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Key Questions for Consideration as a New Federal Teen Pregnancy Prevention Initiative Is Implemented

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The federal government spent well over $1.5 billion over the past decade, including mandatory matching grants from the states, to promote education programs focused solely on promoting abstinence outside of marriage that provide either no information or negative information about contraceptives and contraceptive use. But even as funding for these rigid programs grew with the strong support of the Bush administration and social conservatives, so did evidence of their failure either to stop teen sex or to help teens adopt protective behaviors when they do become sexually active.

Legislation approved by Congress and signed into law by President Obama in December 2009 promises a significant shift away from this type of rigid programming. Gone is funding for programs that had to conform to the infamous, eight-point statutory definition of an eligible "abstinence education" program, which required teaching "that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects" and that "a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity." Gone, especially, is the overarching requirement that a fundable program have nonmarital abstinence promotion as its "exclusive purpose." To not run afoul of this statutory mandate, funded programs had the choice of either remaining silent on contraception or discussing contraceptive use only in a way to emphasize its potential for failure. In the place of all this is a new teenage pregnancy prevention initiative championed by the White House that will focus on programs required to be age-appropriate, medically accurate and based on research demonstrating their effectiveness.

It is now up to the administration to develop a plan to implement this important new initiative. In doing so, however, it will need to address a number of questions—the answers to which will be key to the initiative's success.

The Teen Pregnancy Prevention Initiative

As part of his first budget, Obama proposed and Congress approved essentially intact a $114.5 million teenage pregnancy prevention initiative, designed as a competitive grant program, aimed at reducing the risks of pregnancy. Under this effort, $75 million would be reserved for replicating programs "proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors." The bulk of the remaining funds (not less than $25 million) would be available for research and demonstration grants to test new models and approaches that have shown promise.

Report language accompanying the spending bill, which explains what Congress intended this provision to accomplish, stipulates that "a wide range of evidence-based programs should be eligible" for the larger pot of funds. Further, all programs funded under this initiative must "stress the value of abstinence and provide age-appropriate information to youth that is scientifically and medically accurate." Beyond this, however, Congress was silent on the specific content of these programs or the subjects that should be taught.

The new initiative will be administered by a newly created Office of Adolescent Health within the Department of Health and Human Services (DHHS), working in cooperation with the Administration for Children and Families, the Centers for Disease Control and Prevention and other relevant DHHS agencies. Unlike the Community-Based Abstinence Education (CBAE) program, which provided funds exclusively to local organizations, including faith-based groups, the new teen pregnancy prevention initiative is open to "public and private entities," inviting applications from a wide range of not-for-profit organizations, community groups, for-profit companies, school districts, local governments, tribes and others.

Implementation Questions

The Office of Adolescent Health will oversee the effort to interpret the law and is expected to issue a funding announcement later this spring that will provide more specificity at the program level for how to achieve the initiative's goals. In determining which programs are eligible for funding, administration officials will need to answer such questions as what defines a program as effective or promising? What is age-appropriate information? And what is a scientifically and medically accurate program?

Effective or Promising

In determining which programs or groups of programs are (or are not) effective, it is important to think about both the reliability of the study and the magnitude of the impact. In *Emerging Answers 2007*—a comprehensive review of the impact evaluations of more than 100 teenage pregnancy prevention programs across the country—researcher Douglas Kirby identifies 14 criteria for judging the quality of research methods and evidence. The only good way to gauge the strength of the evidence, says Kirby, is by examining the research methods used to evaluate the programs. Is the research design strong enough to establish causation? Is the sample size sufficient and did the researcher select an appropriate group for study? Is the time frame of the study long enough to detect an impact, including effects that are not apparent in shorter periods of time? The magnitude of success is also important. Which populations were impacted and for how long? Were the results statistically significant and were the improvements enough to justify replicating the program?

Based on these criteria, Kirby found that a large body of evidence shows that more comprehensive approaches—those that encourage abstinence, but also contraceptive use for young people who are having sex—can be effective in helping young people do both. "Two-thirds of the 48 comprehensive programs that supported both abstinence and the use of condoms and contraceptives for sexually active teens had positive behavioral effects," writes Kirby. Many either delayed or reduced sexual activity, reduced the number of sexual partners or increased condom or contraceptive use. Kirby concludes, "Emphasizing both abstinence and protection for those who do have sex is a realistic, effective approach that does not appear to confuse young people."

Rigid, moralistic abstinence-only programs of the type promoted under previous federal policy, on the other hand, are a failed experiment: A strong body of research has shown that they simply do not work either to delay sexual activity or to increase contraceptive use when teens do begin to have sex. Chief among these is a nine-year, $8 million congressionally mandated study, released in 2007, that closely examined four federally funded abstinence-only programs considered by state officials and abstinence education experts to be especially promising. After following more than 2,000 teens for as long as six years, the evaluation found that even in these promising programs, individuals who received abstinence instruction were no more likely than those who did not to abstain.

These findings were consistent with a number of other comprehensive reviews of sex and HIV education programs. Notable among these are studies examining the effectiveness of virginity pledges, which are the centerpiece of many abstinence education programs. According to the most recent of such studies, published in the January 2009 issue of *Pediatrics*, teens who take virginity pledges are just as likely to have sex as

those who do not, but are less likely to use condoms or other forms of contraception when they become sexually active. This study builds on past research showing that although virginity pledges may help some teens to delay sexual activity, teens who break their pledge are less likely than teens who do not pledge to use contraceptives and to get tested for sexually transmitted infections (STIs), and may have STIs for longer periods of time.

This is not to say that no intervention focusing only on abstinence can ever work for any population under any circumstances. A well-designed study published earlier this year found that a "theory-based" abstinence-only intervention aimed at very young, African-American adolescents did successfully delay sexual initiation among participants in the program. The evaluation adds important new information to the question of "what works" in sex education—and, indeed, this type of program would be eligible to compete for funding under the new teen pregnancy prevention initiative—but it essentially leaves intact the significant body of evidence demonstrating that abstinence-only-until-marriage programming that met previous federal guidelines is ineffective (see box).

Age-Appropriate

Because adolescence is a time of rapid change, it is critical that sex education interventions adapt to the needs of young people as they change. Although some say that all unmarried teens should simply be taught to abstain because sex outside of marriage is always wrong, other experts argue that once a significant proportion of students are having sex, sex education programs should progressively include more information about contraceptives and less about abstinence. "In every school district, there is some grade level where very few, if any, students are having sex," said Kirby in a 2007 interview. "At this grade level, emphasizing only abstinence—without denigrating condoms or other forms of contraception—may be appropriate. However, I do oppose programs in schools that only address abstinence in grades where some teens are having sex. Once 10% to 20% of students in a given school district are beginning to have sex, I believe they have the right to accurate and balanced information about abstinence, condoms and other forms of contraception. Furthermore, from a public health standpoint, they should be given information, as well as the skills and access to condoms and contraception, so that they are more likely to use protection if they do have sex."

Medically Accurate

The Office of Adolescent Health will need to adopt requirements for medical accuracy for programs funded under the initiative. John Santelli, department chair and professor of clinical population and family health at Columbia University's Mailman School of Public Health, has studied the process by which health professionals and U.S. government advisory groups reach scientific consensus and review the legal requirements and definitions for medical accuracy. In a 2008 *American Journal of Public Health* article, Santelli proposes a definition of medically accurate information that incorporates an understanding of the scientific process. Medically accurate information, he says, is information "relevant to informed decision-making based on the weight of scientific evidence, consistent with generally recognized scientific theory, conducted under accepted scientific methods, published in peer-reviewed journals and recognized as accurate, objective and complete by mainstream professional organizations....The deliberate withholding of information that is needed to protect life and health (and therefore relevant to informed decision-making) should be considered medically inaccurate."

This last point is particularly important given the recent experience with federally funded abstinence-only programs that were prohibited from discussing the potential benefits of contraception, lest they be seen as violating the requirement that these programs exclusively promote abstinence. Santelli says efforts to promote abstinence by disparaging condoms and other contraceptive methods are unethical: "If adolescents are sexually active—or will be shortly—they need information to protect their health and lives. Where there is a need to know, medically incomplete is medically inaccurate." In that light, it is

An Effective Abstinence-Only Program?

At long last, a rigorously evaluated intervention focused solely on abstinence has demonstrated a significant delay on initiation of teen sexual activity. The study by John B. Jemmott and colleagues published in the February 2010 issue of Archives of Pediatrics & Adolescent Medicine *followed 662 African-American students in grades six and seven (with an average age of 12) for two years after their participation in several program interventions. One-fifth had been randomly placed in an abstinence-only program, whereas others had been assigned to a more comprehensive program that encouraged abstinence and condom use. Another group, which served as the control group, was assigned to an intervention promoting general health.*

According to the study, 33% of the students in the abstinence-only program who were sexually inexperienced at the start of the study had had sex two years after completing the program; 47% of comparable students in the control group became sexually experienced during the two-year follow-up. Thus, the abstinence-only program significantly reduced the rate of sexual initiation relative to the control group.

This is not to say that the comprehensive approach failed, said Jemmott in an interview with the Philadelphia Inquirer. *The difference in delaying sex between participants who completed the comprehensive class and those who completed the abstinence class was small and not statistically significant. So, it is accurate to say that they performed comparably, said Jemmott.*

Moreover, Jemmott and his colleagues took pains to point out that the abstinence-only program they tested was a far cry from and would not have met the restrictive federal criteria for programs that, until this year, were eligible for federal abstinence-only-until-marriage funding. Unlike those programs, the abstinence program in this study did not promote abstinence until marriage, but rather until students are older and can handle the consequences of sex. Moreover, according to the study's authors, "The intervention did not contain inaccurate information, portray sex in a negative light, or use a moralistic tone. The training and curriculum manual explicitly instructed the facilitators not to disparage the efficacy of condoms or allow the view that condoms are ineffective to go uncorrected." Therefore, the evaluation does not contradict the strong body of evidence that rigid abstinence-only-until-marriage programs of the type previously funded under federal law do not work: "The results of this trial should not be taken to mean that all abstinence-only interventions are efficacious."

The Jemmott study demonstrates that a "theory-based" abstinence-only program tailored to the specific needs of very young African-American adolescents can be effective in delaying sexual initiation. This is obviously good news, especially as this is a group of young people at especially high risk of sexually transmitted infection and unplanned pregnancy. And yet the facts remain that 20% of participants in the abstinence-only program had been sexually active before the program started and one-third of those who had been sexually inexperienced ended up having sex by the two-year follow-up. This is hardly surprising. Although sexual activity is relatively rare among very young adolescents (but somewhat higher among African-American youth), it is more common among older teens: About one-quarter of all teens have sex by their 16th birthday, including half of black males. Therefore, the enduring challenge lies in helping teens, especially young teens, delay sexual initiation, while also preparing them with the information and skills needed to protect themselves and their partners when they do become sexually active. In the words of the study's authors, "Theory-based abstinence-only interventions might be effective with young adolescents but ineffective with older youth or people in committed relationships. For the latter, other approaches that emphasize limiting the number of sexual partners and using condoms, including the comprehensive interventions used in this trial, might be more effective."

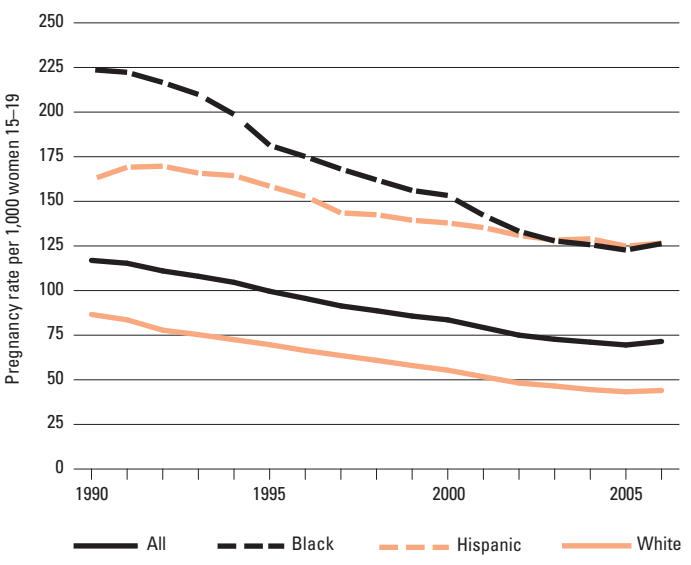
critical to ensure that the information provided about condoms and contraceptives in programs funded under the initiative is inclusive of not only the imperfections and limitations of these technologies, but also their effectiveness when used consistently and correctly in preventing pregnancy and disease, as well as their corollary health benefits. (Use of the pill, for example, prevents ectopic pregnancy and decreases women's risk of endometrial cancer, ovarian cancer and benign breast tumors.) Withholding such "positive" information should be considered, per se, inaccurate, and denigration of condoms or contraceptives, directly or indirectly, preemptively prohibited.

Devil in the Details

New data from the Guttmacher Institute show that following a steep decline in the 1990s and a flattening out in the early 2000s, teen pregnancy rates increased among all ethnic and racial groups between 2005 and 2006 (see chart). Among all teens, the increase was 3%, and it reflected increases in both teen pregnancies resulting in births and those resulting in abortions. Earlier research had documented that the significant drop in teen pregnancy rates in the 1990s overwhelmingly had been the result of more and better use of contraceptives among sexually active teens. However, this decline started to stall out in the early 2000s, at the same time that abstinence-only programs became more widespread, teens were receiving less information about contraception in schools and their use of contraceptives was declining.

DISTRESSING TREND

Teen pregnancy rates declined among all racial and ethnic groups between 1990 and 2005, but then reversed in 2006.



Source: Guttmacher Institute, 2010.

In that sense, the administration's new teen pregnancy prevention initiative could hardly be getting off the ground at a more propitious time. This is not to say that it is immune to criticism—from either the right or the left. Obviously, it is a huge set-back for proponents of the kind of rigid, moralistic abstinence-only programming funded so generously over the past decade. Although still eligible for federal support, interventions seeking to focus solely on abstinence—as indeed all interventions—must now compete for funding and, first and foremost, demonstrate that they are either proven or at least promising. But in some ways, the new initiative is something of a disappointment to proponents of comprehensive sex education, who argue that by focusing narrowly on teenage pregnancy prevention, the administration has missed an opportunity to endorse truly comprehensive sexual health approaches designed not just to prevent negative outcomes like teen pregnancy, but to promote healthy behaviors and relationships among all young people.

Nevertheless, the new initiative is an important victory for and vindication of evidence-based policymaking, and with its enactment, the heyday of federal funding for rigid abstinence-only programming has finally come to an end. Social conservatives may be expected to attempt to restore a dedicated funding stream for such programming (and, in fact, the Senate but not the House version of the still-pending health care reform legislation includes an annual $50 million in such grants to states through FY 2014). Even if such efforts were successful, the vast majority of federal dollars would still be programmed in the other direction. This turnaround comes after years of debate as the case against rigid abstinence-only education mounted—debate not just in Washington, but at the state level as well (see

State Sex Education Policies in Transition

The federal government is not alone in grappling with questions around the content of sex education programs. Debates over what kind of information teens should get in schools have been playing out in state governments for decades. As the level of concern over teenage pregnancy—and later AIDS—increased in the 1970s and 1980s, so did the number of states that had policies requiring or encouraging the teaching of sex education. Today, 35 states and the District of Columbia require that public schools teach some form of sex or STI/HIV education. And most, including some that do not mandate the instruction itself, also place requirements on how abstinence or contraception should be handled when included in a school district's curriculum. Currently, this guidance is heavily weighted toward stressing abstinence; in contrast, although many states allow or even require that information about contraception be covered, none require that it be stressed.

More recently, as the case against the effectiveness of rigid abstinence-only-until-marriage programming mounted, policymakers in several states were taking steps toward requiring that sex education within their borders be more comprehensive. One manifestation of this is that in the last few years, a number of states had declined to participate in the federally funded abstinence-only program, which provided an ongoing guarantee of $50 million annually to the states for abstinence education programs that had to conform to a highly restrictive eight-point definition enshrined in Title V of the Social Security Act. By the time the Title V abstinence-only program expired in June 2009, roughly half the states had declined to apply for funds under the program.

Meanwhile, the number of states that have acted to require state-supported sex education to be both "medically accurate" and "age-appropriate" has proliferated. Between 2007 and 2009, policymakers in six states (Colorado, Hawaii, Iowa, North Carolina, Oregon and Washington) adopted new requirements that sex education be both medically accurate and age-appropriate. And this trend continues: Wisconsin this year adopted a measure that amends the state's sex education law to ensure that programs be medically accurate and age-appropriate, and teach students about contraception and abstinence. Fifteen states overall have medical accuracy requirements, and 27 states and the District of Columbia require sex education to be age-appropriate.

box). That said, it remains to be seen just how robust and successful the new initiative will be. It is now up to administration officials to draft the rules and regulations that will determine the parameters of the program and begin to get money out the door to programs around the country. In light of the recent increase in teen pregnancy rates after a long period of decline, public health advocates are hoping for the best as they seek to hold the administration accountable, seize this moment of change and make the most of it. www.guttmacher.org

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