

# **Sexual Risk Avoidance (SRA) Education:**

Considerations for Protecting Teen Health

## **Part 1: Challenging the Content, Research, and Funding of Comprehensive Sex Education's Risk Reduction Approach**

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## Sexual Risk Avoidance (SRA) Education: Considerations for Protecting Teen Health

### *Part 1: Challenging the Content, Research, and Funding of Comprehensive Sex Education's Risk Reduction Approach*

Today, American teens encounter unprecedented pressures from all sides to engage in sexual activity. Media, the culture in general, and even sex education classes too often communicate a message that encourages sexual experimentation<sup>i</sup> and downplays the risks associated with that behavior.

Parents and taxpayers are told that so-called "Comprehensive" Sex Education (CSE) programs offer the best approach to address this problem. In reality, these programs often add to the problem by promoting curricula that normalize teen sex and encourage youth to discover "outercourse" alternatives to intercourse – and they mistakenly refer to such risky behaviors as "abstinence."<sup>ii</sup> The CSE approach too ignores a needed priority on risk avoidance and, instead, primarily focuses on merely reducing the physical risks of teen sex, without prominently addressing the many other possible consequences of that activity.

The CSE approach has been the mainstay of sex education for decades, receiving the lion's share of all funding even though research results for this approach are dismal,<sup>iii</sup> particularly in the school setting. During this same time, STD rates have skyrocketed<sup>iv</sup> while condom use has increased.<sup>v</sup> Emotional consequences of teen sex also persist, yet the message remains primarily focused simply on increasing condom use, rather than decreasing sexual activity. Today, a mistaken view argues that merely adding more funding to this failed approach will yield better results.

Part I of the definitive report, Sexual Risk Avoidance Education: Considerations for Protecting Teen Health, provides an authentic look at so-called "comprehensive" sex education. It explores the curricula currently being implemented with taxpayer dollars in schools across the nation. It discusses the debatable research metrics that are being used by the current Administration to elevate CSE education to national model status and it unveils the unprecedented anti-abstinence bias of the Obama Administration.

This report calls for a fresh look at the sex education battle – one that focuses the lens on optimal health for youth, rather than political scoreboards; one that requires an honest look at the content, the context, and the desired outcomes for America's teens, in tandem with the research; and one that refuses to use objective-sounding terminology as a cover for dubious agendas. A productive conversation must begin with common access to the facts, rather than to the sound-bytes. It begins now.

## **Problem:** The growing risks to teen health in a sexualized culture.

The topic of sex education has long been the source of significant national discussion and the debate regularly becomes a part of policy-making deliberations. Decision makers frequently find it challenging to adequately understand the issue because the subject is too-often reduced to an exchange of clichéd sound-bytes that can belie the best health interests of youth. This report is important for policy makers so that they can craft sound sex education policy, based on reliable information, rather than politically charged rhetoric. Only then, can policy effectively respond to the pressing health needs of America's students.

Youth are at risk on many fronts, but several harmful and pervasive influences make them exceptionally vulnerable to serious sexual health threats.

### The Reality: A Sex Saturated Media Culture

Youth are growing up in a sex-saturated culture where sexual themes and explicit images are accessible in unprecedented ways through a ubiquitous social media environment. In fact, images, conversations, and symbols that were once considered unacceptably graphic are now a growing part of conventional media and popular culture; creating what academic researcher Brian McNair coined the "pornographication of the mainstream."<sup>vi</sup>

Within this disintegration of cultural sexual boundaries, teen sexual experimentation has become an expected norm that is often glamorized as without negative consequences. This permissive attitude toward sex is linked to a "shift from a relational to a recreational model of sexual behavior," thus promoting a dangerous normalization of teen sex.<sup>vii</sup> Each day, the average U.S. adolescent is bombarded with almost 40 sexual messages.<sup>viii</sup> Teens are especially vulnerable because they are not only highly impressionable but they are also the most 'media connected' generation.

They watch almost twice as many videos on their mobile devices as the general population, with music videos being the most popular selection.<sup>ix</sup> Music videos contain more sexual content per minute than any other media genre.<sup>x</sup> Almost 80% of teens also use social networks and advertising targeted to this age group is often sexual in nature.<sup>xii</sup> Teens regularly attend movies, daily watch more than three hours of TV and spend about one hour in 24 on their computer.<sup>xiii</sup>

Three quarters of teens say that movies and TV normalize sex for them and younger teens rank the media as their top source for sex education.<sup>xiv</sup> Continuous sexual messaging contains inherent risks, especially for younger teens. Research suggests this cultural sexualization may lead to a distorted view of healthy sexual behavior and younger youth, in particular, are at greater risk for internalizing and acting on age-inappropriate sexual information, resulting in a pattern of early, risky behavior, including early sexual initiation.<sup>xv</sup>

Research also shows that teen girls are at significant risk. The American Psychological Association (APA) conducted a study on the sexualization of girls and found that "sexualization has negative effects [on girls] in a variety of domains, including cognitive functioning, physical and mental health, sexuality and attitudes and beliefs," too often causing girls to suffer from self-image problems when they fail to live up to the external cultural measure for feminine perfection and sexiness.<sup>xvi</sup>

The sexualization of culture comes at a great cost socially, physically and emotionally. But the costs are also economically burdensome to society, since intervention strategies are always more costly than prevention. These costs will be discussed later in the report.

### Escalation of Single Parenting

The social science and economic benefits of discouraging sexual initiation and childbearing until it takes

child well being. But current Obama Administration policy ignores this preponderance of data.

It is not surprising that the sex-saturated culture does not exist in a vacuum. The shift from marital “relational” to non-marital “recreational” sex escalated with the ubiquitous availability of birth control and the liberalization of abortion laws in the 1960s and 1970s. These events greatly reduced the fear of an “unplanned” pregnancy and birth. While one would expect that greater access to contraception and abortion would reduce non-marital birth rates, the opposite has been true, a fact that demands thoughtful scrutiny as we attempt to develop public policies that are responsive in combatting the effects of a sexualized culture, especially on youth.

Births to unmarried mothers began to rise sharply in the 1970s and those percentages continue to escalate at an alarming rate. In 1960, 5.3% of births were outside of marriage, but by 2010, 41% of all births were to single parents.<sup>xvii</sup> Among teens, however, the percentage of non-marital births skyrocketed to 87.4%.<sup>xviii</sup>

The escalation in non-marital births is of grave concern to healthy family formation as well as to general societal health. Overwhelming social science research indicates that children fare better, on average, when they are born within a stable and supportive marriage relationship. Yet societal concern over single parenthood has greatly diminished, which further increases the risk to the vulnerable child.<sup>xix</sup>

A recent ChildTrends report on non-marital child-bearing<sup>xx</sup> provides a stark assessment of the disadvantages that are more likely to beset a child born outside of a stable biological-parent marriage:

Children born to unmarried mothers are more likely to grow up in a single-parent household, experience instability in living arrangements, live in poverty, and have socio-emotional problems.<sup>xxi</sup> As these children reach adolescence, they are more likely to have low educational attainment, engage in sex

at younger ages, and have a premarital birth.<sup>xxii</sup> As young adults, children born outside of marriage are more likely to be idle (neither in school nor employed), have lower occupational status and income, and have more troubled marriages and divorces than those born to married parents.<sup>xxiii</sup>

Also impacting the risk to child well-being is the striking correlation between fatherlessness and male incarceration. Youth who live in single mother households are three times more likely to face incarceration than those who live with their married parents.<sup>xxiv</sup>

Further, marriage is a highly protective factor that cannot be replaced by cohabitation. Although an increasing number of Americans live together prior to (or in place of) marriage,<sup>xxv</sup> the research is clear that the same benefits are not afforded children born in this less committed arrangement. The ChildTrends report also reviews this data on cohabitation:

An increasing proportion of unmarried births occur to cohabiting parents.<sup>xxvi</sup> Although children born to cohabiting parents are more likely to see their parents eventually marry than are those born to non-coresidential parents,<sup>xxvii</sup> nevertheless children born to cohabiting parents experience higher levels of socioeconomic disadvantage and fare worse across a range of behavioral and emotional outcomes than those born to married parents.<sup>xxviii</sup>

Recent research similarly finds that children experience better health outcomes when their parents are married rather than merely living together, even if they are a “stable” cohabitating couple.<sup>xxix</sup>

The ChildTrends report also summarizes research findings that non-marital birth additionally limits the economic and social prospects of single mothers:

Women who give birth outside of marriage tend to be more disadvantaged than their married counterparts, both before and after having a nonmarital birth. Unmarried mothers generally have lower incomes, lower education levels, and greater dependence on welfare assistance than do married mothers.<sup>xxx</sup> Women who have a nonmarital birth also tend to fare worse than single women; for example, they have reduced marriage prospects compared to single women without children.<sup>xxxi</sup>

In addition to the toll on children and their parents, however, the increase in single parenting also places a tremendous economic burden on society. Single parenthood is one of the most accurate predictors of poverty and dependence on government assistance. Census figures paint a stark contrast in the economic disparity between female-household families with no husband present and those of married couples. If mom and dad are married, only 5.5% live in poverty, but the percentage soars to 28.7% in female-headed households.<sup>xxxii</sup> This means that the child raised in a married home is about 23.2% less likely to live in poverty.

This disparity is even more disturbing when the generational effect is examined. Children born to teen mothers are three times more likely to become teen parents themselves,<sup>xxxiii</sup> thus beginning a cycle of poverty from generation to generation that is increasingly difficult to escape.<sup>xxxiv</sup> It is no surprise, therefore, that the first broadly implemented abstinence education program was a part of the Welfare Reform Act of 1996. Congress understood that decreasing the non-marital birthrates would reduce the economic entitlement burden on taxpayers and empower individuals previously caught in generational poverty to attain self-sufficiency. The nation's sex education policies directly impact these important social and economic concerns.

### Fallacy of “Comprehensive” Sex Education and Its Effect on Teen Life Outcomes

The teen pregnancy prevention program, commonly called the “comprehensive” sex education approach, is built on the premise that teens either cannot, or will not, abstain from sex; therefore they must learn to take “precautions” that will decrease their risk of becoming pregnant.<sup>xxxv</sup> The current emphasis on “teen pregnancy prevention” is actually a relic from the 1970s when President Nixon and Congress authorized the Title X (ten) family planning program.

This program became the first (and only) federal program solely devoted to pregnancy prevention through easy availability to contraceptive education and services.<sup>xxxvi</sup> As a result of this funding, the number of teens who received contraceptive education and services jumped 600% between 1969 and 1976.<sup>xxxvii</sup> In 1978, President Carter amended Title X to mandate that a portion of the education and services target single teens, thereby beginning an express funding stream for community-based educational pregnancy prevention programs for teens.<sup>xxxviii</sup> During this same time, school-based clinics (SBC) also began springing up to provide students easy access to birth control and pregnancy testing as an in-school companion to their sex education instruction.<sup>xxxix</sup> As a result of this policy, minimizing the physical consequences of sex has become the overwhelming priority in most sex education classrooms today. Therefore, CSE programs primarily focus on contraception and condom negotiation as key skills needed for “responsible” behavior. The Patient Protection and Affordable Care Act (PPACA) included additional, new funding for SBCs and new adolescent sex education funding for preventing pregnancy,<sup>xl</sup> further enabling this sex education strategy to be implemented throughout the country.

But while the approach is called “comprehensive,” closer examination will reveal that, in actuality, it is a narrow, inadequate response to the problem of non-marital teen sex. Major weaknesses in the

- **Narrow Focus:** CSE is almost solely focused on reducing the physical consequences of sex, while ignoring its holistic nature. The goal is to help teens minimize their risk of becoming pregnant, and to a lesser degree, of acquiring an STD. Therefore, great emphasis is placed on condom negotiation skills and contraceptive use.<sup>xli</sup> Such an approach, however, grossly oversimplifies the impact that sexual activity has on a teen. Simply put, when a teen has sex, the decision affects more than the sexual organs but the CSE strategy ignores this fact by minimizing the broader implications of this behavior.

Research suggests that teens, and especially girls, who add sex to their relationships are likely to experience negative consequences that exceed the typical worries of pregnancy and STDs. A sizeable number experience emotional fallout, including “feeling used” or “feeling bad about themselves.” One study found that 58% of those who had sex reported at least one negative effect, but

“girls were more than twice as likely as boys to say they felt bad about themselves. Girls were also more than three times as likely to say they felt used as a result of having sex.”<sup>xi</sup>

Young teens are especially vulnerable to mental health problems when sex is added to casual dating relationships.<sup>xiii</sup> More than two-thirds of sexually experienced teens express regrets about having sex so soon. Broken down by gender, 60% of boys expressed regret and 77% of girls wish they had waited.<sup>xiv</sup> While sex is often perceived as being commitment-and consequence-free, it is not inconsequential for the individuals involved.<sup>xv</sup>

Teens who engage in casual sex “are at greater risk for lower grades and problems in school, and are more likely to be expelled or suspended, less likely to be attached to school, and less likely to go to college.”<sup>xvi</sup> And the negative consequences persist even into adulthood. A recent study found a causal relationship between teen sex and more than twice the risk of divorce later in life.<sup>xvii</sup>

A teen may not become pregnant and may even escape contracting an STD, but still experience difficult consequences to sexual activity. These consequences are not diminished by consistent or correct condom use; they are not eliminated by the use of any form of contraception. Only by avoiding sexual activity are consequences eliminated.

- **Ignores any Meaningful Priority on Risk Avoidance**

The CSE approach assumes that teen sexual is a natural and normal part of adolescent development<sup>xlviii</sup> as contrasted with natural sexual curiosity at this developmental stage. The primary concern of the CSE approach is not so much in delaying sexual initiation, as it is in ensuring that sex is consensual and that contraception is used.<sup>xlix</sup> According to this approach, sex education policy must primarily focus on risk reduction (risk being limited to pregnancy and STDs), rather than risk avoidance (risk being applied to include all the potential risks of sex) that is the core focus of abstinence education.

Despite the fact that CSE proponents insist that the approach places significant emphasis on abstinence, even sometimes referring to these programs as “abstinence –plus,” a 2007 U.S. Department of Health and Human Services (HHS) Report, entitled, Review of Comprehensive Sex Education Curricula, examined the most popular CSE texts and found very little abstinence within the pages.<sup>l</sup> A CSE curriculum might contain an obligatory statement such as “abstinence is the only way to assure 100% protection from pregnancy and STDs” but few, if any abstinence skill-building exercises are included, leaving teens without any meaningful help in maintaining or regaining a behavioral choice of abstinence. Rather, the skill-building activities usually center on condom-skills, such

The ideal way to demonstrate the proper way to use a condom is to use a plastic or ceramic model of a penis... Give each participant a condom and lubricant. Each participant should practice putting condoms on their fingers. Then let them give you a demonstration<sup>li</sup>

[Student Activity]: “Researching Methods of Protection... Name of store... location... Describe where the protective products (e.g. condoms, foam) are located in the store... What protective products are sold here ? (List up to 3 brands of condoms and up to 2 types of spermicides): Product... brand name,... price,... lubricated?... reservoir or plain?<sup>lii</sup>

The few CSE texts that do discuss abstinence do so using ambiguous and inaccurate definitions. For example, one 2010 HHS-approved curriculum describes abstinence this way: “You can express yourself sexually with a wide range of behaviors.”<sup>lviii</sup> Another popular curriculum published by Planned Parenthood, entitled *Making Sense of Abstinence*, says this about abstinence:

“Participants will define sexual abstinence for themselves... Ask participants what sexual behaviors a person could engage in and still be abstinent... Imagine someone has decided to be ABSTINENT. According to your own definition of abstinence, circle the following sexual behaviors you believe a person can engage in and still be ABSTINENT.”<sup>lv</sup>

Among the choices for students to select: “reading erotic literature,” “cuddling naked,” “mutual masturbation,” “showering together,” and “watching porn.”<sup>lv</sup> These confusing and individual definitions for abstinence cannot be termed risk avoidance. Some of the activities that are tacitly or explicitly condoned under the above “abstinent” definition introduce teens to STD risk because science shows the most infectious STD viruses can be transmitted without intercourse as long as there is skin-to-skin contact, such as Herpes and Human Papillomavirus (HPV).<sup>lvi</sup>

Additionally, many of the activities described above are a prelude to subsequent sexual intercourse. Suggesting that sexual gateway activities are appropriate and without risk displays not only a startling disregard of how STDs can be transmitted but ignorance of the natural progression that leads to sexual intercourse. Engaging in these supposed “abstinent activities” assumes that teens can volitionally abort a progression that most adults would find difficult to accomplish.

- **Medically Inaccurate**

CSE curricula often give teens a false sense of security by inaccurately placing abstinence and condom use on equivalent planes.

Numerous texts exaggerate the effectiveness of condoms in preventing pregnancy and STDs. These overstatements deliver the message that teen sex is safe and without consequences as long as a condom is used. For example, *Reducing the Risk*, one of the most widely used, federally funded and HHS-approved CSE texts makes this medically inaccurate statement:

“Recognize that abstaining from sexual activity or using contraception are the only ways to avoid pregnancy, HIV and other STDs.”<sup>lvii</sup>

This statement suggests that contraceptive use and abstinence are both equally protective, but this is not true. Only abstinence provides complete protection against pregnancy and the transmission of STDs, including Human Immunodeficiency Virus (HIV).

Another curriculum approved for use and cited as “effective” by HHS, *Be Proud! Be Responsible!* (2006 edition), contains similarly inaccurate statements:

“Safer sex will prevent HIV infection. If HIV infection can indeed be prevented, then there is nothing to fear.”<sup>lviii</sup>

When [condoms] are used in conjunction with a spermicide such as nonoxynol-9, condoms become even more effective in preventing disease transmission.”<sup>lix</sup>

Both statements are inaccurate. In the first quote, the term “safer sex” refers to the use of a condom, but condom use, alone, does not prevent the transmission of HIV, although condoms do reduce the risk. Only abstinence completely protects against the sexual transmission of HIV. The second statement is false because research findings indicate that Nonoxynol-9 is no more protective against HIV and other STDs than other lubricated condoms and some studies suggest that its usage can actually increase the transmission rates of some STDs, including HIV.<sup>lix</sup>

*Making a Difference*, another CSE curriculum that is considered “effective” by HHS, urges teachers to withhold details on the limited effectiveness of condoms: “Don’t bash condoms or provide information on failure rates.”<sup>lxi</sup> When teens only receive incomplete information on condom effectiveness, they are censored from receiving the facts they need to make knowledgeable and healthy decisions.

The same text places students at additional risk when it fails to inform them that skin-to-skin contact can also transmit some highly contagious STDs, such as HPV and Herpes Simplex Virus (HSV). It omits this vital information when it inaccurately states “any behavior that involves exposure to blood, semen, or vaginal secretions can transmit STDs, including HIV.”<sup>lxii</sup>

These three CSE curricula are not unique in their overstated and misleading information. Indeed, they are included in this report as examples of the consistent exaggerations and distortions regularly found in CSE texts. The medically inaccurate statements provide a false sense of security to teens, and by withholding vital information, they are denied access to the information that will help them make optimal and sexually healthy decisions.

- **Normalizes Teen Sex**

Because the CSE approach presupposes that teens will not or cannot refrain from sexual initiation, it presses the boundaries for content that could be reasonably inserted under a “pregnancy prevention” approach. It takes the fatalistic theory of “learned helplessness,” which, when applied to teens, assumes inevitable sexual behavior and dismisses the view that youth are capable of sexual self-regulation.<sup>lxiii</sup> Popular CSE curricula encourage sex play as a part of their instruction. A few examples from three programs termed as “effective” models for replication by HHS in 2010 illustrates how this normalization of sexual experimentation is used within a pregnancy prevention discussion:

*“Touching and stroking can lead to orgasms for both males and females. It is a safe way to avoid pregnancy and STD.”<sup>lxiv</sup>*

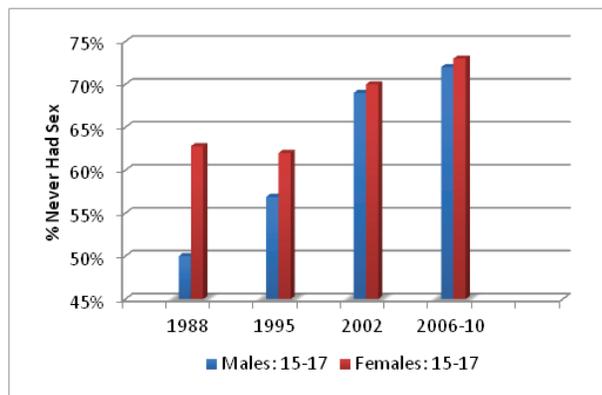
*“Activity: How to make condoms fun and pleasurable. Examples: eroticize condom use with partner, store condoms under a mattress, use condoms as a method of foreplay; think up a sexual fantasy using condoms; hide them on your body and ask your partner to find it; wrap them as a present and give them to your partner before a romantic dinner; have fun putting them on your partner; pretend you are different people or in different situations.”<sup>lxv</sup>*

*[Before presenting a detailed tutorial on sexual manipulation and response, the instructor is encouraged to say:] “If you aren’t sexually active now, one day you probably will be. I believe this information about sexual response is important for you to learn. It might make you feel a little uncomfortable at first as I go through it, but let’s all learn together and have fun.”<sup>lxvi</sup>*

*“Remind students that knowing where to go, and how to get there and whom to talk to about protection is an important aspect of responsible sexual behavior.”  
“There are other pleasurable sexual behaviors people can engage in besides sexual intercourse.”<sup>lxvii</sup>*

Encouraging sexual experimentation puts young people at risk for STDs and sexual initiation, but it also fails to reinforce the healthy behaviors among a growing number of teens that have never had sex. Recent data, released by the National Center for Health Statistics, reveals that 72% of boys and 73% of girls between the ages of 15 and 17 have never had sexual intercourse.<sup>lxix</sup> Teens between the ages of 15 and 17 are the most frequently-targeted age group to receive sex education, so the data punctuates the fact that abstinence resonates with teens and that it is indeed a realistic approach. Further, recent data released by the National Center for Health Statistics reveals that 52.4 % of boys and 60.3% of girls between the ages of 15 and 17 have never had sexual contact with the opposite sex.<sup>lxx</sup> Sexual contact refers to all types of sexual activity in this study, including, but not limited to sexual intercourse. In 2002, the CDC reported that only 46% of boys and 49% of girls indicated no sexual contact, demonstrating that the “sexual delay” trend is moving in the right direction.<sup>lxxi</sup>

*Abstinent Behavior Increases Among Teens Aged 15-17* <sup>lxxii</sup>



The normalization and encouragement of teen sexual activity obstructs further improvement in sexual delay among America’s youth and may harm the sexual health of currently abstinent youth by stimulating their transition toward sexual activity.

The age of sexual initiation is another concern in the normalization of teen sex because it is strongly correlated to the total number of lifetime partners. The more sexual partners a person has during his or her lifetime, the greater the risk for acquiring STDs and HIV. <sup>lxxiii</sup>

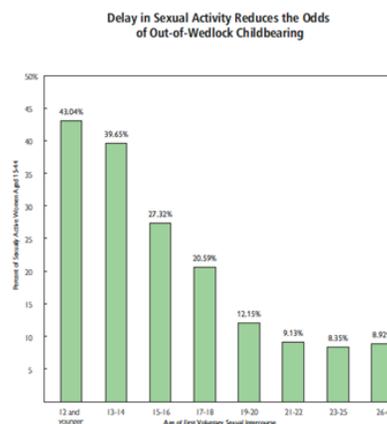
If a male teen initiates sex by 14, he has almost a 75% likelihood of having 6 or more partners by the time he reaches 20 years of age. A teen girl has 58% likelihood of 6 or more sexual partners by age 20 if she initiates sex by age 14. That risk drops to 10% respectively if the teen waits until he or she is at least 17 years of age. <sup>lxxiv</sup> Sexual delay until marriage provides the optimal health outcomes, but even a shorter postponement greatly reduces the STD risk.

Sexually transmitted disease and infection is of great concern, particularly among adolescents.

Young adults, aged 15-24 comprise only 25% of the sexually active population, but it is estimated that they acquire almost half of all new STDs. <sup>lxxv</sup> Teen girls are especially vulnerable because of their developing, but still immature reproductive system that makes them more susceptible to sexually transmitted diseases. <sup>lxxvi</sup> Girls, aged 15-19 years old have the highest rates of gonorrhea as compared to every other group. <sup>lxxvii</sup> In addition, the CDC estimates that one in four teen girls has at least one STD from the list of the most common viral or bacterial STDs (HPV, HSV, Chlamydia, and trichomoniasis). <sup>lxxviii</sup> Delaying sexual initiation has enormous health benefits, but normalizing teen sexual experimentation does little to encourage this healthy behavior.

The age of sexual initiation also directly impacts the likelihood of becoming a single mother. If a teen girl becomes sexually active at 13 or 14, she has almost a 40% chance of childbearing as a single woman. If she waits until she is 21 or 22, her chances drop to about 9%. <sup>lxxix</sup> So, programs that are genuinely designed to reduce teen pregnancy rates should place an emphasis on the benefits of delaying sexual onset, rather than normalizing teen sex and merely commending their “proud choice” of having sex with a condom, as does one of the HHS “proven effective” curricula. <sup>lxxx</sup>

*Delay in Sexual Activity Table* <sup>lxxx</sup>



- **Undermines the Role of Parents**

When surveyed, teens say that the people they most want to talk to about dating, sex and related topics are their parents.<sup>lxxxii</sup> Not their peers - mom and dad. Yet, many CSE curricula often remind students that their sexual health decisions can be without parental oversight and that they can receive “reproductive health services” *without* parental notification. These same curricula encourage students to find out the “confidentiality policies” of a clinic before they visit. One of the most widely used CSE curricula, and designated by HHS as an “effective” program recommended for replication, *Reducing the Risk*, directs the teacher to have students...

“Ask about confidentiality policies at the clinics and the importance of these policies. Why are these important? Pull for the idea that sex and sexuality are private and that people should and do have control over their choices to use birth control from clinics or drugstores.”<sup>lxxxiii</sup>

Rather than encouraging teens to involve their parents in very serious decisions related to their sexual health, the CSE approach too-often undermines their input, leaving youth at the disposal of advocates who may not have their best health interest at the forefront.

A report released by the US Department of HHS on August 23, 2010 found that approximately 70% of parents opposed pre-marital sex in general and for their own children. Most parents favored the delivery of abstinence messages within their children’s sex education classes. Teens registered similar views.<sup>lxxxiv</sup> A 2007 survey of American parents found that they want their children to understand that condoms do not make sex safe and they do not support condom demonstration exercises in the classroom.<sup>lxxxv</sup> Most parents favor a risk avoidance abstinence message over a CSE approach by a margin of 2:1.<sup>lxxxvi</sup> In other words, parents think sex education should be more than just a discussion about preventing pregnancy.

Parents believe sex education should be a holistic dialogue that assists their teens in making decisions that will be of life-long benefit. The CSE approach fails the “parent approved” test.

- **Lacks Proven Effectiveness in the Classroom**

CSE programs have been federally funded since the 1970s - much longer than sexual risk avoidance programs and at a much higher funding level - so one would expect many rigorous and replicated studies of individual curricular programs. If CSE programs were effective, one could also expect to see changes on the cultural level related to typical risk reduction indicators. Indeed, teen condom use has risen significantly since the CDC began tracking it in 1991,<sup>lxxxvii lxxxviii</sup> yet young people currently have four times the reported chlamydia and gonorrhea rates of the total population,<sup>lxxxix</sup> which calls into question the effectiveness of the risk reduction approach. The premise of the approach, simply put, claims that sex with a condom is “responsible” and “protective.” That same premise ignores the fact that certain STDs are easily transmissible even with the use of a condom<sup>xc</sup> thus questioning the basic theoretical framework for risk reduction and adding to the explanation of why STD rates increase even as condom rates increase.

The same is true with CSE empirical research, for although the claim and resulting perception is that these programs are “effective” in the classroom, the evidence does not support this assertion. Rigorous research must follow generally accepted protocols and avoid serious pitfalls that can compromise the results.<sup>xcj</sup> Unfortunately, research commonly used to support the CSE approach regularly commits these research pitfalls:

- o **Inaccurately Generalized Results.** A primary flaw involves the fact that although sex education is most commonly implemented in a school-based setting, most CSE research takes place outside of the classroom, and often in a clinical-type setting.

Research practice cautions against generalizing results captured in one venue (for example, a clinic setting) to a much different venue (for example, a school setting). This practice is reckless because clients in a clinic are typically self-motivated participants who self-referred for services, making them much more driven to complete the treatment and make positive behavioral changes. However, in a school setting, students are required to attend as a part of their education and they may not be particularly motivated to participate in the process. For example, sex education is often inserted as one part of a required school health class. In the school setting, intervention and follow up are a much less precise science and attrition is always a very real concern. Research findings have also been used to generalize success found in narrow populations to the student population at large, another misuse of research.

**o Conflict of Interest.** Another flaw involves the absence of independent researchers to perform the evaluation study. Much of the research was led and published by researchers who were either employed by the curriculum publishing company and/or personally wrote the curriculum being studied, a clear conflict of interest that calls into question the validity and objectivity of the reported positive findings.

Until recently, several reports were used to bolster the inaccurate assertion that the CSE approach is effective and superior to the risk avoidance approach. The more widely referenced summaries included

- o *Emerging Answers*, a 2007 publication written by Douglas Kirby, director of research at ETR Associates, a publisher and distributor of some of the most widely used and funded CSE curricula.<sup>xcii</sup>
- o *What Works 2008: Curriculum-based programs that prevent teen pregnancy*, a publication created by the National Campaign to Prevent Teen and Unplanned Pregnancy.<sup>xciii</sup>

The findings in these reports were analyzed

during a 2008 hearing of the House Oversight and Government Reform Committee. The analysis, provided a significant examination of previously published CSE research and found that the evidence is very thin.<sup>xciv</sup> The literature review analyzed 115 different studies contained in the two commonly-cited reports and concluded that:

“there were no school- or community-based comprehensive condom-based sex education programs with evidence of having reduced STDs...

This clear lack of evidence for STD reduction is coupled with another under reported failure. The primary strategy of providing condom education to adolescents depends upon consistent and correct use according to the federal Centers for Disease Control. However, this important outcome was either not measured or did not increase... This lack of evidence for the central strategy of condom use by sexually active adolescents flies in the face of the common perception that there is scientific support for comprehensive or condom-centered sex education... If scientific evidence for success is so crucial for the continuation of abstinence education, should it not also be applied to the comprehensive, condom centered programs that receive considerably more funding?”<sup>xcv</sup>

The *Emerging Answers* and *What Works* reports were among those used for foundational research in the development of a national sex education literature review, but were soon set aside upon the release of a new HHS report in 2010.

The current Administration made a major shift toward embedding CSE into the core fabric of sex education policy. Therefore, they called for the most rigorous literature review of all CSE programs. It is contained in a new compendium produced by the US DHHS, entitled, *Programs for Replication – Intervention Implementation Reports*.<sup>xcvi</sup> The report was created in order to identify “evidence-based programs qualifying for replication under the new community Teen Pregnancy Prevention Initiative”.<sup>xcvii</sup> Seventy-five million dollars in TPP funding was distributed for replication of any of the initial 28 programs included in the “evidence-based” list,

essentially making the named programs federally mandated models for sex education. Although the metrics for the HHS report appear rigorous and objective at first blush, the 28 programs that initially qualified for replication had the same weaknesses in basic research protocols that were identified in earlier reports, as well as the several common and disturbing weaknesses that were discussed during the 2008 House Oversight and Government Reform Committee hearing, also noted above.

The Institute for Research and Evaluation (IRE), a research organization with 20 years of experience, has conducted independent program evaluations in 30 states and three foreign countries. They reviewed the 28 programs in the HHS report that were cited as “evidence-based” models for replication with federal TPP funds. *Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be*<sup>xcviii</sup> questions the validity of the statement by HHS that these programs have been “proven to be effective through rigorous evaluation.”<sup>xcix</sup> The findings contained in the IRE report are important and greatly inform the analysis in this section. The common problems found with CSE research in general is also true of the 28 programs cited by HHS as “proven effective.” The IRE report names these weaknesses:

#### o Lacks evidence of rigor

- “For most of the TPP programs, there is inadequate evidence of program effectiveness.”<sup>c</sup>
- “For two-thirds of the 28 TPP programs the ‘rigorous proof’ of program effectiveness consists of the evidence from only one study conducted by the program’s author.”<sup>ci</sup>

#### o No long-term effects

- “More than one-third of the TPP programs (9/28) did not demonstrate any long-term effects (lasting at least one year after the end of the program).”

- “Only 9 (36%) of the 25 ‘comprehensive’ TPP programs produced a long-term increase in teen condom use.”<sup>cii</sup>
- “Only one of the 28 TPP programs demonstrated a reduction in teen pregnancy one year after the program.”<sup>ciii</sup>
- “Only 3 of the 28 programs demonstrated any long-term positive impact on the teen population in a school classroom setting (which is likely the most cost-effective way to reach the largest number of youth).”<sup>civ</sup>

#### o Weak protective or short-term outcomes

- “This lack of demonstrated success was not reported in the TPP documentation. Instead, improvements on less protective or short-term outcomes were cited as ‘proof’ that these programs were effective.”<sup>cv</sup>
- “For example: The Safer Sex program was designed ‘to reduce the incidence of STDs and improve condom use among high-risk female adolescents.’ It failed to achieve either of these outcomes, but did reduce ‘number of partners’ (a less-protective outcome) 6 months after the program. However, this effect had disappeared 12 months after the program. Nonetheless, this lesser 6-month effect was cited as ‘proof’ of program effectiveness, despite the fact the program failed to improve the two more protective outcomes.”<sup>cvi cvii</sup>
- “...In sum, this lack of credible evidence of lasting effects on major protective outcomes constitutes a serious lack of evidence of effectiveness and contradicts the TPP claim that these programs have been ‘proven to be effective.’ Notwithstanding this lack of proof, these programs have been federally endorsed and recommended for federal funding and widespread distribution.”<sup>cviii</sup>

(Note: Recently, the HHS list was expanded to 31 programs, one being the only authentic SRA abstinence education program [*Heritage Keepers*], on the list. Initial review shows that the two additional CSE curricula contain the same flaws noted in the analysis of the 28 original studies.

The single, strong SRA program follows accepted research protocol, in contrast to most of the approved SRR programs. The Heritage Keepers program was implemented in a school-based setting; independent third-party scientists created the article and data analysis. The analyses were rigorous. Base line equivalence was established through propensity score methods, theoretical mediators were tested, proven with mediation analysis, and shown to be almost entirely responsible for the strong behavioral differences between program and non-program students. The behavioral results held up 12 months after program completion. After a year [12 months], students were 1/3 as likely to be sexually active as their peers and the results were significant across age, gender and race. The study is a replication of earlier research which showed that program students initiated sex at a rate 1/2 that of similar non-program students. Such replication is a standard requirement for “model” programs. This research methodology and program model offers important strategies for program development and evaluation.)

The following additional weaknesses are present in the HHS Programs for Replication – Intervention Implementation Reports:

- **Conflict of Interest.** Twenty-eight of the 31 programs were evaluated by the program developer or publisher, calling into serious question the reliability and objectivity of the findings. The most stunning example is that of one program developer team who wrote the curricula and also conducted their own research on 8 of the 31 programs included in the TPP list of programs for replication. <sup>cxix</sup>
- **Inaccurately Generalized Results.** Only 5 of the 31 programs showed impact within a school-based setting, the typical location for sex education. Yet all are explicitly or tacitly considered “evidence-based” for effective use in schools.

In addition, many studies only reported intervention effect on a small subgroup, rather than the entire group that received the intervention, a practice that is treated with extreme caution in serious research. <sup>cx</sup>

- **Measures for “Success” Offer Little Protection.** The measures for success for CSE programs often do not accurately gauge risk reduction, thereby calling into question their claims of protective “effect.” For example, behavioral impact results may show outcomes in “condom use at first intercourse” or “condom use at last intercourse” but these measures do not give any indication that the usage is either correct or consistent. The Centers for Disease Control and Prevention (CDC) describes the requirements for maximum protective effect, which would suggest that the measured “success” indicators for CSE programs may not be accurately termed “successful”: “Inconsistent [condom] use can lead to STD acquisition because transmission can occur with a single act of intercourse with an infected partner. Similarly, if condoms are not used correctly, the protective effect may be diminished even when they are used consistently.” <sup>cxii</sup> Some studies indicate that inconsistent condom usage may actually increase an individual’s risk of acquiring certain STDs. <sup>cxiii</sup> This phenomenon is likely due to a concept known as risk disinhibition in which people engage in higher risk behaviors because they believe they are “protected” by even inconsistent condom usage. <sup>cxiii</sup>
- **Lack of Effect on Optimal Protective Factors.** Only 12 of the 31 programs demonstrated positive behavioral impact for at least one year on abstinence, consistent condom usage, or STD or pregnancy rates, but only four sustained these results from a program implemented in a school setting. <sup>cxiv</sup>

- Fails Replication Requirement for “Model” Programs.** Since the 31 programs are regarded as national models by their inclusion in the HHS report, the standard applied to the programs is inadequate for such a designation. There is a growing consensus that minimum benchmarks are required before a program can be regarded as a “model” for broad dissemination. The Society for Prevention Research creates a blueprint for youth prevention programs,<sup>cxv</sup> which requires consistent replication of findings from at least two different studies. A similar requirement is found in the *Blueprints for Violence Prevention*<sup>cxvi</sup> and a U.S. Department of Education guide on *Identifying and Implementing Educational Practices Supported by Rigorous Evidence*.<sup>cxvii</sup> Most of the 31 Teen Pregnancy Prevention (TPP) “comprehensive” sex education programs only have a single positive published study. Some programs had other published research that showed either “no effect” or “negative effect” yet the strategies were still included as part of the 31 model programs. For example, The CAS Carrera program was replicated broadly in two other studies, but both showed an increase in teen pregnancy among program participants, yet the program is still considered a model worthy of replication by HHS.<sup>cxviii</sup> A guidebook prepared by the Coalition for Evidence-Based Policy argued that “strong” evidence of effectiveness requires at least two studies showing similar results because “a single finding of effectiveness can sometimes occur by chance alone” and “the results of a trial in any one site may be dependent on site-specific factors and thus may not be generalizable to other sites.” The FDA requires a new drug or medical device to show effectiveness in at least two different studies for the same reasons.<sup>cxix</sup>

The research evidence repeatedly used to support the CSE approach is flawed inconsistent with established research protocol, yet an

objective research review for CSE programs is not yet a meaningful part of policy formation. On the contrary, even though important metrics selected for determining “effective” CSE programs fall outside of accepted practices for objective research, 31 programs are currently being implemented across the nation as recognized “models” for sex education, but few follow accepted research protocols. (Note: The authentic abstinence curriculum on this list is described under the SRA portion of this report.)

### Current Policy Under the Obama Administration Adds to the Growing Risks to Teen Sexual Health

As indicated above, there has been a major policy shift in sex education under the Obama Administration, moving away from an environment that supported the SRA approach to one that almost exclusively focuses on CSE. Notwithstanding the fact that most teens and their parents overwhelmingly support an abstinence until marriage focus on sex education and in spite of CDC data confirming that [a] most teens are abstinent and [b] that the trend continues to move in the right direction, the current attitude by the Obama Administration and specific policies at the US Department of Health and Human Services (HHS) are decidedly anti-abstinence. In addition, the highly sexual messages that teens receive from the media are presently being reinforced and amplified by special interest groups whose members are now serving as trusted advisors to the current Administration. This hostile, anti-abstinence atmosphere has resulted in the following alarming regulatory policies, decisions, and statements:

- Obama’s consistent opposition to abstinence education.** As background, Candidate Obama stated that he would eliminate funding for abstinence education, if elected President.<sup>cxiii</sup>

**Details:** During the 2008 Presidential Campaign, Barack Obama was criticized for supporting a bill in the Illinois Legislature that would have implemented K-12 sex education in the state.<sup>cxxiv</sup>

Although the bill never passed, it provided insight on his views on sex education and his long history of support for so-called comprehensive sex education. His promise to eliminate abstinence education funding, if elected president is well documented.<sup>cxxv</sup>

- **Elimination of abstinence programs from federal funding.** After taking office, President Obama's first budget request (FY 2010) to Congress, called for the elimination of all funding for abstinence education.<sup>cxxvi</sup>

**Details:** At the President's request, Congress eliminated the Title XX Adolescent Family Life prevention grants, in existence since the 1980s and, cut short the Community Based Abstinence Education (CBAE) grants which were midstream in their service provision and midstream in their scientific research. At the same time, after being signed into law by President Bill Clinton and reauthorized by a bipartisan Congress, the Title V state block grant program for abstinence education was permitted to expire on June 30, 2009, per the President's request. This action broke with the historic precedent for bipartisan support for these SRA programs. Before the President's proposed cuts, there existed a 4:1 funding disparity between so-called comprehensive sex education (CSE) and Sexual Risk Avoidance abstinence education (SRA). His cuts gave 100% of all sex education funds to the CSE approach.<sup>cxxvii</sup>

- **Creates new funding for contraceptive-centered education.**<sup>cxxviii</sup> President Obama's FY 2010 budget not only called for removing abstinence programs, but also added even more money for contraceptive-centered programs with the inauguration of the

Teen Pregnancy Prevention (TPP) Program and the Personal Responsibility Education Program (PREP).

**Details:** In FY 2010, the Consolidated Appropriations Act created the new TPP Program, which provided \$75 million to Tier 1 initiatives that require replication of programs identified by HHS as "proven effective." An additional \$25 million was designated for Tier 2 "innovative" programs.<sup>cxxix</sup> Although the White House assured abstinence providers that they could be funded under the Tier 2 portion of TPP if they could offer evidence that their approach could work,<sup>cxxx</sup> only three programs and less than \$3 million of the funding went to SRA abstinence programs.<sup>cxxxi</sup> However, the majority of the funding was given to the contraceptive-centered approach.<sup>cxxxii</sup> Planned Parenthood affiliates alone were awarded nearly \$20 million of the \$100 million in order to provide pregnancy prevention education to students. The list of grantees and the focus of their educational services makes it obvious that TPP was intended to create even more funding for contraceptive-centered programs, putting SRA abstinence education programs at a further disadvantage.<sup>cxxxiii</sup>

In addition, the Patient Protection and Affordable Care Act (PPACA) created another, new funding stream for CSE, with the PREP program, a state block grant that is expressly focused on proving CSE throughout the 50 states.

- **Mandates explicit and age inappropriate sex education.** The TPP program mandates that \$75 million of the \$100 million in taxpayer-funded grants be used to replicate some of the most explicit published sex education curricula.<sup>cxxxiv</sup>  
**Details:** Tier 1 of the TPP program

requires grantees to replicate one of 31 curricula that HHS has identified as “proven effective”<sup>cxxxv</sup> An HHS report previously reviewed the content of some of the most widely used so-called comprehensive sex education curricula. Several of the curricula that were identified by HHS in 2007 as explicit and medically inaccurate or medically misleading<sup>cxxxvi</sup> are now on the list of 31 that must be replicated in communities across the United States. In a practical sense, this new TPP mandate elevates some of the most egregious curricula to “model”

**status.** (More information on some of these curricula is provided in the previous section of this report, *Fallacy of “Teen Pregnancy Prevention” and its effect on teen life outcomes*)

- **Uses taxpayer-funded website to ignore SRA skill building and advocate controversial sexual beliefs.** The HHS website, Quick Guide to Healthy Living, is designed to be a resource for parents and their children on a variety of topics, including sex. It ignores important guidance that could help parents direct their children to optimal sexual health choices. Instead, it spends significant time talking about a variety of controversial topics that suggest the promotion of a radical sexual agenda. Within the site, it links to other websites that give further information on the subject of sex. Objectionable
  - o It perpetuates the unsubstantiated beliefs, promoted by controversial researcher, Alfred Kinsey<sup>cxxxvii</sup> that infants are sexual from birth – somehow equating curiosity with nascent sexual interest.<sup>cxxxviii</sup>
  - o It suggests that by age 2 or 3 a child begins to develop gender identity: “a sense of being a male or female.” The site suggests that perhaps this identity is a “product of

a child’s environment” rather than, or in addition to being biologically determined.<sup>cxxxix</sup>

- o It advises parents only be concerned about their child’s masturbation “if a child seems preoccupied with it to the exclusion of other activities.”<sup>cxl</sup>
- o The site normalizes teen sex – both homosexual and heterosexual experimentation.<sup>cxli</sup>
- o The site is detailed and explicit on birth control measures and usage instructions.<sup>cxlii</sup> Its treatment of teen sexual activity under-emphasizes the many negative consequences to this risk behavior.<sup>cxliii</sup>
- o Its attention to SRA is profoundly under-emphasized. The site does contain a section on “virginity” in which it states that it is “okay” to wait for sex because “you are ultimately the person in charge of your own happiness and your own body,”<sup>clxiv</sup> but the section is non-directive and inadequately communicates the superior health benefits to SRA. The top site to which teens are sent for more information on “virginity,” is *Teenwire*, the Planned Parenthood site that encourages sex play for adolescents.<sup>clxv clxvi</sup>
- o Under an “abstinence” section, it spends a scant four paragraphs informing students on “how to do” abstinence – the closest thing to SRA skill-building on the entire site. For more information, on “abstinence” its top referral sends teens to *Teenwire*, the Planned Parenthood site that encourages sex play for adolescents.<sup>clxvii</sup> By contrast, the information on contraception is copious, it devotes an *entire* topical section to each one

of the following: “About birth control; birth control patch; birth control pill; birth control ring; birth control shot; cervical cap; condom; diaphragm, emergency contraception; IUD; implantable contraception, spermicide; talking to your partner about condoms, withdrawal.”<sup>clxviii</sup>

o It answers questions that teens might have about sex, including: “Will I bleed the first time I have sex?”

The only sexual behavioral advice to the young girl who asked the question is “Remember to always use a condom every time you have sex.”<sup>clxix</sup>

Another girl asks if she can get pregnant from oral sex. The response is that she cannot get pregnant but reminds her “whenever oral sex is being performed on a girl, a dental dam should be used.”<sup>cl</sup> These responses indicate a total disregard for any guidance that would encourage teens to avoid the risks associated with sex.

- **Disguises an ideological agenda as “evidence-based research.”** HHS created a list of 31 “proven effective” programs to be used as national models for sex education under the guise of “rigorous” research, but most curricula on the list ignored even the most basic research protocols for measuring true effectiveness in the process.

**Details:** Earlier in this report, the weak and inconsistent results for CSE research were explained in detail. Research protocols for identifying model programs were also discussed at length, so they will not be repeated here. In summary, objective scientific protocols would never identify most of the 31 programs as “proven effective” nor would they give them carte blanche entry into school and community venues across the nation.

The “proven effective” designation also ignores

the fact that even if a program could be so designated, one must ask if increased condom or contraceptive usage, as the primary indication of success, should deem a curriculum “proven” to achieve optimal health standards for teens. Thirty of the 31 curricula serve to further entrench an agenda into schools that compromises the health interests of the youth it targets.

(More information on the disingenuous nature of CSE research is provided in the previous section of this report, *Fallacy of “Teen Pregnancy Prevention” and its effect on teen life outcomes*)

- **Rejects most pre-marital abstinence curriculum as not “effective.”** HHS created a metric for identifying programs as “effective” that nearly ignores the positive behavioral impacts of abstinence education programs.<sup>cli</sup>

**Details:** The measures used by HHS to identify “effective” programs originated with a rigorous research requirement, but then compromised on many results, permitting rigorous design alone to trump optimal protective behavioral impacts in many cases.<sup>clii</sup> An objective review of the evidence for both CSE and SRA programs, particularly in the school setting, reveals more optimal health outcomes for the SRA programs. While SRA research is still accumulating and the rigor is gradually becoming further developed as it progresses, existing credible research was largely ignored in producing the list of 31 programs “proven effective.” The research is explained in detail in other parts of this report, so it is not repeated here.

(More information on the nature of TPP selection of the 31 programs is provided in the previous section of this report, *Fallacy of “Teen Pregnancy Prevention” and its effect on teen life outcomes*). Information on the effectiveness of SRA education is discussed in the next section of this report, *Effectiveness of the SRA approach*.

- **Redefines abstinence education funding.** Congress reauthorized the Title V Abstinence Education state block grant, despite President Obama’s opposition to their doing so. The reauthorization was signed into law on March 30, 2010. The Obama administration then wrote grant guidance that permitted the funds to be used for programs that include *no abstinence education whatsoever* and that blatantly ignore

the original congressional intent of the Title V program.<sup>cliii</sup>

**Details:** The specific purpose of the Title V Abstinence Education block grant is to “exclusively” focus on the SRA approach. Following the very specific A-H guidelines, states are instructed to use these funds to encourage students to refrain from sex until marriage.<sup>cliv</sup> HHS, however, changed the congressional intent of this SRA program, clearly having no legal authority to do so. HHS amended legislative intent within their Funding Announcement to the states as follows:

- o States can determine the “relative emphasis” to place on each of the A-H components. This permits states to solely focus on “self sufficiency” but not sexual risk avoidance- an exclusion that dilutes the holistic nature of SRA and one that makes it an effective educational strategy.<sup>clv</sup>
- o States may choose to use the funds for mentoring, counseling, or adult supervision activities to the exclusion of any SRA educational skill building whatsoever.<sup>clvi</sup> This is a clear departure from Congressional intent.<sup>clvii</sup>

- **Refusal to release pro-abstinence findings.** The Administration for Children and Families at HHS (HHS/ACF) initially refused to release a government-funded report, National Survey of Adolescents and their Parents: Attitudes and Opinions about Sex and Abstinence, which showed both parents and teens overwhelmingly support a risk avoidance abstinence-centered approach for sex education, a finding in direct opposition to the Obama policy on sex education.<sup>clviii</sup>

**Details:** In 2006, a public opinion survey examined the attitudes of parents and teens about abstinence and sex. The report was finalized in February 2009, but ACF “saw no reason ... to proactively disseminate the document.”<sup>clix</sup> Therefore, when a university professor from Colorado,

conducts research on youth issues, requested a copy of the findings in August 2010, her request was denied.<sup>clx</sup> A HHS/ACF internal email exchange noted that they did not want to release the positive findings of the report at the very time that they were deconstructing all vestiges of SRA abstinence education programs in the department: “(HHS) did not want to disseminate a study that would complicate messaging on any changes being made to previous iterations of the abstinence program.”<sup>clxi</sup> In other words, the results of the survey would “complicate” the administration’s talking points surrounding their recent sex education policy change. Abstinence programs were zeroed out in the President’s proposed 2010 budget and by Congress in their final appropriations bill. They were then replaced with programs containing a risk reduction message that put no emphasis on abstinence until marriage (a clearly supported message among both parents and teens in the survey) and actually placed almost no emphasis on teen abstinence for any length of time. Subsequently, and within only one week’s time, about 800 additional FOIA requests were submitted to HHS<sup>clxii</sup> which prompted the mainstream media to inquire about the cover-<sup>clxiii</sup> up, eventually making it politically damaging for them to continue to refuse release as noted by a ACF staffer: “Once the number of requests became too large to answer individually, ACYF (HHS Administration on Children, Youth and Families) immediately began working to make the study accessible online.”<sup>clxiv</sup>

- **Manipulates pro-abstinence report.** After receiving 800 Freedom of Information Act (FOIA) requests to release the National Survey of Adolescents and their Parents: Attitudes and Opinions about Sex and Abstinence report, HHS/ACF relented and posted the report, but not before involving the White House and rewriting the report to make the findings appear as bland as possible.

**Details:** Internal communications within HHS, obtained through a FOIA request submitted to acquire communications related to the refusal by HHS to release the *National Survey of Adolescents and their Parents: Attitudes and Opinions about Sex and Abstinence* report, make it clear that even though the sheer volume of FOIA requests necessitated release of the findings showing that both parents and teens strongly favor the abstinence until marriage message, they did not want to do so until they substantially changed the “limitations” section of the study. The “limitations” section is that portion of the study that informs the reader on limits to the interpretation of the findings. A Counselor to the Secretary for Human Services Policy at HHS noted: “I think the limitations need to be beefed up a bit,”<sup>clxv</sup> later assuring her colleagues that she “did a substantial expansion to what was there [in the limitations section].”<sup>clxvi</sup> In other words, HHS changed the original report to make the findings appear less significant than originally communicated. “Beefing up” the limitations section essentially tempered the overwhelming support of abstinence until marriage registered by both parent and teen respondents. The White House was informed of the changes, involved in the process, and registered no objections.<sup>clxvii clxviii</sup> In addition, HHS “cleaned up” their messaging as to the reason for their delayed release of the study. Although internal communications cited a deliberate decision to bury the report findings because they would “complicate” messaging for their current sex education policy,<sup>clxix</sup> the reasons they gave the general public and the media were much different. In its public response, HHS insisted that no cover-up was involved. Rather it was simply that the “recently confirmed Commissioner of the Administration on Children, Youth and Families (ACYF) had not yet had an opportunity to review it.”<sup>clxx</sup>

- Demands that risk avoidance texts must add contraceptive information but does not require contraceptive-centered texts to add risk avoidance skills.** HHS issued a Funding Announcement for a Patient Protection and Affordable Care Act (PPACA)-initiated program, the Personal Responsibility Education Program (PREP), in which they required grantees to amend abstinence curricula with amplified contraceptive information, but was silent in requiring any changes be made to contraceptive texts that lacked any abstinence skill-building exercises.

**Details:** The PREP program is a new CSE program authorized under PPACA in 2010. The funding announcement specifically singles out abstinence education, cautioning states to amend these programs with increased contraceptive information.<sup>clxxi</sup> However, while the congressional intent of PREP is to “emphasize abstinence and contraception for the prevention of pregnancy and sexually transmitted infections,” the funding announcement gives no similar requirement that any contraceptive-centered curricula must be adapted to include abstinence skills and information.<sup>clxxii</sup> In 2007, HHS conducted an earlier analysis of typical CSE curricula and found that they contained almost no abstinence education or SRA skills.<sup>clxxiii</sup> Therefore, although congressional language requires an equal emphasis on both contraception and the SRA message, the practical implementation of HHS policy for PREP disregards this mandate.
- Circumvents normal funding process for new contraceptive-focused sex education program.** For FY 2013, Secretary Kathleen Sebelius removed the Administration’s new Teen Pregnancy Prevention Program (TPP) from normal Appropriations/LHHS committee oversight, creating a safe haven for this controversial program and its generous funding stream.

**Details:** In FY 2010 - FY 2012, the TPP program received funding under normal congressional practices, but for FY 2013, the Secretary of HHS moved it outside of the authority and oversight of Congress by reassigning funding for TPP to a fund created in PPACA entitled the Prevention and Public Health Fund.<sup>cxxxiv</sup> This fund's usage is at the discretion of the Secretary and the action virtually guarantees that unless the fund is eliminated by an act of Congress, this new CSE funding stream will continue since the Prevention and Public Health Fund is authorized in perpetuity within PPACA.<sup>cxxxv</sup>

taxpayer funds. Youth must receive the skills and reinforcement to continue their present trend away from early sexual initiation. It is essential that federal policy be corrected to reflect a genuine emphasis on the sexual risk avoidance model.

Each of these decisions works to create a supportive climate for programs that normalize teen sex, putting America's youth at greater health risk. Unfortunately, the recent policy shift also reveals an agenda that is at least as much about abolishing the abstinence education approach as it is about supporting the CSE approach. These efforts to abolish risk avoidance in favor of a message that only concentrates on reducing the risk of unhealthy sexual behaviors are shortsighted and detrimental to America's youth. As described earlier in this chapter, the CSE approach fails to meaningfully empower youth with the skills they need to avoid risk, yet present federal policy is almost singularly focused on this narrow approach. A paradigm shift solely based on ideological anti-abstinence underpinnings ignores the public health model that most effectively addresses risk behaviors. In many ways, current federal policy is effectively superimposing many of the negative influences of the sex-saturated culture directly into the classroom. There is a health crisis in our nation and in our current sex education policy. Teens are assaulted on all sides with a chorus of messages that assure them that casual sex is okay, as long as they use a condom, that reducing their risk of pregnancy, and to a lesser degree STDs, are their only real concerns. This inaccurate view should not be the message that is promoted through federal policy and with

i Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2006). *Be Proud! Be Responsible!* New York: Select Media, Inc., p 128.

ii Taverner, B., Montfort, S. (2005). *Making Sense of Abstinence*. Morristown, NJ: Planned Parenthood of Greater Northern New Jersey. pp 61-66.

iii Weed, S. (2008). Testimony before the U.S. House of Representatives Committee on Oversight and Government Reform, April 23, 2008.

iv Centers for Disease Control. (2011). *2009 Sexually Transmitted Diseases Surveillance - STDs in Adolescents and Young Adults*. Accessed August 29, 2011 at <http://www.cdc.gov/std/stats09/adol.htm#foot1>; Atlanta: Author.

v Centers for Disease Control (2011). *Trends in the prevalence of sexual behaviors: National YRBS: 1991-2009*. Atlanta: CDC. Accessed August 28, 2011 at [http://www.cdc.gov/healthyouth/yrbs/pdf/us\\_sexual\\_trend\\_yrbs.pdf](http://www.cdc.gov/healthyouth/yrbs/pdf/us_sexual_trend_yrbs.pdf)

vi McNair, Brian (2002) *Striptease Culture: Sex, Media and the Democratization of Desire*. London & New York: Routledge.

vii Bernstein, Elizabeth (2001) 'The meaning of the purchase: Desire, demand and the commerce of sex', *Ethnography* 2 (3): 389-420.

viii Committee on Public Education. (2001). Sexuality, contraception, and the media. *Pediatrics*, 107, 191-194.

APA Task Force on the Sexualization of Girls (2007). "Report of the APA Task Force on the Sexualization of Girls". Washington D.C.: American Psychological Association.

ix Anstandig, D., (2011). The class of 2011: How teens interact with media. *Radio-info.com*. Accessed online on August 29, 2011 at <http://www.radio-info.com/new-media/connected/the-class-of--2011-how-teens-interact-with-media>

x Rich, P. (2003). *Understanding, assessing and rehabilitating juvenile sexual offenders*. Hoboken, NJ: John Wiley & Sons, Inc. p. 66.

xi Lenhart, A., Madden, M., Smith, A., Purcell, K., Zichuhr, K., Rainie, L. (2011). Teens, kindness and cruelty on social network sites. Washington, D.C.: Pew Research Center. Accessed on December 26, 2011 at <http://pewinternet.org/Reports/2011/Teens-and-social-media.aspx> p. 1.

xii Korn, Daniel, "Ethical Judgments of Sexual Appeals in Advertising Image - Based Products to Teens" (2006). Senior Honors Projects. Paper 5. <http://digitalcommons.uri.edu/srhonorsprog/5>

xiii Anstandig, D., (2011). The class of 2011: How teens interact with media. *Radio-info.com*. Accessed online on August 29, 2011 at <http://www.radio-info.com/new-media/connected/the-class-of--2011-how-teens-interact-with-media>

xiv AAP Committee on Communications (1995). Media violence. *Pediatrics*.95 (6).

xv Kaeser, F. (2001). "The effects of increasing sexualization on children". Towards a Better Understanding of Children's Sexual Behavior.

xvi APA Task Force on the Sexualization of Girls (2007). "Report of the APA Task Force on the Sexualization of Girls". Washington D.C.: American Psychological Association.

xiii Anstandig, D., (2011). The class of 2011: How teens interact with media. Radio-info.com. Accessed online on August 29, 2011 at <http://www.radio-info.com/new-media/connected/the-class-of-2011-how-teens-interact-with-media>

xiv AAP Committee on Communications (1995). Media violence. *Pediatrics*.95 (6).

xv Kaeser, F. (2001). "The effects of increasing sexualization on children". *Towards a Better Understanding of Children's Sexual Behavior*.

xvi APA Task Force on the Sexualization of Girls (2007). "Report of the APA Task Force on the Sexualization of Girls". Washington D.C.: American Psychological Association.

xvii National Center for Health Statistics. (2011). Births: Preliminary data for 2010. Retrieved June 1, 2012, from [http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60\\_02.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf)

xviii National Center for Health Statistics. (2010). *Births: Preliminary data for 2009*. Table 7. Retrieved August 25, 2011, from [http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59\\_03.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_03.pdf)

xix National Center for Health Statistics. (2006). *Fertility, contraception, and fatherhood: Data on men and women from Cycle 6 (2002) of the National Survey of Family Growth*. Vital Health Stat 23(26).

xx Child Trends (2010). Percentage of Births to Unmarried Women. Washington, D.C.: Author. Retrieved on August 26, 2011 from [www.childtrendsdatbank.org/?q=node/196](http://www.childtrendsdatbank.org/?q=node/196)

xxi Thomas, A., Sawhill, I. (2005). "For Love and Money? The Impact of Family Structure on Family Income. *Marriage and Child Wellbeing*, 15.

Haveman, R., Wolfe, B., & Pence, K. (2001). Intergenerational effects of nonmarital and early childbearing. In L. L. Wu, & B. Wolfe (Eds.), *Out of wedlock: causes and consequences of nonmarital fertility*. New York: Russell Sage Foundation.

Demo, D., and Cox, M. (2000). Families with young children: A review of research in the 1990s. *Journal of Marriage and the Family*. 62 (4) 876-895.

McLanahan, S. and Sandefur, G. (1994). *Growing up with a Single Parent: What Hurts, What Helps*. Cambridge: Harvard University Press

xxii Carlson, M., Corcoran, M. (2001) "Family Structure and Children's Behavioral and Cognitive Outcomes." *Journal of Marriage and the Family*, 63.

Aquilino, W. S. (1996). "The Life Course of Children born to Unmarried Mothers: Childhood Living Arrangements and Young Adult Outcomes." *Journal of Marriage & the Family*, 58(2), 293-310.

Musick, Kelly. (2002) "Planned and Unplanned Childbearing among Unmarried Women." *Journal of Marriage and the Family*, 64 (4).

McLanahan, S., Sandefur, M. (1994). *Growing up with a single parent: What hurts, what helps*. Cambridge, MA: Harvard University Press.

xxiii Amato, P. (2005). "The Impact of Family Formation Change on the Cognitive, Social, and Emotional Well-Being of the Next Generation." *The Future of Children*, 15(2).  
[http://www.futureofchildren.org/usr\\_doc/05\\_FOC\\_15-2\\_fall05\\_Amato.pdf](http://www.futureofchildren.org/usr_doc/05_FOC_15-2_fall05_Amato.pdf)

xxiv Harper, C. C., McLanahan, S. S. (1999). *Father absence and youth incarceration: Center for research on Child Wellbeing Working Paper #99-03*. Princeton: Center for Research on Child Wellbeing.  
<http://www.sharedparentinginc.org/WP99-03-HarperFatherAbsence.pdf>

xxv Hofferth, S. L. (2006). Residential father family type and child well-being: Investment versus selection. *Demography*, 43, 53–77.

xxvi Kennedy, S. & Bumpass, L. (2008). Cohabitation and children's living arrangements: New estimates from the United States. *Demographic Research*, 19(47), 1663-1692.

xxvii Carlson, M., McLanahan, S., & England, P. (2004). Union formation in fragile families. *Demography*, 41(2), 237-261.

xxviii Brown, S. (2004). Family structure and child well-being: The significance of parental cohabitation. *Journal of Marriage and the Family*, 66, 351-367.

xxix Schmeer, K. K. (2011), The Child Health Disadvantage of Parental Cohabitation. *Journal of Marriage and Family*, 73: 181–193.

xxx Lichter, D., Graefe, D., & Brown, J. (2003). Is marriage a panacea? Union formation among economically disadvantaged unwed mothers. *Social Problems*, 50, 60-86.

Terry-Humen, E., Manlove, J., & Moore, K. A. (2001). Births outside of marriage: Perceptions vs. reality. *Child Trends Research Brief*. Washington, DC: Child Trends.

Driscoll, A. K., Hearn, G. K., Evans, V. J., Moore, K. A., Sugland, B. W., & Call, V. (1999). Nonmarital childbearing among adult women. *Journal of Marriage & the Family*, 61, 178-187;

Centers for Disease Control, (1995). Executive summary: Report to Congress on out-of-wedlock childbearing. Atlanta: Author

xxxi Lichter, D., Graefe, D. (2001). "Finding a mate: The marital and cohabitation histories of unwed mothers." In L. Wu and B. Wolf, *Out of wedlock: Causes and consequences of nonmarital fertility*. New York, NY, US: Russell Sage Foundation: 317-343.

Upchurch, D., Lillard, L., & Panis, C. (2001). "The impact of non-marital childbearing on subsequent marital formation and dissolution," In L. Wu and B. Wolf, *Out of wedlock: Causes and consequences of nonmarital fertility*. New York, NY: Russell Sage Foundation: 344-380

xxxii U.S. Census Bureau (2010). Poverty status in the past 12 months of families: 2005–2009 American community survey 5-year estimates. Washington, D.C.: Author. Accessed on August 29, 2011 at [http://factfinder.census.gov/servlet/STTable?\\_bm=y&geo\\_id=01000US&-qr\\_name=ACS\\_2009\\_5YR\\_G00\\_S1702&-ds\\_name=ACS\\_2009\\_5YR\\_G00\\_](http://factfinder.census.gov/servlet/STTable?_bm=y&geo_id=01000US&-qr_name=ACS_2009_5YR_G00_S1702&-ds_name=ACS_2009_5YR_G00_)

xxxiii Hoffman, S.D. (2006). *By the Numbers: The Public Costs of Adolescent Childbearing*. Washington, D.C.: The National Campaign to Prevent Teen Pregnancy.

xxxv Cellini, S.R., McKernan, S., Ratcliffe, C. (2008). The dynamics of poverty in the United States: A review of data, methods, and findings. *Journal of Policy Analysis and Management*, 27,577-605.

xxxv St. Lawrence, J. S. (1998). *Becoming a responsible teen*. Santa Cruz, CA: ETR

xxxvi Planned Parenthood (2008). Title X: America's Family Planning Program –Fact sheet. New York: Author.

xxxvii Scales, P. (1981). Sex Education in the '70s and '80s: Accomplishments, obstacles and emerging issues. *Family Relations*, 30, 557-566.

xxxviii U.S. Department of Health and Human Services. (1970). Public law 91-572. Retrieved August 25, 2009, from <http://www.hhs.gov/opa/about/legislation/pl91-572.html>

xxxix Card, J. J. (1999). Teen pregnancy prevention: Do any programs work? *Annual Review of Public Health*, 20, 257-285.

xl Public Law 111-148 Patient Protection and Affordable Care Act. Accessed on August 31, 2011 at <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html>

xli U.S. Department of Health and Human Services. (2007). Review of comprehensive sex education curricula. Washington D.C.:HHS.

xlii Brady, S. (2007). "Adolescents' Reported Consequences of Having Oral Sex Versus Vaginal Sex". *Pediatrics* 119 (2): 229–236

xliii Meier, Ann. (2007 May 24). Teen Sex And Depression Study Finds Most Teens' Mental Health Unaffected By Nonmarital Sex. *ScienceDaily*. Retrieved August 16, 2011, from <http://www.sciencedaily.com/releases/2007/05/070523113756.htm>

xliv Albert, B. (2007). *With One Voice 2007*. Washington, DC: the National Campaign to Prevent Teen Pregnancy.

xlv Stammers, T. (2000). Doctors should advise adolescents to abstain from sex. *British Medical Journal*, 321(7275), 1520-1521.

Williams, H. & Davidson, S. (2004). Improving adolescent sexual and reproductive health. A view from Australia: learning from the world's best practice. *Sexual Health*, 1 95-105.

xlvi Bloomberg Businessweek, (2010). *How teen sex affects education*. Accessed at <http://www.businessweek.com/lifestyle/content/healthday/642031.html> from American Sociological Association, news release, Aug. 15, 2010.

xlvii Paik, A., (2011) Adolescent sexuality and the risk of marital dissolution. *Journal of Marriage and Family*, 73:472-485.

xlviii Planned Parenthood. (n.d.). *Tools for educators: Adolescent sexuality*. New York: Author. Accessed Aug. 29, 2011 at [http://www.plannedparenthood.org/resources/research--papers/adolescent-sexuality-26782.htm?\\_\\_utma=1.2766249620722458000.1249948412.1314486814.1314497417.20&\\_\\_utmb=1.6.10.1314497417&\\_\\_utmc=1&\\_\\_utmz=1.1314497417.20.6.utmcsr=google%7Cutmccn=\(organic\)%7Cutmcmd=organic%7Cutmctr=teenwire&\\_\\_utmvl=-&\\_\\_utmk=193004973](http://www.plannedparenthood.org/resources/research--papers/adolescent-sexuality-26782.htm?__utma=1.2766249620722458000.1249948412.1314486814.1314497417.20&__utmb=1.6.10.1314497417&__utmc=1&__utmz=1.1314497417.20.6.utmcsr=google%7Cutmccn=(organic)%7Cutmcmd=organic%7Cutmctr=teenwire&__utmvl=-&__utmk=193004973)

xlix Sex, etc (2010). *No regrets: Teens on the first time*. Retrieved on Aug 29, 2011 at [http://www.sexetc.org/story/deciding\\_sex/2028](http://www.sexetc.org/story/deciding_sex/2028)

l U.S. Department of Health and Human Services. (2007). *Review of comprehensive sex education curricula*. Washington D.C.:HHS.

*li* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2006). *Be Proud! Be Responsible!* New York: Select Media, Inc., p 78,79)

*lii* Coyle, K. K., Fetro, J. V. (1998). *Safer Choices*. Scotts Valley, CA: ETR Associates. P. 195.

*liii* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2005). *Making a Difference*. New York: Select Media. P. 66.

*liv* Taverner, B., Montfort, S. (2005). *Making Sense of Abstinence*. Morristown, NJ: Planned Parenthood of Greater Northern New Jersey. Pp. 1, 4, 15

*lv* Taverner, B., Montfort, S. (2005). *Making Sense of Abstinence*. Morristown, NJ: Planned Parenthood of Greater Northern New Jersey. Pp. 1, 4, 15

*lvi* CDC (2010) Genital Herpes – CDC fact sheet. Atlanta: Author. Accessed Aug 28, 2011 at <http://www.cdc.gov/std/Herpes/STDFact-Herpes.htm>

CDC (2011) Genital HPV infection – Fact sheet. Atlanta: Author. Accessed Aug 28, 2011 at <http://www.cdc.gov/std/HPV/STDFact-HPV.htm>

*lvii* Barth, R. P. (2011). *Reducing the Risk: Building Skills to Prevent Pregnancy, STD & HIV*, 5th edition, Scotts Valley, CA: ETR Associates. p.1.

*lviii* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2006). *Be Proud! Be Responsible!* New York: Select Media, Inc., p. 7.

*lix* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2006). *Be Proud! Be Responsible!* New York: Select Media, Inc., p 81)

*lx* Centers for Disease Control and Prevention. (2002). Sexually transmitted treatment guidelines 2002. MMWR 2002;51(RR-6).

World Health Organization. (2003). WHO/CONRAD Technical consultation on nonoxynol-9. WHO, Geneva, 9-10 October 2001. Summary Report. Geneva: World Health Organization.

Food and Drug Administration. (2003). Over-the-counter vaginal contraceptive drug products containing nonoxynol-9; Required labeling. *Federal Register*. 68(11):2254-2262.

*lxi* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2005). *Making a Difference*. New York: Select Media. P. 75.

*lxii* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2005). *Making a Difference*. New York: Select Media. P. 65.

*lxiii* Maier, S. F.; Seligman, M. E. (1976). Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General*. 105: 3-46.

*lxiv* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2006). *Be Proud! Be Responsible!* New York: Select Media, Inc., p. 128.

*lxv* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2006). *Be Proud! Be Responsible!* New York: Select Media, Inc., p. 80, 81.

*lxvi* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2006). *Be Proud! Be Responsible!* New York: Select Media, Inc., p. 127-8.

*lxvii* Barth, R. P. (2011). *Reducing the Risk: Building Skills to Prevent Pregnancy, STD & HIV*, 5th edition, Scotts Valley, CA: ETR Associates p 111

*lxviii* Jemmott, L. S., Jemmott, J. B., McCaffree, K. A. (2005). *Making a Difference*. New York: Select Media. P. 94. See also p 66,67.

*lxxix* National Center for Health Statistics. ( 2011). Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2006–2010 . National Survey of Family Growth. *National Health Statistics Reports* 23(31) : 14, 15.

*lxx* National Center for Health Statistics. ( 2011). Sexual behavior, sexual attraction, and sexual identity in the United States: Data from the 2006–2008 National Survey of Family Growth. *National Health Statistics Reports* .36 :17, 18

*lxxi* National Center for Health Statistics. ( 2011). Sexual behavior, sexual attraction, and sexual identity in the United States: Data from the 2006–2008 National Survey of Family Growth. *National Health Statistics Reports* .36 :17.

*lxxii* National Center for Health Statistics. ( 2011). Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2006–2010 . National Survey of Family Growth. *National Health Statistics Reports* 23(31) : 14, 15.

*lxxiii* U.S. Department of Health and Human Services (2001). *Trends in the Well-Being of America's Children and Youth, 2000*. Office of the Asst Secretary for Planning and Evaluation, Washington, DC

*lxxiv* U.S. Department of Health and Human Services (2001). *Trends in the Well-Being of America's Children and Youth, 2000*. Office of the Asst Secretary for Planning and Evaluation, Washington, DC

*lxxv* Weinstock H, Berman S, Cates W Jr. (2000). Sexually transmitted diseases among American youth: incidence and prevalence estimates,. *Perspect Sex Reprod Health*. 2004;36(1):6-10.

*lxxvi* Centers for Disease Control, (2011). 2010 Sexually Transmitted Diseases Surveillance - STDs in Adolescents and Young Adults; Centers for Disease Control and Prevention. Atlanta: Author. Accessed December 27, 2011 at <http://www.cdc.gov/std/stats10/adol.htm>

*lxxvii* Centers for Disease Control, (2011). 2010 Sexually Transmitted Diseases Surveillance - STDs in Adolescents and Young Adults; Centers for Disease Control and Prevention. Atlanta: Author. Accessed December 27, 2011 at <http://www.cdc.gov/std/stats10/adol.htm>

*lxxviii* Centers for Disease Control Press Release, (March 11, 2008). Nationally Representative CDC Study Finds 1 in 4 Teenage Girls Has a Sexually Transmitted Disease. Retrieved August 29, 2011 from <http://www.cdc.gov/stdconference/2008/press/release-11march2008.htm>

*lxxix* Rector, R., Johnson, K., Noyes, L., & Martin, S. (2003). *The harmful effects of early sexual activity and multiple sexual partners among women: A book of charts*, p. 7. Washington, DC. The Heritage Foundation.

*lxxx* Jemmott, L. S., Jemmott, J., McCafree, K. (2005). *Making Proud Choices!* New York: Select Media.

*lxxxi* Rector, R.E., Johnson, K. A., Noyes, L. R., Martin, S. (2003). *The harmful effects of early sexual activity and multiple sexual partners among women: A book of charts*. Washington DC: Heritage Foundation. P. 8. (Chart 5)

*lxxxii* Miller, B. (1998). *Families Matter: A Research Synthesis of Family Influences on Adolescent Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy.

*lxxxiii* Barth, R. P. (2011). *Reducing the Risk: Building Skills to Prevent Pregnancy, STD & HIV*, 5th edition, Scotts Valley, CA: ETR Associates p .198.

*lxxxiv* U.S. Department of Health and Human Services (2010) National Survey of Adolescents and Their Parents: Attitudes and Opinions About Sex and Abstinence. Washington, D. C. : HHS. Accessed August 29, 2011 at [http://www.acf.hhs.gov/programs/fysb/content/doc/20090226\\_abstinence.pdf](http://www.acf.hhs.gov/programs/fysb/content/doc/20090226_abstinence.pdf)

*lxxxv* Zogby International. (2007, April). *Survey of parents of 10-16 year old children*. Utica, NY: Author.

*lxxxvi* Zogby International. (2007, April). *Survey of parents of 10-16 year old children*. Utica, NY: Author.

*lxxxvii* Centers for Disease Control (2011). Trends in the prevalence of sexual behaviors: National YRBS: 1991-2009. Atlanta: CDC. Accessed August 28, 2011 at [http://www.cdc.gov/healthyouth/yrbs/pdf/us\\_sexual\\_trend\\_yrbs.pdf](http://www.cdc.gov/healthyouth/yrbs/pdf/us_sexual_trend_yrbs.pdf)

*lxxxviii* National Center for Health Statistics. (2011). Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2006–2010. National Survey of Family Growth. National Health Statistics Reports 23(31) :31ff

*lxxxix* Centers for Disease Control (2011). STD rates by age. Atlanta: CDC. Accessed on Aug 28, 2011 from <http://www.cdc.gov/std/health-disparities/age.htm>

*xc* Centers for Disease Control (2010) Genital Herpes – CDC fact sheet. Atlanta: CDC. Accessed Aug 28, 2011 at <http://www.cdc.gov/std/Herpes/STDFact-Herpes.htm>

Centers for Disease Control (2011) Genital HPV infection – Fact sheet. Atlanta: CDC. Accessed Aug 28, 2011 at <http://www.cdc.gov/std/HPV/STDFact-HPV.htm>

*xc* Society for Prevention Research. (2004). Standards of Evidence: Criteria for Efficacy, Effectiveness, and Dissemination. Falls Church, VA: author. Available at <http://www.preventionscience.org/StandardsOfEvidencebook.pdf>

*xcii* Kirby, D. (2007). *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.

*xciii* National Campaign to Prevent Teen and Unplanned Pregnancy. (2008). What works 2008: Curriculum-based programs that prevent teen pregnancy. Washington, D. C. : Author.

*xciv* Weed, S. (2008) *Testimony before the US House of Representatives Committee on Oversight and Government Reform*. Hearing on domestic abstinence-only programs before the House Committee on Oversight and Government Reform, 110th Congress, 2nd Sess.

*xcv* Institute for Research and Evaluation. (2008). *Waxman hearing on abstinence education reveals little evidence of success in comprehensive sex education programs*. Press release. Salt Lake City: Author.

*xcvi* U.S. Department of Health and Human Services (2010). *Programs for replication – Intervention implementation reports*. Washington, D.C.: HHS OPHS. Accessed on August 29, 2011 at <http://www.hhs.gov/ash/oah/prevention/research/programs/index.html>

*xcvii* U.S. Department of Health and Human Services (2010). *Programs for replication – Intervention implementation reports*. Washington, D.C.: HHS OPHS. Accessed on August 29, 2011 at <http://www.hhs.gov/ash/oah/prevention/research/programs/index.html>

*xcviii* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE

*xcix* U.S. Department of Health and Human Services (2010). *Programs for replication – Intervention implementation reports*. Washington, D.C.: HHS OPHS. Accessed on August 29, 2011 at <http://www.hhs.gov/ash/oah/prevention/research/programs/index.html>

*c* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE

*ci* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE

*cii* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE

*ciii* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE

*civ* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE

*cv* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE

*cvi* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE

*cvii* Shrier L.A., Ancheta R., Goodman E., Chiou V.M., Lyden M.R., & Emans S.J. (2001). Randomized controlled trial of a safer sex intervention for high-risk adolescent girls. *Archives of Pediatrics & Adolescent Medicine*, 155(1), 73–9.

*cviii* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE.

*cix* U.S. Department of Health and Human Services (2010). *Programs for replication – Intervention implementation reports*. Washington, D.C.: HHS OPHS. Accessed on August 29, 2011 at <http://www.hhs.gov/ash/oah/prevention/research/programs/index.html>

*cx* U.S. Department of Education (2003). Identifying and implementing educational practices supported by rigorous evidence: A user friendly guide. Washington, D. C.: author.

*cx* Centers for Disease Control and Prevention. (2010). Male Latex Condoms and Sexually Transmitted Diseases –Condoms & STDs: Fact Sheet for Public Health Personnel. National Center for HIV, STD, and TB Prevention. Atlanta, GA: U.S. Department of Health and Human Services (paragraph 1). (Last updated, April 6 2011.)

*cxii* USAID (n.d.). HIV/STI prevention and condoms. Washington, D. C. : Author. Accessed Aug 28, 2011 at [http://www.usaid.gov/our\\_work/global\\_health/aids/TechAreas/prevention/condomfactsheet.html](http://www.usaid.gov/our_work/global_health/aids/TechAreas/prevention/condomfactsheet.html)

Centers for Disease Control and Prevention (2011 ) Condoms and STDs: Fact sheet for public health personnel. Atlanta: CDC. Accessed at <http://www.cdc.gov/condomeffectiveness/latex.htm>

*cxiii* Cassell, M. M., Halperin, D. T., Shelton, J. D., Stanton, D. (2006). HIV and risk behavior – Risk Compensation: The Achilles’ heel of innovations in HIV prevention. *BMJ*. 332:605-607.

*cxiv* Institute for Research and Evaluation. (2010). "Federally Funded Teen Pregnancy Prevention Programs: Not What They Claim to Be. Salt Lake City: IRE.

*cxv* Society for Prevention Research. (2004). Standards of Evidence: Criteria for Efficacy, Effectiveness, and Dissemination. Falls Church, VA: author. Accessed on August 29, 2011 at <http://www.preventionscience.org/StandardsofEvidencebook.pdf>

*cxvi* Center for Violence Prevention (n.d.). Blueprints for violence prevention. Colorado: University of Colorado. Accessed August 30, 2011 at <http://www.colorado.edu/cspv/blueprints/criteria.html>.

cxvii U.S. Department of Education (2003). Identifying and implementing educational practices supported by rigorous evidence: A user friendly guide. Washington, D. C.: author.

cxviii Kirby D, Rhodes T, Campe S. (2005, unpublished). The Implementation and impact of a multi-component youth program to prevent teen pregnancy modeled after the Children's Aid Society-Carrera Program. In Laris BA & Kirby D. (2007). One-page Summaries of the Evaluations Referenced in Emerging Answers 2007 (p. 56). Washington DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

Wiggins M, Bonell C, Sawtell M, Austerberry H, Burchett H, et al. (2009). Health outcomes of youth development programme in England: prospective matched comparison study. *BMJ* 2009;339:b2534.

cxix U.S. Department of Education (2003). Identifying and implementing educational practices supported by rigorous evidence: A user friendly guide. Washington, D. C.: author. P. 10. Accessed August 30, 2011 at <http://www2.ed.gov/rschstat/research/pubs/rigorous/ridrigorous.pdf>

cxix U.S. Department of Health and Human Services (2010) National Survey of Adolescents and Their Parents: Attitudes and Opinions About Sex and Abstinence. Washington, D. C.: HHS. Accessed August 29, 2011 at [http://www.acf.hhs.gov/programs/fysb/content/docs/20090226\\_abstinence.pdf](http://www.acf.hhs.gov/programs/fysb/content/docs/20090226_abstinence.pdf)

cxvi Centers for Disease Control (2011). Trends in the prevalence of sexual behaviors: National YRBS: 1991-2009. Atlanta: CDC. Accessed August 28, 2011 at [http://www.cdc.gov/healthyouth/yrbs/pdf/us\\_sexual\\_trend\\_yrbs.pdf](http://www.cdc.gov/healthyouth/yrbs/pdf/us_sexual_trend_yrbs.pdf)

cxvii Centers for Disease Control (2011). Trends in the prevalence of sexual behaviors: National YRBS: 1991-2009. Atlanta: CDC. Accessed August 28, 2011 at [http://www.cdc.gov/healthyouth/yrbs/pdf/us\\_sexual\\_trend\\_yrbs.pdf](http://www.cdc.gov/healthyouth/yrbs/pdf/us_sexual_trend_yrbs.pdf)

cxviii Cochrane, D. J., Goodwin, K., (2007). *Where do they stand? The gay men's health crisis report on the 2008 Presidential candidates and HIV/AIDS*. Washington, D. C.: Gay Men's Health Crisis. [Score card is currently off-line but is cited in the following link: <http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&featureID=915>]

Lynch, A., (2007). Sen. Barack Obama's RH issues questionnaire. Washington, DC: RH Reality Check. Retrieved December 27, 2011 from <http://www.rhrealitycheck.org/print/5779>

cxix Illinois General Assembly, (2005). *Full text of SB0099*. Retrieved August 24, 2009, from <http://www.ilga.gov/legislation/fulltext.asp?DocName=&SessionId=3&GA=93&DocTypeID=SB&DocNum=0099&GAID=3&LegID=73&SpecSess=&Session=>

cxv SIECUS. (2007). *The Politics of HIV/AIDS Prevention 2008: Presidential Candidates Provide Views on Sex Education, Needle Exchange, National AIDS Plan, PEPFAR*. Washington, D. C.: Author. Accessed on Aug 24, 2011 at <http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&featureid=915&pageid=483&parentid=478>

cxvi U.S. Department of Health and Human Services. (2009). Fiscal Year 2010 budget in brief. Washington D.C.: HHS p. 77,78. Accessed December 27, 2011 at <http://www.hhs.gov/asfr/ob/docbudget/2010budgetinbrief.pdf>

cxvii U.S. Department of Health and Human Services. (2008). Health and Human Services funding for abstinence education, education for teen pregnancy, and HIV/STD prevention, and other programs that address adolescent sexual activity. Washington D.C.:HHS.

cxviii U.S. Department of Health and Human Services.. (2009). Fiscal Year 2010 budget in brief. Washington D.C.: HHS p. 77,78. Accessed December 27, 2011 at <http://www.hhs.gov/asfr/ob/docbudget/2010budgetinbrief.pdf>

cxix U.S. Department of Health and Human Services, Office of Adolescent Health. (2010). Teenage Pregnancy Prevention: Replication of Evidence-based Programs (Tier 1) – Funding Opportunity Announcement and Application Instructions. Washington, D. C.: Office of Public Health & Science, U.S. Department of Health & Human Services.

cxix Fitzpatrick, E. (2010). New teen pregnancy funds revive sex ed debate. *Youth Today*. Accessed online on August 30, 2011 at [http://www.youthtoday.org/view\\_article.cfm?article\\_id=3733](http://www.youthtoday.org/view_article.cfm?article_id=3733)

cxix U.S. Department of Health and Human Services. (2010). Teenage pregnancy prevention: Summary of funded evidence-based programs for 2010. Washington, D. C.: OAH/HHS. Accessed August 30, 2011 at [http://www.hhs.gov/ash/oah/prevention/grantees/models\\_2010\\_programs.html](http://www.hhs.gov/ash/oah/prevention/grantees/models_2010_programs.html)

Note: Only three programs were funded that included authentic SRA curricula in their proposals. They were PATH (\$988,164), Live the Life Ministries, Inc (\$891,533), and University of Texas Health Science Center at San Antonio (\$851,450).

cxix U.S. Department of Health and Human Services. (2010). Teenage pregnancy prevention: Summary of funded evidence-based programs for 2010. Washington, D. C.: OAH/HHS. Accessed August 30, 2011 at [http://www.hhs.gov/ash/oah/prevention/grantees/models\\_2010\\_programs.html](http://www.hhs.gov/ash/oah/prevention/grantees/models_2010_programs.html)

cxix U.S. Department of Health and Human Services. (2010). Teenage pregnancy prevention: Summary of funded evidence-based programs for 2010. Washington, D. C.: OAH/HHS. Accessed August 30, 2011 at [http://www.hhs.gov/ash/oah/prevention/grantees/models\\_2010\\_programs.html](http://www.hhs.gov/ash/oah/prevention/grantees/models_2010_programs.html)

cxix U.S. Department of Health and Human Services. (2007). Review of comprehensive sex education curricula. Washington D.C.: U.S. Department of Health and Human Services.

cxix U.S. Department of Health and Human Services, Office of Adolescent Health. (2010). Teenage Pregnancy Prevention: Replication of Evidence-based Programs (Tier 1) – Funding Opportunity Announcement and Application Instructions. Washington, D. C.: Office of Public Health & Science, U.S. Department of Health & Human Services.

cxix U.S. Department of Health and Human Services. (2007). Review of comprehensive sex education curricula. Washington D.C.:HHS.

cxix Kinsey, A. (1948). Sexual behavior in the human male. Philadelphia: W. B. Saunders.

cxix Questions & Answers About Sex. (Direct link from HHS site, Talk to your kids about sex.) Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/parent/emotions/feelings/questions\\_sex.html#cat20015](http://websrv02.kidshealth.org/parent/emotions/feelings/questions_sex.html#cat20015)

cxix Understanding early sexual development. (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/parent/growth/sexual\\_health/development.html](http://websrv02.kidshealth.org/parent/growth/sexual_health/development.html)

*cxl Questions & Answers About Sex.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/parent/emotions/felings/questions\\_sex.html#cat20015](http://websrv02.kidshealth.org/parent/emotions/felings/questions_sex.html#cat20015)

*cxli About Sexual Attraction and Orientation.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/parent/positive/talk/sexual\\_orientation.html](http://websrv02.kidshealth.org/parent/positive/talk/sexual_orientation.html)

*Sexual Attraction and Orientation: Adolescence in a Time of Change.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/teen/sexual\\_health/girls/sexual\\_orientation.html#cat20015](http://websrv02.kidshealth.org/teen/sexual_health/girls/sexual_orientation.html#cat20015)

*cxlii Talking to your partner about condoms.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/teen/sexual\\_health/girls/talk\\_about\\_condoms.html#](http://websrv02.kidshealth.org/teen/sexual_health/girls/talk_about_condoms.html#)

*cxliii About Birth Control: What Parents Need to Know.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://kidshealth.org/parent/growth/sexual\\_health/about\\_bc.html](http://kidshealth.org/parent/growth/sexual_health/about_bc.html)

*cxliv Virginity: A Very Personal Decision.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/teen/sexual\\_health/girls/virginity.html#](http://websrv02.kidshealth.org/teen/sexual_health/girls/virginity.html#)

*cxlv Virginity: A Very Personal Decision: Resources.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/PageManager.jsp?dn=KidsHealth&lic=1&article\\_set=20459&cat\\_id=20015&&ps=205#cat20018](http://websrv02.kidshealth.org/PageManager.jsp?dn=KidsHealth&lic=1&article_set=20459&cat_id=20015&&ps=205#cat20018)

*cxlvi Planned Parenthood.* (2010, Oct 13). *Info for Teens: Ask the Experts.* Accessed online on August 30, 2011 at <http://asktheexperts.plannedparenthood.org/?p=459>

*cxlvii Virginity: A Very Personal Decision: Resources.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/PageManager.jsp?dn=KidsHealth&lic=1&article\\_set=20459&cat\\_id=20015&&ps=205#cat20018](http://websrv02.kidshealth.org/PageManager.jsp?dn=KidsHealth&lic=1&article_set=20459&cat_id=20015&&ps=205#cat20018)

*cxlviii Sexual Health.* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://websrv02.kidshealth.org/teen/sexual\\_health/#cat20018](http://websrv02.kidshealth.org/teen/sexual_health/#cat20018)

*cxlix Expert Answers on... "Will I bleed the first time I have sex?"* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://kidshealth.org/teen/expert/sex\\_health/bleeding\\_ft.html](http://kidshealth.org/teen/expert/sex_health/bleeding_ft.html)

*cl Expert Answers on... "* (Direct link from HHS site, Talk to your kids about sex.). Accessed online on August 30, 2011 at [http://kidshealth.org/teen/expert/birth\\_control/pregnancy\\_risk.html](http://kidshealth.org/teen/expert/birth_control/pregnancy_risk.html)

*cli HHS,* (2010). *Overview of the Teen Pregnancy Prevention research evidence review.* Washington, D. C.: Office of Adolescent Health, HHS. Accessed August 31, 2011 at <http://www.hhs.gov/ash/oah/prevention/research/index.html>

*clii Institute for Research and Evaluation.* (2010). "Federally Funded *Teen Pregnancy Prevention* Programs: Not What They Claim to Be. Salt Lake City: IRE

*cliii* Haskins, R., & Bevan, S. (1997). Abstinence education under Welfare Reform. *Children and Youth Services Review*, 19, 465-484.

*cliv* Personal Responsibility and Work Opportunity Reconciliation Act of 1996. PL 104-193. 110 STAT. 2105.

*clv* U.S. Department of Health and Human Services, Administration for Children and Families. (2011). Title V State Abstinence Education Grant Program Announcement and Application Instructions. Washington, D. C.: Family and Youth Services Bureau, U.S. Department of Health & Human Services. P.7.

*clvi* U.S. Department of Health and Human Services, Administration for Children and Families. (2011). Title V State Abstinence Education Grant Program Announcement and Application Instructions. Washington, D. C.: Family and Youth Services Bureau, U.S. Department of Health & Human Services.

*clvii* Haskins, R., & Bevan, S. (1997). Abstinence education under Welfare Reform. *Children and Youth Services Review*, 19, 465-484.

*clviii* U.S. Department of Health and Human Services (2010) National Survey of Adolescents and Their Parents: Attitudes and Opinions About Sex and Abstinence. Washington, D. C. : HHS. Accessed August 29, 2011 at [http://www.acf.hhs.gov/programs/fysb/content/docs/20090226\\_abstinence.pdf](http://www.acf.hhs.gov/programs/fysb/content/docs/20090226_abstinence.pdf)

*clix* U.S. Department of Health and Human Services. (2010). (Internal document) "Background on the CBAE funded report: National Survey of Adolescents and their Parents" Washington D.C.: HHS.

*clx* Jeffrey Kelley. Email to Hilary Haycock (HHS/ASPA) August 25, 2010.

*clxi* Sarah Hunter (ACF). Email to Jeffrey Kelley (ACF), Aug 24, 2010

*clxii* Jeffrey Kelley, Director, Office of Public Affairs, ACF. Email to David Hansell. August 23, 2010.

*clxiii* Anonymous Internal email to Mark Greenberg, Hillary Haycock, Sharon Parrott, David Hansell, Bryan Samuels, August 25, 2010

*clxiv* Sarah Hunter (ACF) Email to Jeffrey Kelley (ACF). Aug 24, 2010.

*clxv* Sharon Parrott (HHS/OS). Email to David Hansell (ACF), Aug 24, 2010.

*clxiv* Sharon Parrott (HHS/IOS). Email to Clare Anders, David Hansell, Mark Greenberg. Aug 24, 2010

*clxv* Sharon Parrott (HHS/IOS) to Clare Anders, David Hansell, Mark Greenberg. Aug 24, 2010.

*clxvi* Sharon Parrott (HHS/IOS) to Mark Greenberg, Bryan Samuels, Danid Hansell. Aug 25, 2010.

Jesse Moore (ACF). Email to Carolyn Kriss (ACF). Aug 27, 2010.

*clxvii* Sarah Hunter ACF). Email to Jeffrey Kelley (ACF). Aug 24, 2010

*clxviii* Jeffrey Kelley (ACF). Email to Hillary Haycock (HHS/ASPA). Aug 25, 2010.

HHS. (n.d.). HHS External Talking Points *National survey of adolescents and their parents: Attitudes and opinions about sex and abstinence. Washington, D.C.: HHS.*

*clxix* U.S. Department of Health and Human Services, Administration for Children and Families. (2011).

*clxx* State Personal Responsibility Education Program (PREP) Funding opportunity Announcement. Washington, D. C.: ACYF, U.S. Department of Health & Human Services. Accessed August 30, 2011 a  
<http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-ACYF-PREP-0125>

*clxxi* U.S. Department of Health and Human Services, Administration for Children and Families. (2011).

*clxxii* State Personal Responsibility Education Program (PREP) Funding opportunity Announcement. Washington, D. C.: ACYF, U.S. Department of Health & Human Services. Accessed August 30, 2011 a  
<http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-ACYF-PREP-0125>

*clxxiii* U.S. Department of Health and Human Services. (2007). Review of comprehensive sex education curricula. Washington D.C.:HHS.

*clxxiv* Office of the President. (2011). Budget of the US Gov't for Fiscal Year 2013/DHHS. Washington, D.C.:Department of Health and Human services.  
<http://www.hhs.gov/budget/>

*clxxv* Redhead, C. S. (2011). *Appropriations and fund transfers in the Patient Protection and Affordable Care Act (PPACA)*. Washington, D.C.: Congressional Research Service. Downloaded on August 24, 2011 from  
[http://bachmann.house.gov/UploadedFiles/CRS\\_Report\\_02\\_10\\_11\\_PPACA.pdf](http://bachmann.house.gov/UploadedFiles/CRS_Report_02_10_11_PPACA.pdf)