about sexuality that prevents the curriculum from directly describing the behavior at issue, confronting the risks it presents or addressing prevention. While such attitudes have a particularly harsh impact on LGBT students, they also impact all students who engage in *any* sexual activity besides vaginal intercourse. This is particularly troubling in light of recent youth surveys showing that while teens are engaging in forms of sexual activity like oral or anal sex, they do not view this as “having sex”—and therefore may be even less cognizant of the risks involved than they are with respect to vaginal intercourse.¹³²

The potential harmful effect of these programs on LGBT youth cannot be overstated, especially given that this population of youth already suffers from disproportionate rates of depression and suicide.¹³³ These curricula ignore or demonize the experiences of an already marginalized, but significant, population.¹³⁴

C. Many of the Funded Activities Contained Minimal Abstinence-Only-Until-Marriage Programming, and Those that Did Had Difficulty Gaining Access to Schools

Many of the programs funded in New York State have functioned as general after-school or youth development programs, with no clear sexuality education component. A significant number of these programs contained minimal programming on abstinence—though all work plans and proposals mentioned the term “abstinence.”

For example, funding was awarded to support the following activities:

- After-school “fun” programs, to “fill a high risk time,” that included reading, writing, math, technology, drama and art.¹³⁵
- Foundation of a “cyber café,” which provided students access to computers and the internet, as well as training in food service work.¹³⁶
- Field trips to businesses to expose students to careers and the workplace.¹³⁷
- Expansion of after-school Spanish classes, arts and crafts, soccer, inline skating, rock-wall climbing, wrestling and hockey.¹³⁸
- Baking, cooking, newspaper, digital music, computer strategy games, social issues discussion groups, chess, crochet, drama, chorus and book groups, cosmetology, football, basketball and softball.¹³⁹

Several of the programs that *did* focus on abstinence-only-until-marriage programming reported that they had difficulty obtaining cooperation with school administrators or met with resistance in gaining access to the classroom, and had to conduct their programming outside of the school setting.¹⁴⁰ Taken together, these findings strongly suggest that both educators and some grant recipients themselves do not believe that abstinence-only-until-marriage programming is appropriate for their student population.

D. New York State Did Not Monitor its Grantees' Choice of Educational Materials, or Adequately Evaluate the Efficacy of their Programs

1. Educational Materials Were Not Monitored for Accuracy or Appropriateness

Although abstinence-only-until-marriage curricula and materials in use in New York State have been repeatedly challenged by medical and professional organizations for scientific inaccuracies and other serious deficiencies, there was no evidence that New York State requires applicants for Title V funding to identify the curricula they plan to use, or to ensure their accuracy or appropriateness.

New York is not alone in failing to monitor or evaluate these programs adequately. A 2006 investigation by the Government Accounting Office (GAO) found that the Administration for Children and Families (ACF) of the Department of Health and Human Services (HHS), the federal agency which awards grants through the two programs that account for the largest portion of federal spending on abstinence-only-until-marriage, does not review its grantees' materials, nor does it require grantees to review their own materials for scientific accuracy.¹⁴¹ Some, but not all, states have filled this gap by conducting their own reviews, but the GAO study

found, and our investigation confirmed, that New York was not among them.¹⁴²

2. Programs Were Not Monitored for Effectiveness

Program evaluation is viewed by public health professionals as “an essential organizational practice in public health.”¹⁴³ There is little evidence that New York State has ever systematically assessed the impact of the funded abstinence-only-until-marriage programs on adolescent behavior. On-site evaluations were neither regular, complete nor systematic. None of the grantees' self-evaluations, which take the form of “progress reports” to DOH, contained any evidence that the programs were succeeding in reducing sexual activity. For the most part, the only measures provided were attendance and enrollment figures, which indicate nothing about their programs' effectiveness.

There is little evidence that New York State has ever systematically assessed the impact of the funded abstinence-only-until-marriage programs on adolescent behavior.

For example:

- Hudson City School District, which received more than \$1 million between 1998 and 2005, stated in its 1998 proposal that its program would be evaluated through questionnaires, interviews and observations. But none of the quarterly reports filed indicated that any of these evaluation tools were ever used.¹⁴⁴
- Builders for the Family Diocese of Brooklyn reported that as a result of a DOH site visit, it was updating its needs assessment, using a new client assessment questionnaire and revising its pre/post-test questionnaire, but the results were not included and there was no other evidence of any

internal assessment of the program’s effectiveness in reaching its goals.¹⁴⁵

- In the Chemung County YMCA program, there was one DOH site visit in 2003, generating a two-page report. Yet the report merely drew subjective conclusions about what was “successful” and what needed improvement. Meanwhile, “successful” was not defined, and there seemed to be no data driving that assessment.¹⁴⁶
- In the Church Avenue Merchant’s Block Association program assessment, the DOH reviewer found after a site visit that “there is no system to evaluate the effectiveness” of the programs that are designed to outreach to high-risk youth, and “no quality

There is no indication that either DOH or the federal government required grantee personnel to meet particular educational requirements, requested plans for personnel training or exercised any oversight whatsoever over the teaching methods used.

improvement plan in place.” Nonetheless, the site reviewer concluded that “there was no documented evidence that work plan objectives are not met.”¹⁴⁷

- In Addison Central School District, on-site visits by a DOH reviewer in September and October 2002 resulted in a generally positive report, with recommendations to involve additional sectors of the community in an advisory capacity, increase youth representation on the initiative’s steering committee and explore strategies to increase opportunities for youth to remain involved in the initiative throughout their high school years. The DOH report asks that an action plan be submitted within 30 days, but no such action plan was included in the documents the NYCLU received.¹⁴⁸

- In at least one of the programs, the Chautauqua County Youth Bureau, there was no record of a site visit at all.¹⁴⁹

3. Programs Were Not Monitored for Adequacy of Teacher Training Or Methodology

Experts in sex education agree that the teacher is the single most important factor in the effectiveness of a sexuality education program.¹⁵⁰ An effective sexuality educator needs a broad base of knowledge in human sexuality content and issues, and teaching skills, including the ability to create a supportive atmosphere, facilitate discussion, maintain confidentiality and design and offer a wide variety of learning activities.¹⁵¹

For the most part, the groups funded were not educational or public health organizations, and had little or no training in teaching generally, or in sexuality education in particular. Nonetheless, there is no indication that either DOH or the federal government required grantee personnel to meet particular educational requirements, requested plans for personnel training or exercised any oversight whatsoever over the teaching methods used.¹⁵²

E. The Government Has Channeled Large Amounts of Funds to Religious Institutions Without Adequate Safeguards Against Inclusion of Religious Content

Although it is permissible to provide public funds to religious institutions performing social services, it is incumbent upon the government to ensure that funds are not used to support religious proselytizing that would run afoul of church-state separation.¹⁵³ Inclusion of religious content in federally funded programs is unconstitutional, and has been subject to legal challenges in other states, leading to court-ordered monitoring of programs.¹⁵⁴

Figure D: New York Abstinence-Only-Until Marriage Funding Awarded to Secular and Faith-Based Organizations in FY 2005

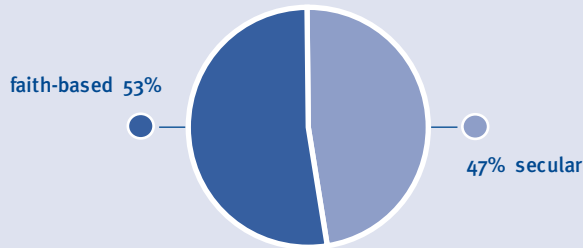
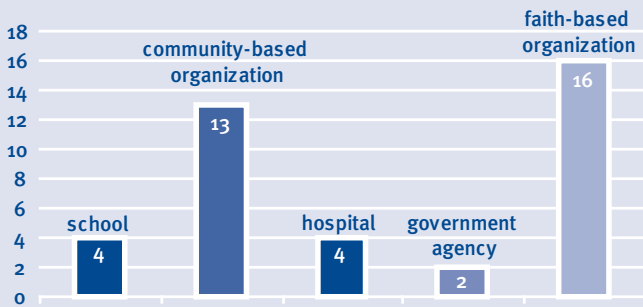


Figure E: Organizations Receiving Abstinence-Only-Until-Marriage Funding in FY 2005



Sixteen out of the 39 grantees reviewed in New York State were religious-affiliated institutions in FY 2005. The groups received at least \$6,370,470 and more than half (53 percent) of all abstinence-only-until-marriage funding in New York that year.¹⁵⁵ [See Figures D & E.] Groups with religious-affiliations received at least \$6,370,470 and more than half (53 percent) of all abstinence-only-until-marriage funding in New York in FY 2005. Requests for proposals state that grantees may not include religious content in their programming.¹⁵⁶ But there was no evidence that either the state or the federal government took proactive steps to ensure that the programming actually remained secular. Indeed, there are indications that some of the programs may have involved religious content. The director of

Project Reach has stated that “the idea of strict separation of church and state that is operative today is a ‘bankrupt concept with a dubious constitutional pedigree.’”¹⁵⁷ One program, H.O.P.E. Initiatives CDC Inc., included a Saturday morning Bible

study.¹⁵⁸ And as mentioned previously, at least five programs partnered or contracted with crisis pregnancy centers,

“The idea of strict separation of church and state that is operative today is a bankrupt concept with a dubious constitutional pedigree.”
 —Director of Project Reach

whose opposition to abortion is often explicitly grounded in religious teaching. ■

IV. *Abstinence-Only and Comprehensive Sex Ed: A View from other States*

A. Rejection of Abstinence-Only-Until-Marriage Funds

The fact that abstinence-only-until-marriage programming does not reduce rates of teen sex, pregnancy or STIs has led states across the country to abandon such programs. A total of 11 states so far have refused to participate, and the number is increasing. In April

A total of 11 states have rejected funding so far, and the number is increasing.

2007, Massachusetts Governor Deval Patrick announced that he planned to forego a \$700,000 abstinence-only grant that the state had received since 1998. The

state's Commissioner of Public Health explained, "We don't believe that the science of public health is pointing in the direction of very specific and narrowly defined behavioral approaches like the one that is mandated by this funding."¹⁵⁹ In March 2007, Ohio Governor Ted Strickland announced that he "did not see the point in taking part" in the abstinence-only-until-marriage funding program anymore. According to his spokesman, "The governor believes that, considering the very challenging budget environment we find ourselves in, that this is an unwise use of tax dollars because there is no conclusive evidence that suggests that the program works."¹⁶⁰ On April 11, 2007, the Washington State legislature passed by a wide margin a law prohibiting public schools from using an abstinence-only-until-marriage approach. In explaining the reason for her vote in favor of the law, one legislator pragmatically noted that, "Teaching teens about scientifically accurate sex ed will not cause

them to have sex, because a great many of them are already having it."¹⁶¹

New York has recently taken steps toward joining the ranks of states that have refused to participate in abstinence-only-until-marriage programming. In June 2007, DOH reportedly sent letters to Title V grantees notifying them that their contracts would not be renewed. Although neither DOH nor the governor's office has made any public statements regarding this decision, advocates hope that this signals a policy decision to move away from funds that are restricted to an abstinence-only-until-marriage message and toward funding for comprehensive sexuality education.

B. Funding and Promotion of Comprehensive Sex Ed

In addition to rejecting federal abstinence-only-until-marriage funds, several states have experimented with other solutions to promote comprehensive sexuality education. While this report does not present a comprehensive survey of such programs and initiatives across the country, it does highlight a few that can serve as models to be emulated or enacted in New York.

1. Mandating and Defining Sex Education

Nineteen states currently mandate that public schools teach some form of sexuality education.¹⁶² States including Maine, Maryland, Minnesota, Vermont and West Virginia contain requirements that sexuality education be taught, that it include instruction regarding

Nineteen states currently mandate that public schools teach some form of sexuality education.

both abstinence and contraception and that the information presented be medically accurate.¹⁶³

Several states have enacted measures specifying that when they are taught, sexuality education programs should be comprehensive and medically accurate. For example, Washington State recently enacted a law requiring that:

[E]very public school that offers sexual health education must assure that sexual health education is medically and scientifically accurate, age-appropriate, appropriate for students regardless of gender, race, disability status, or sexual orientation, and includes information about abstinence and other methods of preventing unintended pregnancy and sexually transmitted diseases. All sexual health information, instruction, and materials must be medically and scientifically accurate. Abstinence may not be taught to the exclusion of other materials and instruction on contraceptives and disease prevention.¹⁶⁴

The law defines “medically and scientifically accurate” as meaning “information that is verified or supported by research in compliance with scientific methods, is published in peer-reviewed journals, where appropriate, and is recognized as accurate and objective by professional organizations and agencies with expertise in the field of sexual health.”¹⁶⁵ The law further directs the superintendent of schools to develop “a list of sexual health education curricula that are consistent with [state] guidelines for sexual health information and disease prevention,” and encourages, but does not require, schools to pick one of them; schools may choose another, non-listed curriculum, so long as it does not conflict with the other requirements of the law.¹⁶⁶

Oregon’s scheme, which includes a mandate for HIV/AIDS instruction but does not

require the teaching of sexuality education, nonetheless specifies that if schools do choose to provide sexuality education courses, those courses must be comprehensive.¹⁶⁷ Although such courses must “promote abstinence for school-age youth and mutually monogamous relationships with an uninfected partner for adults,” they cannot teach abstinence “at the exclusion of other material and instruction on contraceptive and disease reduction messages,” or “devalu[e] or ignor[e] those young people who have had or are having sexual intercourse.”¹⁶⁸

Particular aspects of the different approaches in each of these states can serve as models for New York in several respects. Including a medical accuracy component and/or requiring that when sexuality education is offered it is scientifically accurate and objective prevents the use of curricula that are inaccurate, biased or misleading. By encouraging, but not requiring, schools to choose among a list of approved curricula, the Washington statute provides important guidelines for quality and content, while at the same time permitting local schools flexibility to tailor their programs as appropriate. And language in Oregon’s law specifies that the experiences of youth who are LGBT identified, sexually active, or pregnant or parenting should not be ignored or marginalized.

2. Funding Comprehensive Sex Ed: New York’s “Healthy Teens Act”

Recognizing the difficulties posed by the imbalance in resources dedicated to comprehensive sexuality education as compared to abstinence-only-until-marriage programs, other states have proposed legislation that would establish funding for comprehensive sexuality education. One of the best examples of such funding initiatives is in New York State, where proposed legislation called the “Healthy Teens Act” (HTA)¹⁶⁹ would establish a grant program for “age-appropriate and medically accurate”

sexuality education that “stresses the value of abstinence while not ignoring those adolescents who have had or who are having sexual intercourse.” The HTA specifies that grantees must teach that abstinence is the only sure way to avoid pregnancy and STIs, but also must include discussion of the “health benefits and side effects” of contraceptives and barrier methods as a means to prevent pregnancy and reduce the risk of contracting STIs.

The HTA specifies that grantees must teach that abstinence is the only sure way to avoid pregnancy and STIs, but also must include discussion of the health benefits and side effects of contraceptives and barrier methods as a means to prevent pregnancy and reduce the risk of contracting STIs.

The HTA also contains other important safeguards that address many of the problems identified in this report concerning lack of expertise on the part of grantees and inadequate evaluation or accountability.

For example:

- Grant applicants would be required to demonstrate “a proven record and experience in conducting meaningful and successful age-appropriate sex education programs[.]”
- Up to 9 percent of the funds would be reserved for analyzing the efficacy and benefits of sex education grant programs for purposes of evaluating the programs over a four-year period following the initiation of the grant.
- Applicants would be required to provide DOH with outlines for the curriculum to be covered and the materials to be used, and information on the teaching personnel and their credentials.

- Grant recipients would be required to report on the program to the governor and the legislature.

Thus, the legislation would ensure not only medical accuracy, but also competence and expertise in the teaching of the funded programs, and adequate evaluation and accountability. As such, it should serve as a model for the rest of the nation. ■

V. Conclusion and Recommendations

By withholding accurate information about contraception and disease prevention, the government is putting our youth at risk. A group of adolescent health experts from some of the nation’s leading medical schools calls this a breach of public health ethics:

By withholding accurate information about contraception and disease prevention, the government is putting our youth at risk.

We believe that it is unethical to provide misinformation or to withhold information from adolescents about sexual health, including ways for sexually active teens to protect themselves from STIs and pregnancy. Withholding information on contraception to induce them to become abstinent is inherently coercive. It violates the principle of beneficence (*i.e.*, do good and avoid harm) as it may cause an adolescent to use ineffective (or no) protection against pregnancy and STIs. We believe that current federal [abstinence-only-until-marriage programming] is ethically problematic, as it excludes accurate information about contraception, misinforms by overemphasizing or misstating the risks of contraception, and fails to require the use of scientifically accurate information while promoting approaches of questionable value.¹⁷⁰

New York should follow the advice of these public health experts and commit to providing New York’s young people with comprehensive, age-appropriate sexuality education, and to ending support for abstinence-only-until-marriage programs.

Our analysis of the use of state and federal abstinence-only-until-marriage funds in New York strongly supports this recommendation. In many abstinence-only programs, funds were used to support teaching of curricula that con-

tain medical inaccuracies, scare-tactics and ideological messages. Other curricula promote pernicious gender stereotypes and messages that demonize or marginalize LGBT youth. Several programs used funds for programming that had little or nothing to do with abstinence or sexuality education. In all cases, programs were poorly administered by the government, with lax oversight and no meaningful evaluation or quality control measures. Furthermore, with more than half of the funds going to religious organizations and no mechanisms in place to ensure a secular curriculum, they place children at risk of religious indoctrination at tax-payer expense.

The focus by the Department of Health and some of the grantees on programming unrelated to sex ed or abstinence appears to have been an attempt to make the best of a bad situation—accepting abstinence-only-until-marriage funds, but largely avoiding the abstinence-only-until-marriage message. This focus on youth development, along with the difficulty encountered by more traditional abstinence-only-until-marriage programs in gaining acceptance in the schools, strongly suggests that the abstinence-only-until-marriage model is the wrong fit for New York. Youth development and general after-school activities serve important needs, but they do not teach young people what they need to know about the risks associated with sexual activity and the means to prevent them. Such programs must obtain the funding they need, but they cannot and should not be a substitute for comprehensive sexuality education.

New York State is in dire need of effective programs that give young people the tools they

need to prevent unwanted pregnancies and transmission of STIs. Millions of dollars have

The solution involves a commitment by state and federal policy-makers to promote teaching of comprehensive sexuality education, institute mechanisms to ensure controls for quality and efficacy of funded programs, and stop the flow of funds to abstinence-only-until-marriage programs.

been spent across our state on programs that have been proven ineffective. By accepting these federal dollars and providing the required state matching funds, New York has wasted pre-

cious resources. We can no longer afford to fund such a costly experiment with our children's lives.

The solution to the problem would involve a simple, three-step commitment by policy-makers at the state and federal levels:

- (1) Promote teaching of comprehensive sexuality education.**
- (2) Institute mechanisms to ensure adequate controls for quality and efficacy of funded programs.**
- (3) Stop the flow of funds to abstinence-only-until-marriage programs.**

With these principles in mind, we recommend that policy makers take the following actions:

A. At the Federal Level

1. Congress Should Enact the REAL Act

The Responsible Education About Life (REAL) Act would be the first federal program to fund comprehensive sexuality education, establishing a funding mechanism for programs offering age-appropriate information on both abstinence and contraception. It would

require funded programs to teach medically accurate information. While teens would still learn that abstinence is the only sure way to prevent unintended pregnancy or STIs, the REAL Act would require that sex education programs also include vital information on contraceptive use. Congress should enact this important legislation.

2. Congress Should Stop the Flow of Funding to Abstinence-Only-Until-Marriage Programs, Including Title V, CBAE and AFLA

Abstinence-only-until-marriage programs currently receive the only dedicated federal education funding related to sexuality, despite the fact that they ignore critical facts about sexuality and prevention. Congress should stop funding Title V, CBAE and AFLA, or amend the enabling legislation to specify that these funds must be used for comprehensive, medically accurate sexuality education. No federal money should go to programs that jeopardize the health and safety of our children.

During its consideration of Title V in July 2007, the U.S. House of Representatives proposed several changes to the Title V program including allowing states flexibility in the use of Title V funds to fund either abstinence-only-until-marriage pro-

grams or comprehensive sexuality education. To the extent that states use this money to fund effective comprehensive sexual-

ity education programs, that would be a positive development, but until the flow of dollars to abstinence-only-until-marriage programs is stopped, the fight for comprehensive sexuality education will be an uphill battle. Congress should act now to ensure that *all* young people, no matter what state they live in, have access to the

No federal money should go to programs that jeopardize the health and safety of our children.

information they need to make healthy and responsible life decisions.

B. At the State Level:

Although the proposals previously outlined depend on federal action, the solution lies within our grasp in New York State. No matter what happens at the federal level, New York can still take the steps necessary to protect the lives and health of our youth by enacting the Healthy Teens Act, requiring that health education include medically accurate and age-appropriate sexuality education, and rejecting Title V abstinence-only-until-marriage restricted funds.

New York can take the steps necessary to protect the lives and health of our youth by enacting the Healthy Teens Act, requiring that health education include medically accurate and age-appropriate sexuality education, and rejecting Title V abstinence-only-until-marriage restricted funds.

the Senate. New York should demonstrate its commitment to the health and well-being of our youth by enacting the HTA, and devoting at least the same amount of funds that has been devoted to Title V matching funds to comprehensive sexuality education. The time has come to fund sex ed that works.

2. New York Should Specify that Health Education Includes the Teaching of Scientifically Accurate, Age-Appropriate Sexuality Education That Includes—But is Not Limited to—an Abstinence Message

New York law currently includes a require-

ment that students in public schools be provided instruction in health education. It does not currently include a definition that makes clear that comprehensive sexuality education is a necessary component of health education, although it does require HIV/AIDS education. Promoting full reproductive and sexual health requires more complete instruction.

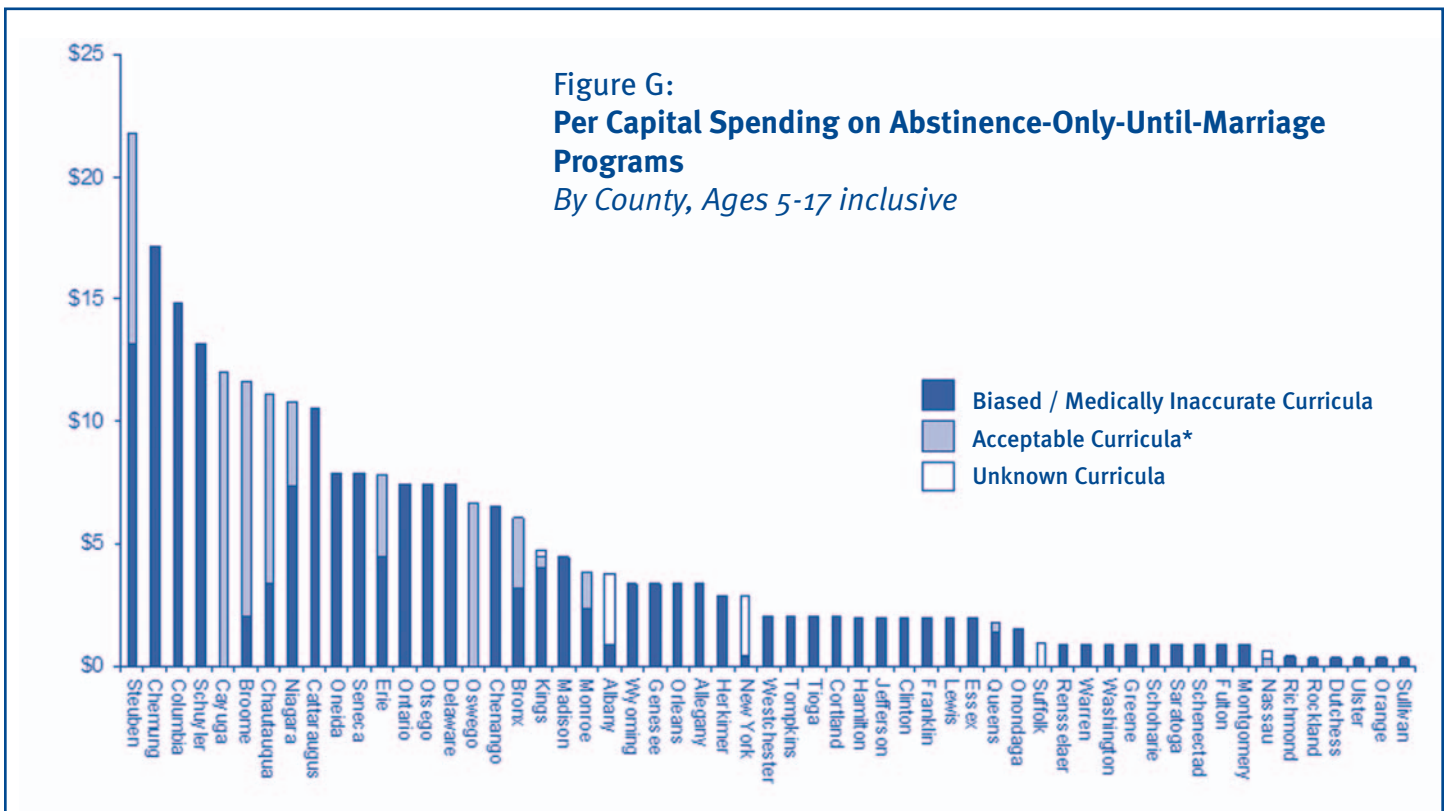
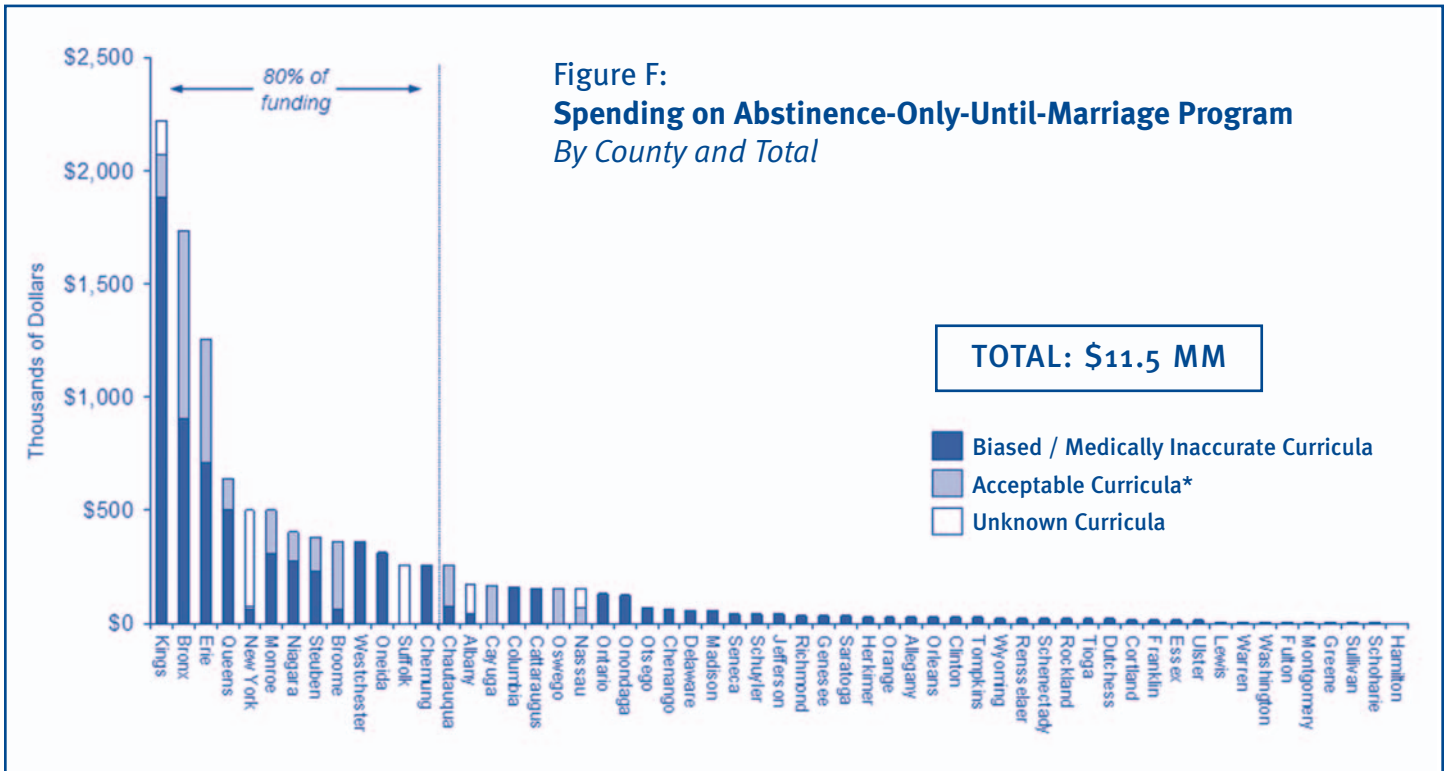
The education law should be amended to clarify that comprehensive sexuality education is a critical component of health education. Such education should be age-appropriate and medically accurate, and should provide information on the benefits and limitations of all FDA approved means of contraception and barrier methods of disease prevention. Medically accurate should be defined, as it is in Washington State, to ensure that programs meet standards of scientific accuracy and objectivity, and language should be included, similar to that in Oregon, to ensure that the needs and experiences of all youth are addressed. In addition, similar to the approach taken in Washington, the commissioners of the Departments of Health and Education should be empowered to develop guidelines collaboratively on the provision of such an educational program and curricula that might be used, and to put in place adequate mechanisms for monitoring, teacher training and evaluation. This would ensure that the requirement is implemented in a manner that leaves sufficient flexibility in the hands of school districts and administrators to craft a program that is appropriate for the particular student population, while still providing guidelines as to the substance of the information that must be covered.

3. New York State Should Reject Title V Abstinence-Only-Until-Marriage Restricted Funds

The time has come for New York to join the growing number of states, including California, Maine, Ohio and Pennsylvania, that have officially rejected federal abstinence-only-until-marriage funding.

Our analysis strongly supports the administration’s recent decision to cancel its existing contracts with Title V grantees. Although this is an encouraging step, our state must go further. The NYCLU urges the state to publicly reject the ineffective and ideologically driven abstinence-only-until-marriage approach, and clarify that it will continue to refuse such funding as long as abstinence-only-until-marriage restrictions are attached. ■

Appendices



* Acceptable curricula are curricula that SIECUS and others have evaluated as effective, and not including biased or fear-based content. Note: No abstinence only programs received funding in Livingston, Putnam, St. Lawrence, Wayne, or Yates counties.

Figure H:
Programs Using Curricula Identified as Biased and/or Inaccurate

Curriculum	Programs Using	
<i>Sex Respect</i>	▶ Delaware-Chenango-Madison-Otsego BOCES	
<i>Project Reality</i>	<ul style="list-style-type: none"> ▶ The Archdiocese of New York’s “My Future First” program ▶ Builders for the Family and Youth of the Diocese of Brooklyn ▶ Catholic Charities of Syracuse (Oneida/Madison) ▶ Catholic Charities of Western New York 	<ul style="list-style-type: none"> ▶ Catholic Charities of Buffalo/ProjectTruth ▶ Hudson City School District ▶ Jewish Child Care Association ▶ Program Reach ▶ Yorkshire-Pioneer Central School
<i>Choosing the Best</i>	<ul style="list-style-type: none"> ▶ The Archdiocese of New York’s “My Future First” program ▶ Community of Maternity Services ▶ H.O.P.E. Initiatives, CDC ▶ Hudson City School District 	<ul style="list-style-type: none"> ▶ King Urban Life Center, Inc. ▶ Niagara Falls Memorial Medical Center/Mount St. Mary’s Hospital ▶ Educators for Children, Youth and Families
<i>WAIT Training</i>	<ul style="list-style-type: none"> ▶ Archdiocese of New York ▶ Catholic Charities-Ogdensburg ▶ Catholic Charities of Western New York ▶ Chemung County YMCA ▶ King Urban Life Center, Inc., Buffalo 	<ul style="list-style-type: none"> ▶ Niagara Falls Memorial Medical Center/Mount St. Mary’s Hospital ▶ Yorkshire-Pioneer Central School ▶ Syracuse Model Neighborhood Facility.

Endnotes

- ¹ See Family and Youth Services Bureau, Administration on Children, Youth and Families, Dep't of Health & Human Servs., *Funding Opportunity: Community-Based Abstinence Education Program*, 70 Fed. Reg. 29,318, 29,320 (May 20, 2005) [hereinafter *2005 CBAE Grant Announcement*] (“Sex education programs that promote the use of contraceptives are not eligible for funding under this announcement”); Family and Youth Services Bureau, Admin. on Children, Youth & Families, U.S. Dep't of Health & Human Servs., *FY 2007 Program Announcement: Section 510 Abstinence Education Program 13* (Aug. 2006) [hereinafter *2007 Title V Program Announcement*], available at <http://www.acf.hhs.gov/grants/pdf/ACYF-FYSB-AE-01-06updated.pdf> (“Neither the State nor any of its sub-awardees may use Federal or matching funds under this award to promote the use of contraception.”); H.R. Conf. Rep. No. 107-347, at 113 (2002) (specifying that AFLA grantees may not teach material inconsistent with eight-point abstinence education definition).
- ² 42 U.S.C. § 710(b)(2) (2007).
- ³ Proposals currently under consideration by Congress have the potential to lift the requirement that programs receiving abstinence-only funds use the eight-point definition. This would leave the decision of whether to use the funds for abstinence-only-until-marriage programs or comprehensive sexuality education up to the states.
- ⁴ See, e.g., Minority Staff of H.R. Comm. on Gov't Reform, Special Investigations Div., 108th Cong., *The Content of Federally Funded Abstinence-Only Education Programs, Prepared for Rep. Henry A. Waxman* (2004) [hereinafter *Waxman Report*], available at <http://oversight.house.gov/Documents/20041201102153-50247.pdf>; Scott H. Frank, MD, MS, Director, Division of Public Health Department of Epidemiology & Biostatistics Dep't of Family Med., Div. of Adolescent Health, Case Western Reserve University School of Medicine, *Report on Abstinence-Only-Until-Marriage Programs in Ohio* (2005) [hereinafter *Ohio Report*].
- ⁵ See Am. Pub. Health Ass'n, *Abstinence and U.S. Abstinence-Only Education Policies: Ethical and Human Rights Concerns* (Nov. 8, 2006), <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1334>.
- ⁶ See Martha E. Kempner, Sexuality Info. & Educ. Council of the U.S. (SIECUS), *Toward a Sexually Healthy America: Abstinence-Only-Until-Marriage Programs that Try to Keep Our Youth 'Scared Chaste'* (2001), available at http://www.siecus.org/pubs/tsha_scaredchaste.pdf
- ⁷ SIECUS is an advocacy organization that, for the past forty years, has been at the forefront of efforts to promote sexuality education for people of all ages, protect sexual rights, and expand access to sexual health. See <http://www.siecus.org/about/index.html>.
- ⁸ SIECUS, *Guidelines for Comprehensive Sexuality Education* (3d ed. 2004), available at <http://www.siecus.org/pubs/guidelines/guidelines.pdf>.
- ⁹ See Am. Med. Ass'n, *Policy H-170.968: Sexuality Education, Abstinence, and Distribution of Condoms in Schools* (May 24, 2007), http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-170.968.htm; Am. Acad. of Pediatrics, *Sexuality Education for Children and Adolescents*, 108 Pediatrics 498 (2001), <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;108/2/498.pdf>; Am. Psychological Ass'n Council of Representatives, *Resolution in Favor of Empirically Supported Sex Education and HIV Prevention Programs for Adolescents* (Feb. 20, 2005), http://www.apa.org/pi/resolution_in_favor_of_empirically.pdf; Soc'y for Adolescent Med., *Abstinence-Only Education Policies and Programs: A Position Paper*, 38 J. Adolescent Health 83 (2006); Am. Public Health Ass'n, *Abstinence and U.S. Abstinence-Only Education Policies: Ethical and Human Rights Concerns* (Nov. 8, 2006), <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1334>; Am. Coll. of Obstetricians & Gynecologists, *Guidelines for Women's Health Care* 149 (2d ed. 2002).
- ¹⁰ See Frank, *Ohio Report*, *supra* note 4, at 4.
- ¹¹ See SIECUS *Toward a Sexually Healthy America: Roadblocks Imposed by the Federal Government's Abstinence-Only-Until-Marriage Education Program* 8 (2001), available at <http://www.advocatesforyouth.org/publications/abstinenceonly.pdf>. at 10.
- ¹² SIECUS, No More Money Campaign, *A Brief History of Abstinence-Only-Until-Marriage Funding*, <http://www.nonewmoney.org/history.html> (last visited Aug. 15, 2007).
- ¹³ 42 U.S.C. § 300z-300z-10 (2007).
- ¹⁴ 42 U.S.C.S. § 710. Title V was enacted as a part of the 1996 welfare reform effort. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, tit. IX, sec. 912, 110 Stat. 2,353 (1996).

- 15 Originally funded under the “special projects of regional significance” program (SPRANS), of Title V section 501(a)(2) of the Social Security Act (codified at 42 U.S.C. § 701(a)(2)), CBAE is presently authorized under Title XI, section 1110 of the Social Security Act, 42 U.S.C. §1310. *See 2005 CBAE Grant Announcement*, 70 Fed. Reg. at 29,319.
- 16 42 U.S.C. § 300z(b)(1).
- 17 *Id.* *See also* Rebekah Saul, *Whatever Happened to the Adolescent Family Life Act?*, Guttmacher Rep. on Pub. Policy 5, 10-11 (1998), available at <http://www.guttmacher.org/pubs/tgr/01/2/gr010205.pdf> (last visited Aug. 15, 2007).
- 18 SIECUS, *A Brief History of Abstinence-Only-Until-Marriage Funding*, *supra* note 12.
- 19 *Id.*
- 20 *2007 Title V Program Announcement*, *supra* note 1, at 6.
- 21 *See* Transitional Medical Assistance (TMA) Extension, Pub. L. No. 110-48, 121 Stat. 244 (2007).
- 22 *See 2005 CBAE Program Announcement*, 70 Fed. Reg. 29,319 (May 20, 2005); SIECUS, *A Brief History of Abstinence-Only-Until-Marriage Funding*, *supra* note 12.
- 23 *See* SIECUS, Pub. Policy Office, *It Gets Worse: A Revamped Federal Abstinence-Only Program Goes Extreme* (2006) (special report), available at http://www.siecus.org/policy/Revamped_Abstinence-Only_Goes_Extreme.pdf.
- 24 *See* SIECUS, *A Brief History of Abstinence-Only-Until-Marriage Funding*, *supra* note 12.
- 25 *See* Debra Hauser, Advocates for Youth, *Five Years of Abstinence-Only-Marriage Education: Assessing the Impact* (2004), <http://www.advocatesforyouth.org/publications/stateevaluations.pdf>; Peter S. Bearman & Hannah Bruckner, *Promising the Future: Virginity Pledges and First Intercourse*, 106 Am. J. Sociology 859 (2001); Human Rights Watch, *Ignorance Only: HIV/AIDS, Human Rights, and Federally Funded Abstinence-Only Programs in the United States: Texas: A Case Study*, Vol. 14:5(G), Sept. 2002, at 13-15, available at <http://hrw.org/reports/2002/usa0902/USA0902.pdf>; Kristen Underhill et al., *Sexual Abstinence Only Programmes to Prevent HIV Infection in High Income Countries: Systematic Review*, 55 British Med. J. 248 (2007), available at <http://www.bmj.com/cgi/reprint/335/7613/248>.
- 26 *See* John Santelli et al., *Abstinence and Abstinence-Only Education: A Review of U.S. Policies and Programs*, 38 J. Adolescent Health 72 (2006), available at <http://genderhealth.org/pubs/JAHAAbstinenceReview.pdf>.
- 27 Christopher Trenholm et al., Mathematica Policy Research, *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report* (2007) [hereinafter *Mathematica Study*], available at <http://www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf>. This longitudinal study compared students who had attended Title V-funded abstinence-only-until-marriage programs with students who received “only the usual services available in the absence of these programs” but who were similar in all other respects. The researchers selected four program sites: (1) *My Choice, My Future!* in Powhatan, VA; (2) *ReCapturing the Vision* in Miami, FL; (3) *Families United to Prevent Teen Pregnancy* in Milwaukee, WI; and (4) *Teens in Control* in Clarksdale, MS. Each of the four programs had qualities commonly found in programs supported by Title V funding, all delivered services in school settings, and all focused on upper elementary and middle school youth. *Id.*
- 28 *Mathematica Study*, *supra* note 27, at 30. This was true whether abstinence was defined as always remaining abstinent, or as being abstinent during the preceding 12 months. *Id.*
- 29 *Id.* at 31.
- 30 *Id.*
- 31 *Id.* at 33.
- 32 *Id.* at 32.
- 33 *Id.* at 35.
- 34 *See* sources cited *supra* note 9.
- 35 Am. Pub. Health Ass’n, *supra* note 9. Moreover, the claim that abstinence-only-until-marriage programming does not deprive teens of this information because they can obtain it by other means, such as other classes or after-school programs, “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[s] the confusion and disenfranchisement some teens are likely to experience when receiving this conflicting information.” *See* Frank, *Ohio Report*, *supra* note 4, at 27.

- ³⁶ See Douglas Kirby et al., Family Health Int'l, *Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries* (2005) [hereinafter *Impact of Sex and HIV Education Programs*]; Advocates for Youth, *Science and Success: Sex Education and Other Programs That Work To Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections* (2003), <http://www.advocatesforyouth.org/publications/ScienceSuccess.pdf>; Advocates for Youth, *Science and Success: Supplement I; Additional Sex Education and Other Programs That Work To Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections* (2006) [hereinafter *Science and Success*], available at http://www.advocatesforyouth.org/publications/sciencesuccess_supplement.pdf; Chris Collins et al., AIDS Policy Research Ctr. & Ctr. for AIDS Prevention Studies, AIDS Research Inst., U. Cal., San Francisco, *Abstinence Only vs. Comprehensive Sex Education: What Are the Arguments? What Is the Evidence?* 9 (2002), available at <http://ari.ucsf.edu/science/reports/abstinence.pdf>; Douglas Kirby, Nat'l Campaign to Prevent Teen Pregnancy, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (2001) [hereinafter *Emerging Answers*], available at <http://www.teenpregnancy.org/resources/data/pdf/emersanssum.pdf>. Even opponents of comprehensive sexuality education are forced to recognize the positive impacts of many curricula. See Admin. for Children & Families, U.S. Dep't of Health & Human Servs., *Review of Comprehensive Sex Education Curricula* (2007) (prepared for Senators Rick Santorum and Tom Coburn), available at <http://www.acf.hhs.gov/programs/fysb/content/abstinence/06122007-153424.PDF>.
- ³⁷ See Kirby, *Emerging Answers*, *supra* note 36, at 8.
- ³⁸ See Advocates for Youth, *Science and Success*, *supra* note 36, at iv.
- ³⁹ See Kirby, *Impact of Sex and HIV Education Programs*, *supra* note 36, at 29.
- ⁴⁰ See Am. Coll. of Obstetricians and Gynecologists, *Strategies for Adolescent Pregnancy Prevention 8-12* (2007), available at <http://www.acog.org/departments/adolescentHealthCare/StrategiesForAdolescentPregnancyPrevention.pdf>; Advocates for Youth, *Science and Success* and *Science and Success: Supplement I*, *supra* note 36.
- ⁴¹ See Amy Bleakley et al., *Public Opinion on Sex Education in US Schools*, 160 Archives Pediatrics & Adolescent Med. 1151, 1154-55 (2006); Norman A. Constantine et al., Pub. Health Inst. Ctr. for Research of Adolescent Health & Development, *Sex Education: The Parent's Perspective* (2007), <http://teenbirths.phi.org/2007SummaryReport.pdf>; SIECUS Pub. Policy Office, *On Our Side: Public Support for Comprehensive Sexuality Education* (2005) (fact sheet), http://www.siecus.org/policy/public_support.pdf (citing Kaiser Family Foundation, *Sex Education in America: General Public/Parents Survey*; Kaiser Family Foundation, *Sex Education in America: A View from Inside the Nation's Classrooms 4* (2000); Othmer Inst. of Planned Parenthood of NYC, *Mobilizing Support for Sex Education* (2002); Planned Parenthood Pub. Policy Network of Wash., *Sexual Health Education Poll of Washington State Parents and Voters* (2004)).
- ⁴² Bleakley et al., *supra* note 41, at 1154.
- ⁴³ Lake Research Partners, *Sex Education in New York State: Highlights of Findings from a Statewide Survey* (2006) (presentation prepared for Family Planning Advocates of New York State) (on file with NYCLU).
- ⁴⁴ *Id.*
- ⁴⁵ See Lawrence B. Finer, Guttmacher Inst., *Trends in Premarital Sex in the United States, 1954-2003*, 122 Pub. Health Rep. 73 (2007) (finding that 95 percent of Americans have had premarital sex and that 75 percent do so before age 20).
- ⁴⁶ See U.S. Census Bureau, *Estimated Median Age at First Marriage, by Sex, 1890 to the Present* (2006), <http://www.census.gov/population/socdemo/hh-fam/ms2.pdf>; U.S. Census Bureau, *Marital Status and Living Arrangements: March 1996* (1998) (current population report), <http://www.census.gov/prod/3/98pubs/p20-496.pdf>.
- ⁴⁷ SIECUS, *Abstinence-Only-Until-Marriage Funding By State, FY 2006*, <http://www.siecus.org/policy/states/2006/finalFundingChart.html> (last visited August 30, 2007).
- ⁴⁸ See SIECUS, *2006 State Profile: New York*, <http://www.siecus.org/policy/states/2006/mandates/NY.html> (last visited Aug. 29, 2007).
- ⁴⁹ See N.Y. Educ. Law § 804 (McKinney 2007) (requiring health education to include “instruction so as to discourage the misuse of alcohol, tobacco, and other drugs,” cancer detection, and violence prevention). New York Education Law and regulations also contain provisions requiring physical education in public and private schools. See N.Y. Educ. Law § 803 (McKinney 2007); 8 N.Y.C.R.R. § 135.4 (2007).

Abstinence-only-until-marriage programming also conflicts with state regulations mandating HIV/AIDS education for public school students. Specifically, a regulation promulgated by the Commissioner of Education requires HIV instruction as part of health instruction in grades K-12: “Such instruction shall be designed to *provide accurate information* to pupils concerning the nature of the disease, methods of transmission, *and methods of prevention*[.]” N.Y. Commissioner’s Reg. Subchapter G Part 135.3(b)(2) (2002) (emphasis added).

- 50 Ctrs. for Disease Control & Prevention, U.S. Dep’t of Health & Human Servs. (CDC), *Youth Risk Behavior Surveillance – United States, 2005*, 55 Morbidity & Mortality Weekly Rep.: Surveillance Summaries 1, 78-79 55, tbls. 44 & 45 (2006).
- 51 *Id.*
- 52 *Id.*
- 53 Guttmacher Inst., *U.S. Teenage Pregnancy Statistics, National and State Trends and Trends by Race and Ethnicity* 11 tbl. 3.1 (2006), available at <http://guttmacher.org/pubs/2006/09/12/USTPstats.pdf>.
- 54 N.Y. Dep’t of Health, *Total Pregnancies and Teenage Pregnancies by Type and Resident County*, Vital Statistics of New York State 2004, tbl. 30 (2006), http://www.health.state.ny.us/nysdoh/vital_statistics/2004/table30.htm.
- 55 *Id.*
- 56 Guttmacher Inst., *supra* note 53.
- 57 CDC, *Cases of HIV infection and AIDS in the United States and Dependent Areas, 2005*, 17 HIV/AIDS Surveillance Rep., 2005, at 23 (2007) [hereinafter *Cases of HIV/AIDS in the U.S.*], <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/pdf/2005SurveillanceReport.pdf>.
- 58 See CDC, *HIV/AIDS Among Youth 2* (2006) (fact sheet), <http://www.cdc.gov/hiv/resources/factsheets/PDF/youth.pdf>.
- 59 CDC, *Cases of HIV/AIDS in the U.S.*, *supra* note 57, at 10. This number only includes HIV diagnoses in the 33 states that have confidential name-based HIV infection reporting.
- 60 HIV Epidemiology Program, N.Y.C. Dep’t of Health & Ment. Hygiene, *New York City HIV/AIDS Annual Surveillance Statistics 2005*, tbl. 1.1 (2006), http://home2.nyc.gov/html/doh/downloads/pdf/ah/surveillance2005_tables_all.pdf.
- 61 See Sarah Kershaw, *Syphilis Cases on the Increase in New York City*, N.Y. Times, August 12, 2007.
- 62 5 U.S.C. § 552 (2006).
- 63 N.Y. Pub. Off. Law §§ 85-90 (McKinney 2007); 8 N.Y.C.R.R. § 187 (2007).
- 64 Specifically, the NYCLU sought “all documents concerning applications and awards granted” under these programs, including but not limited to grant proposals, applications, award letters, contracts, grant reports, proposed budgets, budget reports, and financial reports, as well as all attachments.
- 65 See SIECUS, *Profile of New York State FY 2005*, <http://www.siecus.org/policy/states/2005/mandates/NY.html> (last visited Aug. 30, 2007).
- 66 According to SIECUS’ *Profile of New York State FY 2005*, *supra* note 65, the Orange County Health Department, the Monroe County Health Department, and the Hudson River Health Center received Title V funding in FY 2005, and Catholic Charities of the Southern Tier received a \$280,000 CBAE grant. However, the NYCLU did not receive any documents regarding these grantees. These programs were thus excluded from this analysis. In addition, the NYCLU only received H.O.P.E. Initiatives’ Title V grant application, although the program was reported to have received CBAE funding. All available documents were used to review this program.
- 67 See Letter from Joe LoCicero, Records Access Officer, N.Y. State Dep’t of Health, to Elisabeth Benjamin, Director, NYCLU RRP (Mar. 17, 2006) (on file with NYCLU).
- 68 Several of the companies that publish abstinence-only-until-marriage curricula actually produce a variety of different products or lesson plans. See *infra* notes 70-73 (listing curricula produced by each company). Because several New York grantees identified a curriculum but did not specify which particular lesson plan was in use, and curricula were not produced in response to our document requests, NYCLU was sometimes unable to verify which lesson plan was actually used in a given program. Grantees may also have listed a curriculum, but only used selections. Therefore, while the quotations attributed to curricula discussed here as being used by grantees were part of the curricula or families of curricula listed by the grantee, they may not actually have been the precise materials or language used.
- 69 See Martha E. Kempner, *supra* note 6; Waxman Report, *supra* note 4; Frank, *Ohio Report*, *supra* note 4.
- 70 *Sex Respect* is based in Bradley, Illinois. See <http://www.sexrespect.com/> (last visited Aug. 29, 2007).
- 71 *Choosing the Best* is an Atlanta, Georgia-based provider of “abstinence sex education curricula, training, and resources.” Curricula produced by *Choosing the Best* include *Choosing the Best WAY/Best PATH/Best LIFE* (for middle school students), *Choosing the Best JOURNEY/Best SOUL MATE* (for middle school students). See <http://www.choosingthebest.org> (last visited Aug. 17, 2007).

- 72 *WAIT (Why Am I Tempted?) Training* is a Denver-based nonprofit organization founded in 2001 by people “working in the abstinence and marriage education movement.” See www.waittraining.com/aboutus.asp (last visited Aug. 17, 2007).
- 73 *Project Reality*, based in Glenview, Illinois, develops products “designed to teach the positive benefits of abstinence and to equip teens with the tools to say no to sexual activity and yes to their future goals and dreams.” See <http://projectreality.org/about/index.php?id=10> (last visited Aug. 17, 2007). *Project Reality* also distributes *The Navigator Program* and A.C. Greene’s *Game Plan*. Up until several years ago, it also published *Facing Reality*, though that curriculum is no longer in print.
- 74 *Waxman Report*, *supra* note 4, at i.
- 75 The following New York State grantees stated in their grant applications and/or quarterly reports that they used or planned to use *Choosing the Best* materials: The Archdiocese of New York’s “My Future First” program; Community of Maternity Services; H.O.P.E. Initiatives, CDC; Hudson City School District; King Urban Life Center, Inc.; Niagara Falls Memorial Medical Center/Mount St. Mary’s Hospital; and Educators for Children, Youth and Families.
- 76 *Choosing the Best LIFE, Student Workbook*, at 21, cited in SIECUS, *Curriculum Review: Choosing the Best LIFE*, <http://www.communityactionkit.org/reviews/ChoosingTheBestLife.html> (last visited Aug. 29, 2007).
- 77 Nat’l Ctr. for HIV, STD & TB Prevention, Div. of Sexually Transmitted Diseases, CDC, *Syphilis-CDC Fact Sheet*, <http://www.cdc.gov/std/Syphilis/STDFact-Syphilis.htm#common> (last visited Aug. 28, 2007).
- 78 *Choosing the Best*, Leaders Guide, at 22, cited in Frank, *Ohio Report*, *supra* note 4, at 14.
- 79 See Haishin Fu et al., *Contraceptive Failure Rates: New Estimates from the 1995 Survey of Family Growth*, 31 *Family Planning Perspectives* 56, 56 (1999); CDC, *Update: Barrier Protection Against HIV Infection and Other Sexually Transmitted Diseases*, 42 *Morbidity & Mortality Weekly Rep.* 589 (1993), available at <http://www.cdc.gov/mmwr/PDF/wk/mm4230.pdf>.
- 80 James Trussel et al., *Contraceptive Failure in the United States: An Update*, 21 *Studies in Family Planning* 51, 52 (1990).
- 81 See Frank, *Ohio Report*, *supra* note 4, at 14.
- 82 The following New York State grantees stated in their grant applications and/or quarterly reports that they used or planned to use *Project Reality* materials: The Archdiocese of New York’s “My Future First” program; Builders for the Family and Youth of the Diocese of Brooklyn; Catholic Charities of Syracuse (Oneida/Madison); Catholic Charities of Western New York; Catholic Charities of Buffalo/ProjectTruth; Hudson City School District; Jewish Child Care Association; Program Reach; Yorkshire-Pioneer Central School.
- 83 While all these curricula use the term “sexually transmitted disease” (STD), the NYCLU and many other sexual health advocates use the more accurate and less stigmatizing term “sexually transmitted infection” (STI).
- 84 *Navigator Workbook* (published by *Project Reality*), at 47, cited in SIECUS *Curriculum Review: Navigator*, <http://www.communityactionkit.org/reviews/Navigator.html> (last visited Aug. 29, 2007).
- 85 There has recently been an increase in reported cases of syphilis, and in 2005, the rate of syphilis infection in New York City was twice the national rate. See Kershaw, *supra* note 61.
- 86 See CDC, *Male Latex Condoms and Sexually Transmitted Diseases 2* (2003), <http://www.cdc.gov/nchstp/od/condoms.pdf>.
- 87 Delaware-Chenango-Madison-Otsego BOCES stated in its grant applications and/or quarterly reports that it used or planned to use *Sex Respect* materials.
- 88 *Sex Respect, Teacher Manual*, at 87, 16, cited in SIECUS, *Curriculum Review: Sex Respect* <http://communityactionkit.org/reviews/SexRespect.html> (last visited Aug. 30, 2007).
- 89 *Id.* at 11.
- 90 See *id.* at 63.
- 91 See *id.* at 42. “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.” Frank, *Ohio Report*, *supra* note 4, at 15; see also Farrow et al., *Prolonged use of Oral Contraception Before a Planned Pregnancy is Associated with a Decreased Risk of Delayed Conception*, 17 *Human Reproduction* 2754, 2758 (2002) (finding increased fertility after prolonged hormonal contraception use).

- 92 *Facing Reality, Parent/Teacher Guide*, at P/T 24, cited in Kempner, *supra* note 6, at 18.
- 93 The following New York State grantees stated in their grant applications and/or quarterly reports that they used or planned to use *WAIT Training* materials: Archdiocese of New York; Catholic Charities-Ogdensburg; Catholic Charities of Western New York; Chemung County YMCA; King Urban Life Center, Inc., Buffalo; Niagara Falls Memorial Medical Center/Mount St. Mary's Hospital; Yorkshire-Pioneer Central School; and Syracuse Model Neighborhood Facility.
- 94 *WAIT Training*, at 35, cited in SIECUS, *Curriculum Review: WAIT Training*, <http://communityactionkit.org/reviews/WAIT.html> (last visited Aug. 29, 2007).
- 95 Ann M. Meier, *Adolescent First Sex and Subsequent Mental Health*, 112 *Am. J. Sociology* 1811, 1837 (2007).
- 96 See Traci L. Brooks et al., *Association of Adolescent Risk Behaviors With Mental Health Symptoms in High School Students*, 31 *J. Adolescent Health* 240, 244 (2002) (“[A]ssociations of risk behaviors in a cross-sectional study should not be construed as indicating directionality, causality, or correct temporal relationships.”); Donald P. Orr et al., *Premature Sexual Activity as an Indicator of Psychosocial Risks*, 87 *Pediatrics* 141-147, 146 (1991) (“We are not suggesting that premature sexual experience is a cause or leads to the other negative behaviors.”); see also Valerie Burge et al., *Drug Use, Sexual Activity, and Suicidal Behavior in U.S. High School Students*, 65 *J. Sch. Health* 222 (noting limitation in data because it could not detect “whether a reported sexual behavior was coerced, forced, or voluntary in nature”).
- 97 *Sex Respect, Student Workbook*, at 85, cited in Frank, *Ohio Study*, *supra* note 4, at 16.
- 98 *Choosing the Best LIFE, Leader Guide*, at 31, cited in SIECUS, *Curriculum Review: Choosing the Best LIFE*, *supra* note 76.
- 99 See CDC, 53(SS-9) *Morbidity & Mortality Weekly Rep.: Surveillance Summaries* 1 (2004) (reporting less than one death per 100,000 abortions in 47 states and two cities voluntarily reporting).
- 100 See, e.g., David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 140 *Ann. Intern. Med.* 620, 624 (2004) (“Induced abortion does not harm women’s emotional health; for most women, it allows an overall improvement in quality of life . . . The alleged ‘postabortion trauma syndrome’ does not exist.”); Carol J. Rowland Hogue et al., *Answering Questions About Long-term Outcomes, in A Clinician’s Guide to Medical and Surgical Abortion* 223 (Maureen Paul et al. eds., 1999) (“There is no convincing evidence of significant negative psychological sequelae from induced abortion.”); Nancy E. Adler et al., *Psychological Factors in Abortion: A Review*, 47 *Am. Psychologist* 1194, 1202 (1992) (“For the vast majority of woman, an abortion will be followed by a mixture of emotions, with a predominance of positive feelings.”); Nancy Felipe Russo & Kristin L. Zierk, *Abortion, Childbearing, and Women’s Well-Being*, 23 *Prof’l Psychology* 269, 276 (1992) (finding “that women who had had [one] abortion had higher self-esteem in general, and greater feelings of worth and capableness and fewer feelings of failure in particular, than did women who had had no abortions—despite the fact that they had experienced the stress of an unwanted pregnancy”).
- 101 Grantees listing crisis pregnancy centers as partners were Builders for the Family and Youth of the Diocese of Brooklyn; Project Reach, Catholic Charities Buffalo/ProjectTruth; and Catholic Charities Chemung and Schuyler. The Archdiocese of New York reported that it participated in a rally sponsored by a crisis pregnancy center.
- 102 Emergency contraception is not the same as abortion because it is taken to prevent conception; if a woman who takes it is already pregnant, it has no effect. See K. Gemzell-Danielsson & L. Marions, *Mechanisms of Action of Mifepristone and Levonorgestrel When Used for Emergency Contraception*, 10 *Human Reproduction Update* 341 (2004); Anna Glasier, *Emergency Postcoital Contraception*, 337 *New Eng. J. Med.* 1058, 1060 (1997).
- 103 See Southern Tier Pregnancy Resource Center homepage, www.stprc.org (last visited Aug. 21, 2007).
- 104 In February 2003, the National Cancer Institute convened a workshop of over 100 of the world’s leading experts to examine whether there is a relationship between pregnancy and breast cancer risk, and concluded that having an abortion does not increase a woman’s subsequent risk of developing breast cancer. See Nat’l Cancer Inst., *Abortion, Miscarriage, and Breast Cancer Risk* (2003), http://cis.nci.nih.gov/fact/3_75.htm. See also, e.g., Mads Melbye et al., *Induced Abortion and the Risk of Breast Cancer*, 336 *New Eng. J. Med.* 81 (1997) (concluding that abortion has no overall effect on breast cancer risk).
- 105 Comments from Morristown Central, Presentation on 1/16/02-1/18/02 (on file with NYCLU).
- 106 Comments from Morristown Central, Presentation on 4/30/01 and 5/1/01 (on file with NYCLU).
- 107 Comments from Keene Valley Central High School, Presentation on 3/26/01 (on file with NYCLU).
- 108 Comments from Massena High School, Presentation on 3/5/01-3/9/01 (on file with NYCLU).

- 109 Frank, *Ohio Report*, *supra* note 4, at 15.
- 110 See Kim Witte, *Preventing Teen Pregnancy Through Persuasive Communications: Realities, Myths, and the Hard-Fact Truths* 22 J. Community Health 137, 151 (1997) (“Fear appeals work when accompanied by high efficacy messages Audiences must be taught—clearly and explicitly—how to prevent a threat from occurring.”).
- 111 *Choosing the Best PATH, Leader Guide*, at 19, cited in SIECUS *Curriculum Review: Choosing the Best PATH*, <http://communityactionkit.org/reviews/ChoosingTheBestPath.html> (last visited Aug. 29, 2007).
- 112 *Id.*
- 113 See Realityworks, Life Skills Programs, Parenting Education, <http://www.realityworks.com/default.cms> (last visited Aug. 17, 2007).
- 114 The following New York State grantees stated in their grant applications and/or quarterly reports that they used or planned to use BTIO: The Archdiocese of New York; Cayuga County Department of Health; Delaware-Chenango-Madison-Otsego BOCES; Harlem Hospital; King Urban Life Center; Long Island North Shore Hospital; Niagara Falls Memorial Hospital; Pioneer Central School District; and Syracuse Model Neighborhood Facility.
- 115 Jerrald E. Barnett & Cynthia S. Hurst, *Do Adolescents Take “Baby Think it Over” Seriously?*, 39 *Adolescence* 65, 65-75 (2004).
- 116 See Cheryl L. Somers & Mariane M. Fahlman, *Effectiveness of the “Baby Think It Over” Teen Pregnancy Prevention Program*, 71 *J. Sch. Health* 188, 194 (2001); Judith Kralowski & Catherine Stevens-Simon, *Does Mothering a Doll Change Teens’ Thoughts About Pregnancy?*, 105 *Pediatrics* 30, 35 (2000).
- 117 See Somers & Fahlman, *supra* note 116, at 194; Kralowski & Stevens-Simon, *supra* note 116, at 30.
- 118 Frank, *Ohio Report*, *supra* note 4, at 16.
- 119 See Nat’l Ctr. for Health Statistics, CDC, *Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2002*, Vital & Health Statistics, Vol. 23(24), December 2004, tpls. 7-8 (finding that 19 percent of girls under 14 years old reported that their sexual debut was involuntary, and 27 percent reported that they “didn’t really want [sexual debut] to happen at the time”).
- 120 See SIECUS, No More Money Campaign, *Reality Behind Programs*, <http://www.nonewmoney.org/reality.html> (last visited Aug. 30, 2007).
- 121 *WAIT Training*, at 196, cited in Waxman Report, *supra* note 4, at 17.
- 122 *WAIT Training Workshop Manual*, at 86, cited in Kempner, *supra* note 6, at 44.
- 123 *Choosing the Best SOULMATE*, at 51, cited in Waxman Report, *supra* note 4, at 18. Waxman notes: “This book is the latest in the “Choosing the Best” series and was published since the most recent round of SPRANS grants; it was reviewed because the other Choosing the Best books were all among the most popular programs.” Waxman Report, *supra* note 4, at 18.
- 124 *Sex Respect, Student Workbook* at 82, cited in Frank, *Ohio Report*, *supra* note 4 at 19.
- 125 Frank, *Ohio Report*, *supra* note 4, at 20.
- 126 *Id.* at 19 (referring to similar statements in *Sex Respect* curriculum).
- 127 *WAIT Training, Workshop Manual*, at 6, cited in SIECUS, *Common Characteristics of Fear-Based, Abstinence-Only-Until-Marriage Curricula*, http://www.communityactionkit.org/pdfs/Understanding_Abstinence/common_characteristics.html (last visited Aug. 31, 2007).
- 128 *Facing Reality, Parent/Teacher Guide* at P/T 19, quoted in Kempner, *supra* note 6, at 47.
- 129 *Sex Respect Student Workbook* at 54, quoted in SIECUS, *Curriculum Review, Sex Respect*, *supra* note 88.
- 130 See CDC, *HIV/AIDS Among Women* (fact sheet), <http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/women.pdf> (last visited Aug. 17, 2007).
- 131 *Sex Respect, Student Workbook* at 63, cited in SIECUS, *Curriculum Review, Sex Respect*, *supra*, note 88.
- 132 See Mark A. Schuster et al., *The Sexual Practices of Adolescent Virgins: Genital Sexual Activities of High School Students Who Have Never Had Vaginal Intercourse*, 86(11) *Am. J. Pub Health*, 1570, 1572-73 (1996) (finding that 9 percent of high school “virgins” have engaged in fellatio with ejaculation, and that “[a]mong virgins who engaged in fellatio with ejaculation during the prior year 86 percent had never used [a condom]”); Mitchell Prinstein et al., *Adolescent Oral Sex, Peer Popularity, and Perceptions of Best Friends’ Sexual Behavior*, 28 *J. Pediatric Psych.*, 243, 246-47 (2003)

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- (finding that 40 percent of teens surveyed have participated in oral sex, that they were “significantly more likely to engage in oral sex than in intercourse and engage in oral sex with significantly more partners than for intercourse,” and that they were “unlikely to use STI protection during oral sex”); Lisa Remez, *Oral Sex among Adolescents: Is It Sex or Is It Abstinence?*, 32 *Family Planning Persp.* 298, 301 (2000) (citing survey of sexually active college undergrads finding that 70 percent of men and 57 percent of women reported engaging in oral sex before first intercourse).
- 133 A 1998 study based on nationally representative data found that youth who report attractions to, or relationships with, persons of the same sex were more than twice as likely as their heterosexual counterparts to attempt suicide. See Stephen T. Russell & Kara Joyner, *Adolescent Sexual Orientation and Suicide Risk: Evidence From a National Study*, 91 *Am. J. Pub. Health* 1276, 1278 (2001).
- 134 According to a 2004 national poll commissioned by the Gay, Lesbian & Straight Education Network (GLSEN), approximately 5 percent of America’s high school students, or roughly three-quarters of a million students nationwide, identify as lesbian or gay. This percentage would translate to, on average, every classroom in America having at least one student who identifies as lesbian or gay. See <http://www.glsen.org/cgi-bin/iowa/all/news/record/1970.html> (last visited Aug. 17, 2007).
- 135 Addison Central School District (documents on file with NYCLU).
- 136 *Id.*
- 137 Caribbean Women’s Health Association (documents on file with NYCLU).
- 138 Chemung County YMCA (documents on file with NYCLU).
- 139 Jewish Child Care Association (documents on file with NYCLU).
- 140 Grantees that reported difficulty gaining entry to schools were: Archdiocese of New York; Program Reach; Catholic Charities of Buffalo/ProjectTruth; Catholic Charities of Western New York; Community of Maternity Services; and Builders for Youth and Family.
- 141 See U.S. Gov’t Accountability Office, *Abstinence Education: Efforts to Assess the Accuracy and Effectiveness of Federally Funded Programs* 5 (2006) [hereinafter *GAO Study*], available at <http://www.gao.gov/new.items/d0787.pdf>.
- 142 See *id.* at 15; see also e-mail correspondence from Marcia Crosse, Director, Health Care Issues, U.S. Gov’t Accountability Office, to Loren Siegel, NYCLU (April 13, 2007) (on file with NYCLU).
- 143 CDC, *Framework for Program Evaluation in Public Health*, 48(RR11) *Morbidity & Morality Weekly Rep.: Recommendations and Reports* 1 (1999), available at <http://www.cdc.gov/mmwr/pdf/rr/rr4811.pdf>.
- 144 Hudson City School District (documents on file with NYCLU).
- 145 Builders for the Family Diocese of Brooklyn (documents on file with NYCLU).
- 146 Chemung County YMCA (documents on file with NYCLU).
- 147 Church Avenue Merchant’s Block Association (documents on file with NYCLU).
- 148 Addison Central School District (documents on file with NYCLU).
- 149 Chautauqua County Youth Bureau (documents on file with NYCLU).
- 150 See Evonne M. Hedgepeth & Joan Helmich, *Teaching About Sexuality and HIV: Principles and Methods for Effective Education* 36 (1996); see also Am. Ass’n of Sex Educators, Counselors, & Therapists, *AASECT Requirements for Sexuality Educator Certification*, <http://www.aasect.org/req.asp> (last visited Aug. 29, 2007).
- 151 Hedgepeth & Helmich, *supra* note 150, at 37.
- 152 Grant applicants were required to list educational and professional experience of professional personnel, but there is no evidence that this information had any impact on whether or not a grant was awarded. See, e.g., Family and Youth Services Bureau, Administration on Children, Youth and Families, U.S. Dep’t of Health and Human Servs., *FY 2006 Program Announcement: Section 510 Abstinence Education Program* [hereinafter *2006 Title V Program Announcement*], available at <http://www.acf.hhs.gov/grants/pdf/abs510-2005.pdf>.
- 153 This principle arises from the First Amendment of the United States Constitution, which prohibits the government from making laws regarding “establishment of religion.” U.S. Const. amend. I.
- 154 See *ACLU of Mass. v. Leavitt*, Civ. A No. 05-11000 (D. Mass, Feb. 21, 2005) (settlement agreement), available at <http://www.aclu.org/pdfs/srtsettlementagreement.pdf>; *ACLU of Louisiana v. Foster*, No. 02-1440, 2002 WL 1733651 (E.D. La. July 24, 2002) (issuing preliminary injunction), available at <http://www.aclu.org/FilesPDFs/ACF915.pdf>. In 1983,

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the American Civil Liberties Union (ACLU) challenged the religious bias in AFLA, and in 1985 a U.S. district judge found it unconstitutional, though this decision was reversed on appeal. *Bowen v. Kendrick*, 487 U.S. 589 (1988). A five-year settlement agreement was later reached requiring AFLA grantees to submit curricula to the Department of Health and Human Services for monitoring for religious messages or medical inaccuracies.

- 155 Religiously-affiliated grantees were: Archdiocese of New York; Be'er Hagolah Institutes; Builders for the Family and Youth of the Diocese of Brooklyn; Catholic Charities of Buffalo/ProjectTruth; Catholic Charities of Chemung and Schuylers; Catholic Charities of the Fingerlakes; Catholic Charities of Ogdensburg; Catholic Charities of Oswego; Catholic Charities of Rockville; Catholic Charities of the Southern Tier; Catholic Charities of Syracuse; Catholic Charities of Western New York; Catholic Family Center; Community of Maternity Services; H.O.P.E. Initiatives CDC, Inc; Our Lady of Lourdes Memorial Hospital; and Project Reach.
- 156 See, e.g., *2006 Title V Program Announcement*, *supra* note 152 (“Neither the grantee nor any of its contractors or subgrantees may use Federal or matching funds under this award to support religious instruction, worship, prayer, or proselytizing.”); Family and Youth Services Bureau, Administration on Children, Youth and Families, U.S. Dep’t of Health and Human Servs., 70 Fed Reg. 29318-02 (May 20, 2005) (“Direct Federal grants, sub-award funds, or contracts under this Community-Based Abstinence Education Program shall not be used to support inherently religious activities such as religious instruction, worship, or proselytization. Therefore, organizations must take steps to separate, in time or location, their inherently religious activities from the services funded under this Program.”).
- 157 Project Reach, <http://www.projectreach.org/partnersforacommongood.shtml> (last visited Aug. 29, 2007).
- 158 H.O.P.E. Initiatives CDC; see also *supra* note 66 (noting that documents produced for this program were incomplete).
- 159 Lisa Wangsness, *Patrick Seeks to Forgo Grant, End Classes on Sex Abstinence*, Boston Globe, Apr. 24, 2007.
- 160 Jon Craig, *Gov. to End Abstinence Program*, The Cincinnati Enquirer, Mar. 23, 2007.
- 161 Rachel La Corte, *Legislature OKs Accurate Sex Ed Bill*, The Olympian, Apr. 12, 2007.
- 162 Guttmacher Inst., *State Policies In Brief: Sex and STI/HIV Education* (2007), http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf.
- 163 See Me. Rev. Stat. Ann. Tit. 22, §§ 1902, 1910 (2004); Md. Code Regs. 13A.04.18.02(f), (G), 18.03(3)(c), 18.04 (2007); Minn. Stat. §§ 145.9255, 121A.23 (2007); Vt. Stat. Ann. tit. 16, §§ 906, 131(1), (4) (2007); 22-000-003 Vt. Code R. §§ 2120.8.9(a)(5), 2120.8.10 (2007); W. Va. Code § 18-2-9(b); W. Va. Admin. Code R. §§ 126-44E-4 (H.E. 7.3.2), 126-51-5 (5.3) (2007).
- 164 Healthy Youth Act, 2007 Wash. Sess. Laws Ch. 265, 60th Leg. (to be codified as Wash Rev. Code § 28A.300 (2007)).
- 165 *Id.*
- 166 *Id.*
- 167 Or. Rev. Stat. § 336.455 (2005); Or. Admin. R. 581-022-1440 (2005).
- 168 Or. Rev. Stat. § 336.455(1)(c) (2005).
- 169 A. 2856/S. 1342, 2007 Leg., 230th Sess. (N.Y.).
- 170 Santelli et al., *supra* note 26, at 79. The authors of this article are affiliated with the following medical institutions: The Mailman School of Public Health, Columbia University; Department of Pediatrics, Indiana University School of Medicine; Children’s National Medical Center, George Washington University Medical Center; American College of Preventive Medicine; Mt. Sinai Adolescent Health Center, Mount Sinai School of Medicine.



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