# Recognizing the Sexual Rights of Minors in the Abstinence-Only Sex Education Debate

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## I. Introduction

In this paper, I briefly describe sexual development milestones of adolescents and their sexual health risks. Acknowledging the fact that adolescents are sexual human beings and have attendant health risks and needs compels the question: what responsibilities should adult society shoulder to prepare adolescents for sexual maturity? More specifically, does the current federal policy of funding abstinence-only-until-marriage sexuality education help or hinder adult society in meeting its responsibilities to our youth? If, as the public health literature is suggesting, abstinence-only education leaves minors unprepared to manage their sexuality, does federal support of abstinence-only education constitute a constitutional harm against minors?

Schools are playing an increasingly important role in educating and preparing adolescents for the responsibilities of sexual maturation,[1] whereas instruction about human sexuality and inculcation of sexual values was formerly delegated principally to family and church.[2] Unlike many school curricular decisions, parents, educators, and students are not the only stakeholders when it comes to developing sexuality education curricula. As with most socially significant curricular choices that schools must make,[3] deciding precisely what should be taught in sex education courses has long been a difficult and contentious debate. Control of the content of sex education is regarded as a political battle over who defines America's larger social values.[4]

Currently, federal resources for sexuality education are directed exclusively toward a form of sexuality education called "abstinence-only-until-marriage."[5] The federal government initially provided grants to the states to design programs to promote abstinence.[6] Recently, the federal government has developed funding opportunities that bypass states and allow community and faith-based groups to develop programs that promote the federal message of abstinence.[7]

As Professor Ravitch has noted, the Establishment Clause may be implicated when abstinence-only programs are overtly religious.[8] Likewise, as Professor DeGroff has observed, all sexuality education may implicate parental rights to raise their children without state involvement.[9] This paper instead considers what the rights of the adolescent are to sexuality education. The difficulty in fashioning an argument for sexuality education based directly upon the needs of minors reveals just how impoverished our law is when it comes to children's rights. As Barbara Bennett Woodhouse has urged, we should be "paying attention to children's lives and to what they say and do" rather than "merely listening to what others say about children" if we truly desire that our policies are "conducive to children's growth toward autonomy."[10] When it comes to sexuality, this paper argues that we should be "paying attention to children's lives and to what they say and do" in order to develop sound sexuality education policies.

While there are many competing religious, political, and educational views on the topic of sex education, this paper attempts to refocus the curricular choices schools make and the policies they implement on student needs. Laws concerning adolescent sexuality have granted teens at least some autonomy and privacy rights, perhaps because society recognizes a certain futility in attempting to suppress teenage sexual desire and activity.[11] This paper argues that a logical extension of the procreative rights adolescents possess is recognition of a corresponding right to accurate and comprehensive sexuality education. The recognition of adolescent sexual development, understanding of adolescent needs, and respect for the rights they already enjoy should inform school curricular decisions when it comes to sexuality education.

Part II of this paper describes the sexual maturation of adolescents, including sexual minorities, as well as the attending health

burdens and risks adolescents may encounter. Part III describes various approaches to sexuality education and highlights recent criticisms of the federal government's exclusive focus on abstinence-only-until-marriage education. This part discusses recent medical literature that indicates that abstinence-only sexuality education may actually be placing minors at greater health risks because of the errors and misleading information commonly offered in these courses. Part IV challenges the constitutionality of abstinence-only education, arguing that these courses impair the minor's ability to make sound procreative and reproductive choices. Concededly, the federal government need not fund any sexuality education and if it does, it can choose what messages it wants to support. However, this paper argues that the government crosses the line when it funds programs that affirmatively mislead minors and risks harm to their sexual health.

## II. Teens and Sex

There can be no denying the child's biological march to adulthood. Sexual maturation awakens sexual desires and interests in young people. After the biological process of puberty, teens have sexual capability. However, industrialized societies have recognized a developmental stage of life known as adolescence in which teens are expected not to engage in sexual activity, although they have sexual capacity. Despite social expectations within adult society that teens should exercise sexual restraint, sexually capable teens frequently engage in a variety of sexual activities. Sexual activity exposes teens to preventable health risks and burdens that can have grave, lifelong consequences.

### 1. Adolescent Sexual Development

It is useful to recognize that adolescence and puberty are conceptually different; *adolescence* is a developmental stage of life while *puberty* is the biological process of sexual maturation. Puberty lasts approximately four and a half years.[12] Girls in the United States enter puberty at approximately nine to ten years of age and typically begin menstruation at the age of twelve;[13] boys begin puberty at around eleven and a half years of age.[14] Less is known historically about the age of puberty in males,[15] but for girls, the modern trend in industrialized nations has been that girls enter puberty at an earlier age than in earlier years. In the last hundred years, the average age of menarche in girls in the United States decreased from seventeen to less than fourteen years.[16] In males, spermarche, the onset of reproductive capacity, occurs in mid-puberty, at about the thirteen to fourteen years.[17]

The "social invention" of adolescence as its own developmental stage of life is a recent phenomenon of industrialized societies, including the United States. Recognition of adolescence as a unique stage of life "rested on three important material changes in the nineteenth century," according to historian Jeffrey Moran.[18] First, the American educational system "increasingly segregated and sorted" youth "by age" giving them their own group identity.[19] Second, on average, American youth reached sexual maturity at an increasingly younger age.[20] Third, American youth began to delay marriage as "the period of training and education for young men, especially, grew longer."[21] Unlike youth of a hundred years ago, modern youth experience a period of time where they are sexually mature or maturing, but are not yet recognized as adult members of society with full sexual rights. A substantial portion of these years is spent in school, making teenage sexuality an issue that American schools cannot ignore.

Sexual orientation[22] and gender identity[23] are also commonly developing or solidifying during adolescence.[24] Sexual minorities represent a significant population within the adolescent community, although there is considerable uncertainty as to the precise prevalence of homosexuality[25] and transgenderism[26] in adolescence. Part of the difficulty in estimating prevalence is definitional because as researchers are increasingly recognizing, human sexuality is less categorical and more multidimensional and complex than once perceived: "[t]he relative heterosexual or homosexual direction of each dimension may be inconsistent with others, defying dichoto-

mous classification of individuals."[27] Estimating prevalence is also difficult because sexual identity development during childhood and adolescence has a relative fluidity.[28] Moreover, even via anonymous surveys, researchers theorize that an adolescent's possible internal defensiveness and reluctance toward self-disclosure may undermine the reliability of data.[29]

Although sexual activity during the teen years may not be regarded by adults as socially desirable, it is inescapable that teenagers certainly have sexual and reproductive capacity and often do engage in sexual activity. According to the Centers for Disease Control's (CDC) most recently released data, about sixty-four percent of males and females between fifteen and nineteen have engaged in sexual contact, including vaginal intercourse, oral, or anal sex.[30] Over the latter half of the twentieth century, sexual behavior and attitudes of youth became more permissive; the age of first intercourse decreased from nineteen to fifteen years among women and from eighteen to fifteen years among males.[31] The age of first sexual intercourse among teens has recently shown some upward trend.[32] Today, about half of seventeen year olds have had sexual intercourse.[33] The average age of marriage has also increased over the last century;[34] today, females are generally sexually active for eight, and males for ten years before marriage.[35] Sexual activity must be more broadly defined than just vaginal intercourse; increasingly, minors are also engaging in non-coital sexual behavior such as oral sex in lieu of vaginal intercourse, perhaps as a strategy to delay sexual intercourse.[36]

## 2. Unique Sexual Health Risks of Adolescents

Improvident sexual activity during the teen years carries attendant health risks including sexually transmitted diseases (STDs), HIV/AIDS, and unintended pregnancy. The Center for Disease Control ("CDC") has observed that teens are at peculiar risk for STDs, warning that "sexually active adolescents (ten- to nineteen-year-olds) and young adults (twenty- to twenty-four-year-olds) are at higher risk for acquiring STDs for a combination of behavioral, biological, and cultural reasons."[37] While adolescents and young adults account for twenty-five percent of sexually active individuals in the United States, they represent "nearly one half of all new STDs."[38] In 2003, young people between age thirteen and twenty-four represented twelve percent of those newly diagnosed with HIV/AIDS.[39] Notably, infection rates among teens in the United States are higher than STD rates in other developed countries.[40] Although teens may perceive non-coital sexual activities, such as oral and anal sex, as more socially acceptable and less risky than vaginal intercourse, in fact, these behaviors carry health risks.[41]

In addition to the risk of STDs, unintended pregnancies also pose significant health and socioeconomic risks to sexually active teenage females. While the rate of teen pregnancy in the United States has declined recently, with a birth rate of forty-nine per 1000 adolescent women, the U.S. rate remains substantially higher than that in other developed countries.[42] According to the American Academy of Pediatrics Committee on Adolescence, "[m]ore than [four] in [ten] adolescent girls have been pregnant at least once before [twenty] years of age."[43] Pregnancy is a likely consequence of vaginal intercourse without contraception, a single random act of unprotected sex carries an approximately three percent probability of pregnancy.[44] While contraception use is increasing among adolescents, "[fifty percent]of adolescent pregnancies occur within the first 6 months of initial sexual intercourse" and only sixty-three percent of sexually active high school students "reported having used a condom the last time they had intercourse."[45]

Compared to males, adolescent females bear heightened health and socioeconomic burdens when it comes to the consequences of sexual activity. Because of anatomical differences between males and females, females are more susceptible to acquiring STDs, detection is more difficult because they are frequently asymptomatic during the early course of the disease,[46] and they are more vulnerable to long term health consequences.[47] Even among women, the developing cervical anatomy of

adolescent females make them peculiarly more vulnerable to STDs.[48] Social and cultural factors make women vulnerable as well, "Condom use has to be negotiated and, ultimately, is the decision of the male to use unless the woman has the strength to insist that no condom equals no sex."[49] As a result, STDs expose women to chronic health consequences, including pelvic inflammatory disease, cervical cancer, infertility, and a higher risk of ectopic pregnancy.[50]

Teen pregnancy also carries additional health and socioeconomic burdens that fall principally on females. Among other health burdens, "[p]regnant adolescents younger than eighteen have a higher risk of medical complications involving mother and child than do adult women," including, among others, maternal and neonatal death and low infant birth weight.[51] The socioeconomic burdens of pregnancy, childbearing, and early marriage that fall on women can be lifelong; "[t]he psychosocial problems of adolescent pregnancy include school interruption, persistent poverty, limited vocational opportunities, separation from the child's father, divorce, and repeat pregnancy."[52]

Adolescents are an underserved medical population and this exacerbates their already heightened sexual health risks. "Early, middle, and late adolescents all underutilize physician offices relative to their population proportion;" in fact, "[e]arly adolescents have the lowest rate of [physician] office visits than any age group across the lifespan."[53] Sadly, increased office visits in young adulthood may actually reflect "the adverse health sequalae of early adolescent risk behaviors" rather than improved utilization of health services during adulthood more generally.[54]

Notably, when it comes to sexual health in particular, concerns about confidentiality and the fear of parental notification also keep adolescents away from appropriate health care.[55] A recent survey of 1526 minor adolescent females at seventy-nine family planning clinics found that if the law mandated parental notification, "[eighteen percent of surveyed teens] would engage in risky sexual behavior, and [five percent] would forgo STD services."[56] However, less than [five percent of] sexually active adolescents would stop having sex as a consequence of parental notification.[57]

## C. Special Risks of Sexual Minority Youth

Sexual minority youth are a particularly vulnerable and underserved population and so their unique health risks deserve special consideration. Unfortunately, sexual minority youth often lack supportive family and social resources to help them navigate through adolescence as a sexual minority. While schools could fill the void for this population, schools are often inhospitable to the needs of their sexual minority student body.

Increasingly, lesbian and gay youth are coming out during adolescence, often while they are still living at home and attending school.[58] For sexual minorities, coming out is a "key developmental milestone"[59] that may sometimes "percolate for years or decades."[60] Minors often struggle with both self-disclosure and coming out in isolation, without confiding in parents or other adults. Typically, sexual minority youth first confide in a friend, "[r]arely told first are parents, extended family members, or pediatricians."[61] Fear of telling parents is well founded for some sexual minority youth; some encounter ambivalent or negative family reactions to their sexuality.[62]

Generally, sexual minorities have greater sexual health risks than other youth for a variety of reasons; for example, homosexual male youth "report earlier sexual debuts, higher rates of sexual abuse, more high-risk behaviors, more lifetime sexual partners, less consistent use of contraceptives, and a greater number of episodes of running away from home than their heterosexual peers."[63] In fact, negative social and family reactions lead to adolescent sexual minorities being overrepresented in homeless and runaway youth populations, and this adds to their health risks.[64] Homosexual adolescent males more frequently engage in prostitution than other youth populations.[65] Unfortunately, even though their health risks are high, social stigma associated with their sexual orientation "make it difficult for them to engage in health

protective behaviors such as consistent condom use and immunizations for hepatitis B."[66]

Sexual minority youth are also unlikely to receive adequate health care and sex information within the traditional health care setting. Some health care professionals may have overt homophobic attitudes that impair their relationship with their patient.[67] Although the American Academy of Pediatrics' official view is that the treatment of gay and lesbian youth and their families is important,[68] pediatricians typically are not well trained about the medical needs of sexual minority youth.[69] Studies show that pediatricians often hold misconceptions about the unique health needs and risks of sexual minority youth.[70] Pediatricians report that "discussion of sexual orientation with adolescents is difficult" and that they are not sure how to discuss the matter with their patients.[71] "Consequently, the vast majority of pediatricians ([sixty-eight percent]) do not collect information about sexual orientation in their sexual histories."[72]

Although schools could be an ameliorating influence, often schools are inhospitable to sexual minority youth. Sexual minority youth are frequently victims of harassment and discrimination at school.[73] GLSEN, the Gay Lesbian Straight Education Network, reported in its most recent biannual survey of school climate "that more than [four out of five] LGBT students reported being verbally harassed at school because of their sexual orientation, and more than [nine out of ten] reported hearing homophobic remarks such as "faggot," "dyke" or "that's so gay" frequently or often.[74] Worse, adult bystanders who overheard such remarks "seldom intervene to halt this blatant prejudice."[75] School performance and educational aspirations are demonstrably adversely affected in a hostile educational environment.[76] Harassment also causes sexual minorities youth to suffer corresponding physical and mental health burden.[77] Therefore, and not surprisingly, "considerable research shows that "compared with heterosexuals, gay youth report greater depression, anxiety, substance abuse, school-related problems, delinquency, and suicidality."[78] One need only read a few recently reported cases chronicling persistent name-calling, teasing, taunting, and assault, decided under Title IX, to get a gripping account of what some sexual minority youth endure in the schools.[79]

## III. Sex Education Policy in the United States

The schooling of American youth happens to coincide with this period of life marked by important milestones in sexual maturation and sexual behavior. It is difficult for schools to ignore the sexual nature of adolescents given the momentous physical and behavioral changes they are experiencing. The timing of sexual development during a child's educational years poses unique and thorny challenges for schools that might otherwise prefer to ignore the contentious topic of sex altogether. However, the timing of sexual maturation in the school years also presents an opportunity for schools to assume an important and positive influence in molding sexually responsible individuals. A variety of curricula approaches have been tried to prepare teens for sexual adulthood, encourage sexual restraint, and to instill values that comport with social expectations.

### 1. Curricular Approaches

Because sexual maturation no longer coincides with passage to adulthood, modern schools have felt increasing pressure to cope with educating and socializing a sexually capable student population.[80] While prior to the twentieth century, family and church were the primary institutions expected to define the expectations and inculcate the values children needed to transition to a responsible sexual adult,[81] schools began to play an increasingly important role, in part because teens spend such a large part of their life in age-segregated schools.[82]

Although mundane matters of curricular choices hardly draw attention to those outside the school, the "message" that schools impart on topics such as sexuality becomes part of wider public discourse because instruction on these issues are believed to influence national social values.[83] Thus, schools are often mired in

controversy whenever they implement policies or curricula regarding the sexuality of their students.[84]

Sex education curriculum generally falls into three categories, although there is considerable variability in content: abstinence-only sex education, comprehensive sex education, and abstinence-plus sex education. In general, content in abstinence-only curriculum is designed to promote abstinence from sexual activity as the only acceptable option for adolescents and if condoms or contraception are discussed at all, the instruction merely emphasizes failure rates and does not provide information on their use.[85] Typically, these programs attempt to instill fear about the consequences of sex. They do not acknowledge the health needs of the sexually active teen, exaggerate physical or psychological harm from abortion if abortion is discussed at all, and discuss HIV/AIDS and STDs only in the context of "reasons to avoid sexual activity."[86]

On the other hand, a comprehensive curriculum promotes a positive view of human sexuality and "addresses abstinence as one option for adolescents to avoid pregnancy and STDs in a broader sexuality education program that includes discussion of contraception to prepare [adolescents] to become sexually healthy adults."[87] An abstinence-plus curriculum, falls somewhere in the middle, it "allows contraception to be discussed as effective in protecting against unintended pregnancy and STDs or HIV" but "promote[s] abstinence as the preferred option for adolescents."[88]

Although the debate over what approach to take is usually cast as a debate over the social value of abstinence and chastity as opposed to permissiveness and promiscuity, the controversy is not actually about what values to promote.[89] Sexuality education classes nearly uniformly stress and encourage abstinence as the "best option for teenagers."[90] On closer examination, "the controversy between abstinence education and more comprehensive approaches centers ... on what information should be presented to students about how sexually active people can prevent unwanted pregnancy and STDs."[91] Abstinence-only proponents argue that a fuller discussion of contraception would "contradict or undermine" the abstinence message.[92] However, a comprehensive review of multiple research studies examining sex education outcomes concluded that "[I]n sum, these data strongly indicate that sex and HIV education programs do not significantly increase any measure of sexual activity, as some people have feared, and that to the contrary, may delay or reduce sexual intercourse among teens."[93] Indeed, the American Academy of Pediatrics Committee on Adolescence recently concluded that "[c]urrent research indicates that encouraging abstinence and urging better use of contraception are compatible goals" and that discussing "contraception does not increase sexual activity."[94]

Nationally, about two-thirds of school districts have a policy to teach sex education, while the remaining third leave the decision to individual schools or teachers.[95] Within public school districts it is estimated that "more than one-third of districts with a policy to teach sexuality education require that abstinence be taught as the only option outside of marriage" and either focus exclusively on failure rates of contraceptives and condoms or forbid instruction on contraception at all.[96] Although school curricular choice is typically a local matter, federal funding has increasingly allowed the federal government to wield a strong influence over what teens learn about sex in formal instruction both in school and in community based programs.[97]

Three federal programs fund sex education in schools and communities; under each, programs must deliver the singular message that abstinence before marriage is the "first and best" choice for American teens.[98] From 2001 to 2005, the federal government doubled its spending on abstinence only programs, much of those resources now bypassing states in favor of community based groups.[99] Up until 2000, the federal government provided grants to the states to provide abstinence-only education; however, the Special Projects of Regional and National Significance-Community Based Abstinence Education ("CBAE") created federal grant opportunities directly for community organizations as well as states.[100] CBAE grant recipients may not provide other sex

education content, even with nonfederal funds.[101] As part of President Bush's faith-based initiatives, many recipients of CBAE grants are religious organizations.[102] CBAE is now the largest source of federal sex education money; through it, the federal government can now more directly influence how the abstinence message is delivered.[103]

Federal law defines abstinence-only education by eight specific criteria.[104] Implicitly, the required exclusive focus on abstinence precludes a more comprehensive curriculum. Unlike Adolescent Family Life Act and Section 510 of the Personal Responsibility and Work Opportunity Reconciliation Act state programs, CBAE grantees may not neglect any of the eight definitional provisions and must teach all eight points.[105]

## 2. The Failure of Abstinence-Only Education

Abstinence-only education has received substantial and widespread criticism from many circles. Notably, in 2004, the United States House of Representatives Committee on Government Reform Minority Staff prepared an evaluation of the content of the thirteen most popular of the federally funded programs on behalf of Representative Henry Waxman (Waxman Report). The report concluded:

> [t]his report finds that over two-thirds of abstinence-only education programs funded by the largest federal abstinence initiative are using curricula with multiple scientific and medical inaccuracies. These curricula contain misinformation about condoms, abortion, and basic scientific facts. They also blur religion and science and present gender stereotypes as fact."[106] By endorsing sex only within a heterosexual marriage, abstinence-only education implicitly rejects the potential of positive sexual experiences for sexual minorities and ignores their health needs altogether.[107]

Many influential professional organizations have also criticized the nation's increasing emphasis on abstinence-only education. Among others, the American Medical Association,[108] the American Academy of Pediatrics,[109] the American Public Health Association,[110] the American College of Obstetricians and Gynecologists,[111] the American Psychological Association,[112] the Society for Adolescent Medicine,[113] the National Education Association,[114] the American School Health Association,[115] and the American Association of University Women,[116] officially support comprehensive sexuality education and oppose abstinence-only sexuality education.

At best, abstinence-only education constitutes a waste of federal resources on an unproven sex education approach while forsaking effective programs. Despite generous federal funding, there is little evidence that abstinence-only education is effective at reducing teen sexual activity, minimizing attendant health risks, or preventing pregnancy[117] whereas at least some more comprehensive programs have shown effectiveness.[118] Notably, curricula need not abandon a comprehensive approach in order to embrace the position that abstinence remains the best choice for teens. These messages are not mutually exclusive as opponents suggest.[119] Research indicates that providing more information to teens does not confuse them or increase sexual activity.[120] Thus, the concern that teaching comprehensive sex information will undermine a message that abstinence is the best choice for teens is based on a faulty premise that one negates the other.[121]

More problematic are increasing indications that the programs are not merely ineffective. Research now suggests that curricular flaws in abstinence-only programs may actually expose youths to increased health risk. One problem concerns the definitional ambiguity of the term abstinence[122] and the lack of a clear message these programs impart about precisely what behaviors pose risks. Thus, these programs jeopardize minors who fail to appreciate risks associated with non-coital behaviors such as intimate mutual masturbation, oral or anal sex. [123] In light of the fact that students often engage in oral sex rather than vaginal intercourse, perhaps as a way to delay intercourse, risks and preventive practices associated with such non-coital behaviors need to be understood.[124]

A significant problem associated with abstinence-only programs is that they do not account for their own failure rate as part of their curricular design. Although some abstinence-only programs have reported modest success in delaying intercourse among some specific teen populations, as a rule these programs have a substantial failure rate—i.e., eventually many of their participants will engage in sexual activity.[125] Thus, a fatal deficiency of these programs is the absolute and unequivocal failure to meet the needs of teens who do or will eventually engage in sexual activity.[126] Minors who participate in abstinence-only programs who do not remain abstinent (i.e., their user failures) are not prepared to prevent health risks associated with their sexual activity because they have not been taught how to minimize risks and have not rehearsed or practiced how to negotiate preventive practices with a partner.[127] On the other hand, a comprehensive approach serves both abstinent and sexually active teens.

To make matters worse, abstinence programs typically do not provide accurate information about the effectiveness and failure rates of contraception and condoms.[128] They often fail to distinguish accurately between user failure and method failure.[129] Method failure occurs when the product fails, while user failure occurs when the user uses the product inconsistently or improperly.[130] Education and practice can minimize user failure, the most common form of failure. Therefore, abstinence-only reinforces risky behavior by undermining confidence in condom and contraceptive use among sexually active youth, instead of trying to overcome condom user failure problems.[131] Recently, the State of Ohio, a state that receives more than eight million dollars from the federal government for abstinence-only education, commissioned an evaluation of programs.[132] The highly critical Ohio study observed that the focus on failure rates of contraceptives and the manipulation of the data undermines desirable health practices among sexually active teens:

> In emphasizing the failure rate of contraceptives, abstinence-only-until-marriage curricula programs are exploiting the well established discrepancy between "typical use" and "perfect use" of these tools. There is unquestionably a difference between use in all contraceptive users, and the use in "perfect" users. Ironically, in emphasizing only the failure rate and not how to improve the successful use of contraceptives, programs may contribute to this divide. This strategy is especially troubling if the programs do not also acknowledge the discrepancy between typical and perfect use of the abstinence pledge. While conclusive research is not available, since [eighty-eight percent] of virginity pledgers relate having sex before marriage, it is likely that virginity pledges slip or are broken more often than condoms.[133]

The risks associated with not giving teens accurate information and giving them erroneous information are not merely theoretical. Peter Bearman and Hanna Brückner observed that teens taking public virginity pledges, vowing to abstain from sex until marriage, were "less likely to be prepared for an experience they have promised to forgo"[134] and were one-third less likely to use contraceptives at intercourse.[135] In a recent study garnering substantial media attention, Brückner and Bearman also observed that although pledgers did delay sex, their STD rate was consistent with other adolescents, they were more likely not to use condoms at sexual debut, or to be tested and aware of their STD status.[136]

Some of the programs also employ and perpetuate negative gender stereotypes that can be harmful and demeaning to both males and females. The Waxman Report complained that some of the programs "describe girls as helpless or dependent on men" and state that men "are sexually aggressive and lack deep emotions."[137] The Ohio study, for example, found abstinence-only programs promoted the idea that boys were "without capacity to control sexual thoughts and urges" and that girls were at fault for arousing boys through their conduct and dress.[138] The Ohio study concluded that "[t]his policy of holding females responsible for their own sexual activity; the sexual desires of males; male sexual activity; and male self-esteem

places an unfair burden on females and an unfair judgment on males."[139] The Ohio study warned that "this perpetuation of inaccurate male and female stereotypes is destructive to both genders, and in the worst case may contributed to sexual violence, and unfulfilling sexual relationships. These attitudes should not be taught to or reinforced in teens, and are not scientifically or legally sound."[140]

## IV. Abstinence-Only Education Impairs a Mature Minor's Procreative Rights

Legal commentators have questioned the constitutionality of abstinence programs on a variety of grounds, but rarely are those arguments centered on the needs of youth. Instead, some have argued that the excessive religiosity of these programs violates the Establishment Clause.[141] Other have argued that the restrictions placed on grant recipients impose an unconstitutional condition on speech.[142] Paradoxically, the most compelling logical argument against abstinence-only education, namely, that America's youth are entitled to accurate and truthful sex education, is the most difficult to fashion into a legal argument to oppose abstinence-only education.[143]

The problem of framing a child-centered legal argument is likely rooted in our impoverished and ill-defined concept of children's rights in education cases. As Barbara Bennett Woodhouse has observed, educational conflicts that focus on parental rights versus state rights overshadow what ought to be a child centered approach.[144] "[W]e are so accustomed to the notion that parents have 'rights' while children have mere 'interests' that we hardly notice the yawning hole in our jurisprudence of rights."[145] She laments that educational disputes usually weigh parental private property rights in the child against the state's interest in the child as a "public resource."[146] Nevertheless, this section argues that federal funding for abstinence-only-until-marriage curricula does indeed impair recognized constitutional rights that minors enjoy related to procreative and sexual health.

The difficulty of making such an argument begins with certain concessions to existing law. Easily, the federal government has no obligation to provide sex education and could have simply stayed out of the sex education business without impairing a minor's procreative rights. Although education is an important governmental function,[147] the right to an education, let alone one of a particular quality is not regarded as a fundamental right.[148] Furthermore, while one has to wonder what interest the state might have in funding educational programs that impart false and inaccurate information, it is difficult to construct an argument that, as a general rule, the federal government must be truthful and must fund only truthful messages.[149] Moreover, the federal government certainly has a well-established prerogative to spend federal money to promote messages that it endorses over other messages.[150] Even when fundamental rights of individuals are implicated, merely refusing to fund or facilitate protected activities does not constitute an impairment of that right.[151] In order to influence public policy,

> [t]he Government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternative program which seeks to deal with the problem in another way. In so doing, the Government has not discriminated on the basis of viewpoint; it has merely chosen to fund one activity to the exclusion of the other.[152]

Since the federal government need not fund any sex education, and if it does, it can choose what message it endorses, how then might abstinence only education cross the constitutional line? Nearly thirty years ago, in *Carey v. Population Services, International,* the United States Supreme Court held that minors do enjoy the constitutional right to make procreative choices.[153] In *Carey,* New York enacted a law preventing any distribution of contraceptives to minors under the age of sixteen and limited the distribution of contraceptives to licensed pharmacists for persons over age sixteen.[154] The statute contained an

exception for physicians dispensing drugs.[155] In considering the statutory provision prohibiting the sale of contraceptives to minors under sixteen, the Court first noted that "the right to privacy in connection with decisions affecting procreation extends to minors as well as to adults,"[156] and laws that impair their privacy rights are "valid only if they serve 'any significant state interest ... that is not present in the case of an adult.'" [157] The Court concluded that the law did constitute a significant burden on a minor's access to nonprescription contraceptives, even though it allowed minors to obtain contraceptives through a physician.[158] It explained, even "less than total restrictions on access to contraceptives that significantly burden the right to decide whether to bear children must also pass constitutional scrutiny."[159] New York argued that the law served the State's interest in "discouraging early sexual behavior" and in "emphasi[zing] the seriousness with which the State views the decisions to engage in sexual intercourse at an early stage."[160] However, the Court observed that sexual activity among teens was high "with or without contraceptives," that such a law had no known deterrent effect; and that there was no evidence that "teenage extramarital sexual activity increases in proportion to the availability of contraceptives."[161]

Under *Carey*, and drawing upon the implications in recent public health publications evaluating abstinence-only education, a case against abstinence only programs can be made that is based on the rights of the minor. First, public health literature is increasingly demonstrating that abstinence only programs impair a minor's ability to make the procreative choices he or she is entitled to make because the curricula affirmatively mislead and deceive sexually active teens. Students who take abstinence only courses and then engage in sexual activity are placed at a greater health risk than other teens because they are misinformed about the effectiveness of methods other than abstinence to prevent pregnancy and STDs. They do not know the risks associated with oral and anal sex or how to avoid such risks, even though they may be under the impression that these activities are abstinent behaviors. They do not know that condoms are effective to prevent pregnancy and STDs when used properly. They do not know how to negotiate condom use with their partner. They are not prepared to use a condom when desire overcomes their pledge or promise to remain abstinent. They do not recognize the signs and symptoms of STDs. They do not appreciate what sexual behaviors have put them at risk if they have engaged in sexual activity. If they are a sexual minority, they have not been informed about their health risks or rehearsed behaviors to reduce those risks. They are not informed that preventive measures can minimize their sexual risks. They do not know that health care professionals do have advice available on practices that can reduce their heightened health risks. The silence of abstinence-only education about sexual minority health means that these youth, and their peers, do not know that human sexuality encompasses a universe of human relationships that can include them.

Thus, the right of sexually active youth to make procreative and sexual health choices is impaired by state action, more so than if the government simply had not funded any sex education at all. With the imprimatur of federal support, these programs affirmatively mislead sexually active teens and thereby impair their ability to make informed decisions and expose them to unnecessary health risks. Ignorant students might choose to educate themselves. Deceived students have no such choice because they do not know they are ignorant.

Moreover, under *Carey*, if these programs impair procreation, then the state must show the programs advance a significant state interest. It is hard to even conceive of a significant state interest in promoting an education program that is not truthful, accurate, or comprehensive. While proponents of abstinence only education worry that comprehensive information may dilute their programs, this premise has not been supported by evidence. As the American College of Obstetricians and Gynecologists has observed that "[c]areful and objective scholarly research during the last two decades has shown that sex

education does not increase rates of sexual activity among teenagers...."[162] Even if including comprehensive information about sex did encourage sexual activity, there still could be no justification to affirmatively misleading students, as many of these programs do. As both the Waxman Report and the Ohio State evaluation found, these programs suffer from pervasive inaccuracies and provide false and misleading information to students.[163] Just as New York's argument that availability of condoms might encourage sexual activity failed in *Carey*, so too would any justification advanced without proof that providing adolescents with truthful information about their own sexual health and ways to prevent disease and pregnancy would encourage adolescent sexual behavior.

## V. Conclusion

The sexuality of adolescents is a reality that schools cannot ignore. In fact, we should regard the timing of puberty within the school years as fortuitous; it presents schools with an important opportunity to prepare America's youth to make sexually responsible decisions. Studies indicate that schools can both teach the value of sexual restraint and still provide the information minors need to make sound sexual decisions without compromising the former message.

The federal decision to fund only abstinence-only education squanders the policymakers' opportunity to help schools meet the sexual educational needs of students. These curricula employ a methodology of distortion and deception that is antithetical to any legitimate state interest in education. "A democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies."[164] Sexuality programs that deny youth the accurate, truthful and complete information necessary to make sound procreative choices necessarily cannot be preparing young people to grow into fully sexually responsible citizens.

In addition, the singular focus on heterosexual marriage within these programs fails to acknowledge or give dignity to the full spectrum of human sexual expression. As Mark Yudof has observed that "[o]ur social ideal is a democratic education, one that both prepares our young people to choose for themselves and teaches them that their freedom to do so hinges on their respect and tolerance of the freedom of others to choose differently."[165]

Abstinence-only sexuality education unnecessarily harms students who become sexually active, as most will do before marriage. Since the best that can be said for abstinence-only programs is that some of these curricula may help some limited populations of students to delay sexual intercourse debut, the curricula necessarily fail *all* sexually active teens. By undermining confidence in reliable risk reduction strategies, evidence is mounting that these programs affirmatively place American teens at a greater risk than if they had not taken the course at all. Inflicting such harm must surely offend the constitutional rights of minors.

## Endnotes

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* Professor, Wm. S. Richardson School of Law, University of Hawaii. This paper was prepared for a panel at the American Association of Law Schools Education Law Section Meeting, January 5, 2006, Washington DC. Portions of this paper rely upon and are drawn from an earlier work, Hazel Glenn Beh & Milton Diamond, *The Failure of Abstinence-Only Education: Minors Have a Right to Honest Talk About Sex*, 15 COLUM. J. GENDER & L. 12 (2006).

[1] *See* JEFFREY P. MORAN, TEACHING SEX THE SHAPING OF ADOLESCENCE IN THE 20TH CENTURY, 98–117 (2000).

[2] *Id.* at 64.

[3] Professor Kenneth Karst observes:

> The "common school," as the American public school was called, has been expected from the beginning to inculcate common values. For one social group after another, that expectation has translated into a desire, and often a legislative program, to make the public schools express the group's moral values as the true national values. When our group wins a battle in the schools, we

> see ourselves as capturing part of a huge expressive apparatus that we can point toward a dual purpose. First, we expect the schools to acculturate children to Our authoritative meanings. . . . Second, we hope to capture the schools in order to reassure ourselves of Our group's status dominance as the true Americans.

Kenneth L. Karst, *Law, Cultural Conflict, and the Socialization of Children*, 91 CAL. L. REV. 967, 992–93 (2003).

[4] Moran, *supra* note 1, at 216 ("like the social hygienists at the dawn of the twentieth century, contemporary Americans have wielded the educational system as an instrument for sexual and social reform").

[5] *See infra* notes 98–103 and accompanying text.

[6] *See infra* notes 98–99 and accompanying text.

[7] *See infra* notes 99–103 and accompanying text.

[8] *See* Frank S. Ravitch, *Some Thoughts on Religion, Abstinence-Only, and Sex Education in the Public Schools*, CHILD LEGAL RTS. J., Summer 2006, at 48 (contained in this issue).

[9] *See* Eric A. DeGroff, *Sex Education in the Public Schools and Accommodation of Familial Rights*, CHILD LEGAL RTS. J., Summer 2006, at 21 (contained in this issue).

[10] Barbara Bennett Woodhouse, *Out of Children's Needs, Children's Rights: The Child's Voice in Defining the Family*, 8 BYU J. PUB. L. 321, 323 (1994).

[11] While state laws vary, teens are typically able to obtain STD testing and treatment, prenatal care, and make adoption decisions without parental authority. The Alan Guttmacher Institute tracks reproductive laws by state. *See* Alan Guttmacher Institute, *State Policies in Brief: Minors' Access to STD Services* (2005); Alan Guttmacher Institute, *State Policies in Brief, Minors' Access to Prenatal Care* (2005); Alan Guttmacher Institute, *State Policies in Brief: Minors' Rights as Parents* (2005). Abortion and contraceptive services raise more debate, and laws vary more widely here. *See* Alan Guttmacher Institute, *State Policies in Brief, Minors' Access to Contraceptive Services* (2005) and Alan Guttmacher Institute, *State Policies in Brief, Parental Involvement in Minors' Abortion* (2005).

[12] Anne-Simone Parent, et al., *The Timing of Normal Puberty and the Age Limits of Sexual Precocity: Variations Around the World, Secular Trends, and Changes After Migration*, 24 ENDOCRINE REVIEW 668, 668 (2002).

[13] *Id.* at 670.

[14] *Id.* at 669.

[15] *Id.*

[16] *Id.* at 673.

[17] C.T. Nielsen, et al., *Onset of the Release of Spermatozoa (Spermarche) in Boys in Relation to Age, Testicular Growth, Pubic Hair, and Height*, 62 J. CLINICAL ENDOCRINOLOGY & METABOLISM 532 (1986); H.E. Kulin, et al., *The Onset of Sperm Production in Pubertal Boys*, 143 AM. J. DISEASES OF CHILDHOOD 190 (1989).

[18] Moran, *supra* note 1, at 15.

[19] *Id.*

[20] *Id.*

[21] *Id.*

[22] *See* Ritch C. Savin-Williams & Kenneth M. Cohen, *Homoerotic Development During Childhood and Adolescence*, 13 CHILD AND ADOLESCENT PSYCHIATRIC CLINICS 529, 530 (2004) [hereinafter *Homoerotic Development*].

[23] Kenneth J. Zucker, *Gender Identity Development and Issues*, 13 CHILD AND ADOLESCENT PSYCHIATRIC CLINICS 551, 557 (2004) [hereinafter *Gender Development*].

[24] In one study of junior and senior high school students, researchers noted that [ten point seven percent] of students were "unsure" of their sexual orientation, and "uncertainty about sexual orientation diminished in successively older age groups." The authors commented that their "findings suggest an unfolding of sexual identity during adolescence." Gary Remafedi, et al., *Demography of Sexual Orientation*, 89 PEDIATRICS 714, 716 (1992). Zucker, studying adolescent and childhood gender identity disorder, observes increasing persistence in gender identity from childhood through adolescence, "Like other aspects of the self, ... gender identity seems to become more fixed with development; this consolidation likely contributes to the reason why there is a high rate of persistence among adolescents." *Gender Development*, *supra* note 23, at 558.

[25] *See* William D. Mosher, et al., & Centers for Disease Control, *Sexual Behavior and Selected Health Measures: Men and Women 15–44 Years of Age, United States, 2002*, at 13 (Sept. 15, 2005) (noting of five common methodologies to

estimate sexual orientation, "researchers have suggested that it is difficult to classify the U.S. population into two separate and distinct groups (heterosexual and homosexual), because each measure gives a somewhat different estimate") [hereinafter Mosher & CDC].

[26] PEGGY T. COHEN-KETTENIS & FRIEDEMANN PFÄFFLIN, TRANSGENDERISM AND INTERSEXUALITY IN CHILDHOOD AND ADOLESCENCE, 64–66, 83 (Sage Publications 2003) (noting difficulty in ascertaining prevalence); Kenneth J. Zucker, *Gender Identity Disorder, in Child and Adolescent Psychiatry*, 737, 738–39.

[27] *See* Remafedi, *supra* note 24, at 714, 720–21 (noting incongruities between "attractions, fantasies, behaviors, and perceived identities" among adolescents and cautioning that "[c]lassification of youths' sexual orientation by sexual behavior, or any other single aspect of sexuality, may be unreliable").

[28] *See* Remafedi, *supra* note 24, at 720 (observing that the percentage of students "who were unsure about their sexual orientation steadily declined with age from [twenty-five point nine percent] in [twelve] year old persons to [five percent] in [eighteen] year old students."). Zucker reports that Gender Identity Disorder in most children desists and that "homosexuality without co-occurring gender-dysphoria is probably the most common outcome." Zucker, *Gender Development*, *supra* note 23, at 557.

[29] *See* Remafedi, *supra* note 24, at 720.

[30] Mosher & CDC, *supra* note 25, at Table 7. The age of first intercourse has shifted over time. Before 1970, the average age for females was nineteen and males was eighteen. "By the late 1990s, average age at first intercourse had dropped to 15 years for both genders." Brooke E. Wells & Jean M. Twenge, *Changes in Young People's Sexual Behavior and Attitudes, 1943–1999: A Cross-Temporal Meta-analysis*, 9 REV. GENERAL PSYCH. 249, 254 (2005). Latest CDC data for 2002, reveals the age of first intercourse is increasing, but other sexual activity may be substituted, including oral and anal sex. Mosher & CDC, *supra* note 25, at 5.

[31] Wells & Twenge, *supra* note 30, at 254.

[32] *See* Joyce C. Abma, et al., & Centers for Disease Control, *Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2002* (December 2004) (reporting data form the National Survey of Family Growth).

[33] *See* Mosher & CDC, *supra* note 25, at Tables 5–6.

[34] *See* U.S. Census, *Indicators of Marriage and Fertility in the United States from the American Community Survey: 2000–2003* (reporting the average age of marriage of women as twenty-five and men as twenty-seven).

[35] <http://www.agi-usa.org/pubs/fb_10-02.pdf>.

[36] Mosher & CDC, *supra* note 25 at 5; Bonnie L. Halpern-Felsher, et al., *Oral Versus Vaginal Sex Among Adolescents: Perceptions, Attitudes, and Behavior*, 115 PEDIATRICS 845, 849 (2005) (finding that "more adolescents have had and intend to have oral sex than vaginal sex").

[37] <http://www.cdc.gov/std/stats/adol.htm>. As to heightened biological risks for STDs, the CDC notes, for example, that the structure of an adolescent female's cervix gives them an increased susceptibility to chlamydia. The CDC also reports barriers to STD prevention during adolescence, "including lack of insurance or ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality." *Id.*

[38] *Id.*

[39] <http:www.cdc.gov/hiv/pubs/facts/youth.pdf>.

[40] Jacqueline E. Darroch, *Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use*, 33 FAMILY PLANNING PERSPECTIVES 244, 244 (2001).

[41] *See* Bonnie L. Halpern-Felsher, *supra* note 36, at 849 (finding that "more adolescents have had and intend to have oral sex than vaginal sex" and observing that adolescents perceive that oral sex carries fewer social, emotional, and health risks). *See also* Child Trends Data Bank, *Oral Sex*, Sept. 15, 2005, *available at* <http://www.childtrendsdatabank.org/indicators/95OralSex.cfm>.

[42] Darroch, *supra* note 40.

[43] Jonathan D. Klein & American Academy of Pediatrics Committee of Adolescence, *Adolescent Pregnancy: Current Trends and Issues*, 116 PEDIATRICS 281, 282 (2005).

[44] Allen J. Wilcox, *Likelihood of Conception with a Single Act of Intercourse: Providing Benchmark Rates for Assessment of Post-Coital Contraceptives*, 63 CONTRACEPTION 211, 212 (2001).

[45] Klein & American Academy of Pediatrics, *supra* note 43, at 281–82.

[46] Helen Varney Burst, *Sexually Transmitted Diseases and Reproductive Health in Women, 43 J. of Nurse-Midwifery* 431, 431 (1998). For example, "Thirty to eighty percent of women with gonorrhea are asymptomatic, compared to less than five percent of infected men; eighty-five percent of women with a chlamydia infection may be asymptomatic compared with forty-five percent of infected men." *Id.*

[47] *Id.* at 431.

[48] *Id.* at 436–37 (describing the increased susceptibility of adolescent females).

[49] *Id.* at 434.

[50] STDs are more easy to acquire in females because their reproductive organs are internal and provide a conducive environment for growth of infection. In addition, "microscopic tears in the vagina mucosa that occur during intercourse provide portals of entry." *Id.* at 433.

[51] Klein & American Academy of Pediatrics, *supra* note 43, at 283.

[52] *Id.*

[53] Amitai Ziv, et al., *Utilization of Physician Offices by Adolescents in the United States, 104 Pediatrics* 35, 40 (1999).

[54] *Id.* at 40.

[55] *See*, e.g., Linda Hock-Long, et al., *Access to Adolescent Reproductive Health Services: Financial and Structural Barriers to Care*, 35 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 144, 144 (2003); Diane M. Reddy, *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 JAMA 710, 712 (2002); Rachel K. Jones, et al., *Adolescents' Report of Parental Knowledge of Adolescents' Use of Sexual Health Services and their Reactions to Mandated Parental Notification for Prescription Contraception*, 293 JAMA 340, 340 (2005).

[56] Jones, *supra* note 55, at 347.

[57] Reddy, *supra* note 55, at 713.

[58] Catlin Ryan, *Families of Lesbian, Gay, and Bisexual Adolescents, in Gay and Lesbian Issues in Pediatric Health Care*, 34 CURRENT PROBLEMS PEDIATRIC ADOLESCENT HEALTH CARE, 355, 369 (2004) (teens today may be aware of same-sex attractions around ages nine or ten, and often identify as lesbian or gay in high school—on average, between ages fourteen and sixteen).

[59] Ryan, *supra* note 58, at 374.

[60] *Id.* at 361, 364.

[61] *Id.*

[62] One study described the range of parental reactions: "[M]any parents reacted to learning about their child's lesbian or gay identity with a great deal of ambivalence. Few were initially accepting and some were openly rejected and even reacted with violence and hostility. Some youth were ejected from their homes after their parents learned about their sexual orientation." Ryan, *supra* note 58, at 370.

[63] Lynn Rew, et al., *Sexual Health Risks and Protective Resources in Gay, Lesbian, Bisexual, and Heterosexual Homeless Youth*, 10 J. SPECIALISTS PEDIATRIC NURSING 11, 12 (2005). *See also* Les B. Whitbeck, et al., *Mental Disorder, Subsistence Strategies, and Victimization Among Gay, Lesbian, and Bisexual Homeless and Runaway Adolescents*, 41 J. SEX RESEARCH 329, 330 (2004).

[64] Whitbeck, *supra* note 63, at 330. (observing that "about [twenty percent] of homeless and runaway adolescents are gay, lesbian, or bisexual in larger magnet cities (e.g., Los Angeles, San Francisco, Seattle) with perhaps a slightly lower proportion in smaller, nonmagnet cities"); Rew, *supra* note 63, at 11 (discussing previous study finding 40% of gay and bisexual adolescents have had episodes of running away from home).

[65] Whitbeck, *supra* note 63, at 330.

[66] Rew, *supra* note 63, at 12.

[67] Ryan, *supra* note 58, at 367.

[68] *Id.* at 384 (citing B.L. Frankowsky, *Sexual Orientation and Adolescents*, 113 PEDIATRICS 1827, 1827 (2004)).

[69] Jeffrey A. East & Fadya El Rayess, *Pediatricians' Approach to the Health Care of Lesbian, Gay, and Bisexual Youth*, 23 J. ADOLESCENT HEALTH 191, 192 (1998) (reporting that in their survey "only half of respondents reported having any formal training with regards to lesbian, gay, and bisexual health").

[70] East & El Rayess, *supra* note 69, at 192 (finding for example that surveyed physicians held mistaken beliefs about HIV rates, the age of coming out, suicidality).

[71] *Id. See also* Paul A.S. Benson & Albert C. Hergenroder, *Bacterial Sexually Transmitted Infections in Gay, Lesbian, and Bisexual Adolescents: Medical and Public Health Perspectives*, 16 SEMINARS IN PEDIATRIC INFECTIONS DISEASES 181, 188 (2005) (reporting studies finding that ninety

percent of pediatricians "had significant reservations about discussing sexual orientation when taking a sexual history" and that three quarters of GLB did not discuss their sexual orientation with health care providers when they were between fourteen to eighteen years of age).

[72] Ryan, *supra* note 58, at 367.

[73] Whitbeck, *supra* note 63, at 330.

[74] Joseph Kosciw, *The 2003 National School Climate Survey: The school related experiences of our nation's lesbian, gay, bisexual and transgender youth* (GLSEN 2004), at vii.

[75] Ryan, *supra* note 58, at 369.

[76] *Id. See also* Kosciw, *supra* note 74, at xi.

[77] Ryan, *supra* note 58, at 365.

[78] *Id.* at 366.

[79] *See* Theno v. Tonganoxie Unified Sch. Dist., 394F. Supp.2d 1299, 1299 (D. Kan. 2005), denying JNOV following a jury verdict in favor of Dylan Theno, the court described the failure of school officials to curb incidents of peer on peer harassment against Dylan Theno that occurred from junior high school until he dropped out of school in the eleventh grade. *See also* Perry v. Doe, 316 F. Supp.2d 809, 814 (S.D. Iowa 2004) (describing three years of harassment until student opted to be home schooled in his senior year); Ray v. Antioch Unified Sch. Dist., 107 F. Supp.2d 1165, 1166–67 (N.D. Cal. 2000) (denying summary judgment to school district and describing alleged harassment in middle school that escalated to assault and battery).

[80] *See generally* Moran, *supra* note 1, at 22, 34–40.

[81] Moran, *supra* note 1, at 32.

[82] *See generally* Moran, *supra* note 1, at 37.

[83] *Id.* at 217.

[84] *Id.* at 215–16.

[85] David C. Wiley, *The Ethics of Abstinence-Only and Abstinence-Plus Sexuality Education*, 72 J. SCH. HEALTH 164, 164 (2002).

[86] *See* Scott H. Frank, 6 (2005) <http://plannedparenthood.org/pp2/elvld/Frank-Report.doc>.

[87] David J. Landry, Lisa Kaesener & Cory L. Richards, *Abstinence Promotion and the Provision of Information about Contraception in Public School District Sexuality Education Policies*, 31 FAM. PLAN. PERSP. 280, 283 (1999) [hereinafter Landry, *Abstinence Promotion*]. For a fuller description of comprehensive sex education, *see, Guidelines for Comprehensive Sexuality Education* 20 (3d ed. 2004), *available at* <http://www. siecus.org/pubs/guidelines/guidelines.pdf>.

[88] Landry, *Abstinence Promotion*, *supra* note 87, at 283.

[89] There is a wide chasm between proponents of each approach. The Heritage Foundation, a conservative organization that supports abstinence-only education, has characterized abstinence plus and comprehensive sex education as promoting promiscuity:

> [M]ost "abstinence plus" curricula contain little or no abstinence content. Typically, comprehensive sex-ed curricula contain only a few token sentences on abstinence in a text devoted almost exclusively to promoting condom use. In reality, most of these curricula convey the message that society expects and condones widespread teen sexual activity; none conveys the message that society expects young people to avoid sexual activity throughout their teen years.

Melissa Pardue, Robert E. Rector & Shannan Martin, *Government Spends $12 on Safe Sex and Contraceptives for Every $1 Spent on Abstinence*, BACKGROUNDER No.1718, 1 (Jan. 14, 2004), *available at* <http://www.heritage.org/Research/Family/bg1718.cfm>.

On the other hand, the Sexuality Information and Education Council at the United States ("SEICUS"), a proponent of comprehensive sex education, complains that "abstinence-only-until-marriage curricula and materials [are] designed to control young people's sexual behavior by instilling fear, shame, and guilt." SIECUS Reviews Fear-Based, Abstinence-Only-Until-Marriage Curricula, <http://www.siecus.org/reviews.html> (last visited Mar. 17, 2006) [hereinafter SIECUS Reviews].

[90] David J. Landry, et al., *Factors Associated with the Content of Sex Education in U.S. Public Secondary Schools*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 261, 267 (2003) [hereinafter Landry, *Factors*].

[91] *Id.*

[92] *See* Shannan Martin, Robert Rector & Melissa Pardue, *Comprehensive Sex Education versus Authentic Abstinence: A Study of Competing Curriculum XII* (2004), *available at* <http://www.heritage.org/Research/Welfare/loader.cfm?url=/commonspot/security/getfile.cfm&PageI

D=67539>. The authors are researchers at the conservative research and education organization, the Heritage Foundation. *Id.*

[93] Douglas Kirby, *Effective Approaches to Reducing Adolescent Unprotected Sex, Pregnancy, and Childbearing*, 39 J. SEX RES. 51, 52 (2002).

[94] Klein & American Academy of Pediatrics, *supra* note 43, at 284.

[95] Landry, *Abstinence Promotion*, *supra* note 87, at 282.

[96] *Id.* Landry speculates that this estimate is likely low now, because it was measured in 1998, "well before states began implementing any abstinence-only promotion efforts of their own following enactment of the federal welfare reform legislation that guaranteed federal funds for school- and community-based programs over a five-year period." *Id.*

[97] A recent congressional report prepared for Representative Henry Waxman observed:

> Collectively these three programs reach millions of children and adolescents in the United States each year. In fact, given the scarcity of comprehensive sex education courses in the schools across much of the United States, abstinence-only education programs may be the only formal reproductive health education that many children and adolescents receive.

MINORITY STAFF OF H.R. COMM. ON GOVERNMENT REFORM 108TH CONG., THE CONTENT OF FEDERALLY FUNDED ABSTINENCE-ONLY EDUCATION PROGRAMS 3 (Dec. 2004), *available at* <www.democrats.reform.house.gov/documents/200412011-2153-SO247.pdf> [hereinafter Waxman Report].

[98] Three federal programs provide a funding stream for abstinence-only-until-marriage sex education: the Adolescent Family Life Act, 42 U.S.C. § 300z (2005) (AFLA); Section 510 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 U.S.C. § 710(b)(2)(A) (2005) (Section 510); and the Special Projects of Regional and National Significance—Community Based Abstinence Education, authorized under section 501(a)(2) of the Social Security Act (CBAE).

AFLA and Section 510 provide money to the States and contain particular matching requirements. The States direct the expenditures and can decide where to direct the federal money. SEICUS tracks federal and state expenditures on sexuality education. *See* SEICUS, State Profiles (2004): A Portrait of Sexuality Education and Abstinence-Only-Until-Marriage Programs in the States, <http://www.seicus.org/policy/states/index.html>, (last visited Mar. 17, 2006).

[99] Waxman Report, *supra* note 97, at 1.

[100] Earlier references refer to the program as Special Programs of Regional and National Significance Community-Based Abstinence Education (SPRANS). *See, e.g., id.* However, in 2005, the administration of the program was transferred to the Administration for Children and Families, Family and Youth Services Bureau and is now referred to as Community-Based Abstinence Education (CBAE). U.S. Dep't of Health and Human Services, Maternal and Child Health Bureau: Abstinence Education, <http://mchb.hrsa.gov/programs/adolescents/abstinence.htm> (last visited Mar. 17, 2006).

[101] Department of Health and Human Services Appropriations Act, Pub. L. No. 108-199, 118 Stat. 3 (2004) ("Provided further, that grants under the immediately preceding proviso shall be made only to public and private entities which agree that, with respect to an adolescent to whom the entities provide abstinence education under such grant, the entities will not provide to that adolescent any other education regarding sexual conduct, except that, in the case of an entity expressly required by law to provide health information or services the adolescent shall not be precluded from seeking health information or services from the entity in a different setting than the setting in which the abstinence education was provided").

[102] White House Office of Faith-Based and Community Initiatives, Abstinence, <http://www.whitehouse.gov/government/fbci/grants-catalog-abstinence.html>.

[103] Waxman Report, *supra* note 97, at 3. Abstinence only money received by the states could be targeted to certain school age populations or media programs, but abstinence-only might not have to be a state's singular message. *See* Helen M. Alvaré, *Saying "Yes" Before Saying "I Do": Premarital Sex and Cohabitation as a Piece of the Divorce Puzzle*, 19 NOTRE DAME J.L. ETHICS & PUB. POL'Y 7, 50 (2004) (observing

that SPRANS-CBAE allows the federal government to "[s]idestep[] some states' less-than-enthusiastic use of PRWORA abstinence money").

[104] The definition of abstinence education in 42 U.S.C. § 710 applies to all federal programs. The statute provides:

> (2) For purposes of this section, the term "abstinence education" means an educational or motivational program which—
>
> (A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
>
> (B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
>
> (C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
>
> (D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
>
> (E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
>
> (F) teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society;
>
> (G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
>
> (H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

42 U.S.C. § 710(b)(2) (2003).

[105] Community-Based Abstinence Education Project Grants (CBAE), 68 Fed. Reg. 68,632, 68,634 (Dec. 9, 2003) ("Curriculum developed or selected for implementation in the SPRANS Community-Based Abstinence Education Grants Program must address all eight elements of the Section 510 abstinence education definition and may not be inconsistent with any aspect of that definition").

[106] Waxman Report, *supra* note 97, at 22. (extensive evaluation of six programs concluded that "although they vary, these curricula share a number of common characteristics: they are based on religious beliefs, rely on fear and shame, omit important information, include inaccurate information, and present stereotypes and biases as fact") SIECUS Reviews, *supra* note 89.

[107] *See* James McGrath, *Abstinence-Only Adolescent Education: Ineffective, Unpopular, and Unconstitutional*, 38 U.S.F. L. REV. 665, 684 (2004) (arguing that as to sexual minorities, abstinence only programs are discriminatory and violate equal protection).

[108] American Medical Association, H-170.968 Sexuality Education, Abstinence, and Distribution of Condoms in Schools, <http://www.ama-assn.org/apps/pf_new/pf_online?f_n=policyfiles/HnE/H-170.968.HTM> (last visited Mar. 20, 2006).

[109] Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence, *Sexuality Education for Children and Adolescents*, 108 PEDIATRICS 498, 499 (2001).

[110] American Public Health Association, *Policy Statement, 9309: Sexuality Education* 84 AM. J. PUB. HEALTH 518, 519 (1994).

[111] AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, ADOLESCENT SEXUALITY AND HEALTH EDUCATION (2006), <http//www.acog.org/departments/dept_notice.cfm?recno=7&bulletin=3271> [hereinafter ACOG].

[112] AMERICAN PSYCHOLOGICAL ASSOCIATION, RESOLUTION IN FAVOR OF EMPIRICALLY SUPPORTED SEX EDUCATION AND HIV PREVENTION PROGRAMS FOR ADOLESCENTS (2005), *available at* <http://www.apa.org/releases/sexed_resolution.pdf>.

[113] Society for Adolescent Medicine, *Position Paper on Reproductive Health Care for Adolescents*, 12 J. ADOLESCENT HEALTH 649, 655 (1991).

[114] Press Release, National Education Association, NEA urges accurate health education: Censorship in abstinence-only programs is placing youth at risk (Oct. 8, 2003),

<http://www.nea.org/newsreleases/2003/nr031008.html>.

[115] AMERICAN SCHOOL HEALTH ASSOCIATION, Quality Comprehensive Sexuality Education, <http://www.ashaweb.org/pdfs/resolutions/Qualcompsexed.pdf>.

[116] American Association of University Women, Attacks on Reproductive Choice: Abstinence-Only Funding (2005), <http://www.aauw.org/issue_advocacy/actionpages/positionpapers/repro_abstinenceonly.cfm#4.

[117] *See* DOUGLAS KIRBY, DO ABSTINENCE-ONLY PROGRAMS DELAY THE INITIATION OF SEX AMONG YOUNG PEOPLE AND REDUCE TEEN PREGNANCY?, (2002) [hereinafter KIRBY, ABSTINENCE-ONLY].

In 1998, Congress authorized funds to evaluate Title V abstinence-only programs and, under a contract with the Department of Health and Human Services, Mathematica Policy Research is now conducting rigorous evaluation of four Title V programs. The results assessing behavioral outcomes will be available in 2006. Preliminary data evaluation showed that participants reported a more supportive attitude toward abstinence than a control group. <http://www.mathematica-mpr.com/press%20releases/abstinence.asp>.

[118] *See* DOUGLAS KIRBY, EMERGING ANSWERS: RESEARCH FINDINGS ON PROGRAMS TO REDUCE TEEN PREGNANCY (SUMMARY) 8–9, (2001) [hereinafter KIRBY, EMERGING ANSWERS], *available at* <www.teenpregnancy.org/product/pdf/emergingSumm.pdf>.

[119] The American Academy of Pediatrics Committee on Adolescence takes the position that "encouraging abstinence and urging better use of contraception are compatible goals." *See* Klein & American Academy of Pediatrics, *supra* note 43, at 284–85.

[120] KIRBY, EMERGING ANSWERS, *supra* note 118, at 8.

[121] *See* Landry, *Factors*, *supra* note 90, at 267 (noting that almost all sex education programs present abstinence as "the best option for teenagers").

[122] Patricia Goodson, et al., *Defining Abstinence: Views of Directors, Instructors, and Participants in Abstinence Only-Until-Marriage Programs in Texas*, 73 J. SCH. HEALTH 91, 91 (2003) (finding "substantial variability" in how abstinence is defined).

[123] Angela Nicoletti, *Perspectives of the Allied Health Care Professional: The Definition of Abstinence*, 18 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 57, 58 (2005) ("Programs that do not define sexual behaviors or what constitutes abstinence ... may be inadvertently exposing teens to greater risk of infection by promoting ignorance of the risk of STD transmission through non-coital sexual activity."); Lisa Remez, *Oral Sex Among Adolescents: Is it Sex or Is It Abstinence?*, 32 FAM. PLAN. PERSP. 298, 302 (2000) (reporting on studies showing disparity and imprecision among teens in defining what constitutes abstinence and observing in abstinence education programs a "lack of consensus on whether and how to specify the behaviors to be abstained from").

[124] Remez, *supra* note 123, at 300 (observing that adolescents sometimes view oral sex as safer, less intimate, and less serious but that "adolescents virtually never use condoms or dental dams to protect against STD infection during oral sex").

[125] Douglas Kirby evaluated ten studies identified by the Heritage Foundation as examples of effective abstinence programs. He noted some modest positive results in delaying initiation of sex in some limited populations. However, he observed that "there do not currently exist any abstinence-only programs with strong evidence that they either delay sex or reduce teen pregnancy." KIRBY, ABSTINENCE-ONLY, *supra* note 117, at 5–6.

[126] *See* Clara S. Haignere, Rachel Gold & Heather J. McDaniel, *Adolescent Abstinence and Condom Use: Are We Sure We are Really Teaching What is Safe?*, 26 HEALTH EDUC. & BEHAV. 43, 48 (1999); KIRBY, EMERGING ANSWERS, *supra* note 118, at 8 (observing "very little rigorous evaluation of abstinence only programs" but of three evaluated "none . . . showed an overall positive effect on sexual behavior").

[127] Haignere, *supra* note 126, at 43.

[128] In a survey of secondary schools, Landry found that 23% taught that abstinence was the only way to avoid STDs, twenty-eight percent characterized other methods as ineffective, and twelve percent did not teach about other methods at all. Landry, *Factors*, *supra* note 90, at 267.

[129] Haignere, *supra* note 126, at 46. For example, the Waxman Report described finding:

> One curriculum says that "the popular claim that 'condoms help prevent the spread of STDs,' is not supported by the data"; another states that '[i]n heterosexual sex, condoms fail to prevent HIV approximately [thirty-one percent] of the time"; and another teaches that pregnancy occurs one out of every seven times that couples use condoms.

Waxman Report, *supra* note 97, at i. In fact, this instruction contradicts the federal Centers for Disease Control's recommendation to use barrier contraceptives to prevent HIV/AIDs. *See* Centers for Disease, *Guidelines for Effective School Health Education to Prevent the Spread of AIDS*, MORBIDITY & MORTALITY WKLY, REP., Jan. 29, 1988, *available at* <http://www.cdc.gov/mmwr/preview/mmwrhtml/00001751.htm>.

[130] Haignere, *supra* note 126, at 47.

[131] The Waxman Report, for example, found "that over [eighty percent] of the abstinence-only curricula, used by over two-thirds of SPRANS grantees in 2003, contain false, misleading, or distorted information about reproductive health." Waxman Report, *supra* note 97, at i.

[132] Frank, *supra* note 86.

[133] *Id.* at 14.

[134] Peter S. Bearman & Hanna Brückner, *Promising the Future: Virginity Pledges and First Intercourse*, 106 AM. J. SOC. 859, 900 (2001).

[135] *Id.* at 899–900.

[136] Hannah Brückner & Peter Bearman, *After the Promise: The STD Consequences of Adolescent Virginity Pledges*, 36 J. ADOLESCENT HEALTH 271, 277 (2005). "[A]lthough pledgers experience sexual debut later than others, most of them will eventually engage in premarital sex. Those who do report lower frequency of condom use at first intercourse. Those who do not are more likely to substitute oral and/or anal sex for vaginal sex." *Id.* Moreover, condom use at first intercourse is a strong indicator of consistent use, raising the question whether these programs reinforce unhealthy practices. *Id.* at 276.

[137] Waxman Report, *supra* note 97, at 17–18.

[138] Frank, *supra* note 86, at 18.

[139] Frank, *supra* note 86, at 19.

[140] *Id.*

[141] *See, e.g.*, Gary J. Simson & Erika A. Sussman, *Keeping the Sex in Sex Education: The First Amendment's Religion Clauses and the Sex Education Debate*, 9 S. CAL. REV. L. & WOMEN'S STUD. 265, 297 (2000) ("respect for the Establishment Clause principles embodied in the endorsement test strongly suggests that the time is ripe for challenging abstinence-only programs in courts on both purpose and effect grounds"); Julie Jones, *Money, Sex, and the Religious Right: A Constitutional Analysis of Federally Funded Abstinence-Only-Until-Marriage Sexuality Education*, 35 CREIGHTON L. REV. 1075, 1105 (2002).

[142] McGrath, *supra* note 107, at 690 (arguing "SPRANS-CBAE violates both the Establishment Clause and also the unconstitutional conditions doctrine with its impermissible restrictions on speech").

[143] Sexually minority youth may also have an equal protection claim because these curricula ignore their needs altogether. *See, e.g.*, McGrath, *supra* note 107, at 684 (arguing that even under a rational basis test, "[a]bstinence-only-until-marriage education programs deny the rights of gay and lesbian adolescents to receive equal protection under the law").

[144] Barbara Bennett Woodhouse, *Speaking Truth to Power: Challenging "The Power of Parents to Control the Education of Their Own"*, 11 CORNELL L.J. & PUB. POL'Y 481, 500–01 (2002).

[145] *Id.* at 485.

[146] Barbara Bennett Woodhouse, *Who Owns the Child?: Meyer and Pierce and the Child as Property*, 33 WM. & MARY L. REV. 995, 1117 (1991).

[147] *See, e.g.*, Wisconsin v. Yoder, 406 U.S. 205, 213–14 (1972) (public education is both a state "interest" and "high responsibility"); Ambach v. Norwick, 441 U.S. 68, 77 (1979) (characterizing public education as an "assimilative force" that "inculca[tes] fundamental values necessary to the maintenance of a democratic political system").

[148] *See, e.g.*, San Antonio Indep. Sch. Dist. v. Rodriquez, 411 U.S. 1, 35 (1973) (observing that while education is an important government function, education is not a fundamental right); Plyer v. Doe, 457 U.S. 202, 223 (1982) (noting that education is not a fundamental right).

[149] *See* Nancy Tenney, *The Constitutional Imperative of Reality in Public School Curricula: Untruths About Homosexuality as a Violation of the First Amendment*, 60 BROOK. L. REV. 1599, 1631–33 (1995) (opining that although "[c]ourts have not addressed directly the theory that inaccurate

or misleading information violates the freedom of speech and the right to receive information," such a right is inherent to the purposes of democratic education and First Amendment principles).

[150] Rust v. Sullivan, 500 U.S. 173, 201 (1991) ("[A] Legislature's decision not to subsidize the exercise of a fundamental right does not infringe the right") (quoting Regan v. Taxation with Representation of Wash., 461 U.S. 840, 849 (1983)).

[151] *Rust*, 500 U.S. at 173 (quoting Harris v. McRae, 448 U.S. 297, 317 (1980)).

[152] *Id.*

[153] Carey v. Population Services, Int'l, 431 U.S. 678, 693 (1977).

[154] *Id.* at 681.

[155] *Id.* at 682.

[156] *Id.* at 693.

[157] *Id.* (quoting Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 75 (1976)).

[158] *Carey*, 431 U.S. at 697.

[159] *Id.*

[160] *Id.* at 697–99.

[161] *Id.* at 695–96.

[162] ACOG, *supra* note 111.

[163] Waxman Report, *supra* note 97, at i–ii; Frank, *supra* note 86, at 3.

[164] Prince v. Mass., 321 U.S. 158, 168 (1944).

[165] MARK YUDOF, WHEN GOVERNMENT SPEAKS: POLITICS, LAW, AND GOVERNMENT EXPRESSION IN AMERICA 55 (1983).