Advocacy Kit

General Advocacy Components  •  Sexuality Education
HIV/AIDS Prevention  •  SBHCs  •  Abortion
Pregnancy Prevention
Contents

• Advocating for Adolescent Reproductive and Sexual Health

• The Role of Coalition Building in Community Education and Advocacy

• Working with Teens

• Involving Religious Communities in Advocacy Campaigns

• Education and Media Campaigns

• Lobbying: The Art of Persuasion

• Responding to Opposition and Criticism

• Common Questions About Sexuality Education

• Common Questions About School-Based and School-Linked Health Centers

• Common Questions About Contraceptive and Condom Availability Programs

• The Needs Assessment

• The Resource List

• Sample Testimony: Advocates for Youth’s Statement Before the President’s Council on Sustainable Development
GENERAL ADVOCACY

COMPONENTS
Advocating for Adolescent Reproductive and Sexual Health

Advocacy is critical in efforts to ensure that adolescent reproductive and sexual health programs are enacted, funded, implemented and maintained. Advocacy (like lobbying) seems intimidating to many—but the idea is more frightening than the activity. All advocacy involves is making a case in favor of a particular cause using skillful persuasion and/or strategic action. In other words, advocacy simply means actively supporting a cause, and trying to get others to support it as well.

Advocacy involves attempts to influence the political climate, public perceptions, policy decisions and funding determinations in order to improve adolescent reproductive and sexual health. Advocates work not only to promote a defined solution, but also to defeat unacceptable proposals.

Advocacy takes many forms. A comprehensive advocacy campaign will first and foremost influence political support for a program by educating policymakers. Depending on the situation, policymakers can include national, state or local legislators; county or city council members; school board members; or anyone else in a position to promote or reject proposals that you care about. Another important target for advocacy campaigns is the public, since public desires affect political decisions. A campaign aimed at the public could target a general community or a specific group such as parents in a particular neighborhood.

The only prerequisite to being an advocate is being committed to the issue at hand. Too often, people who work with and for youth do not see themselves as appropriate advocates because they are not lobbyists for their organizations. In fact, staff of youth-serving and community-based agencies, teachers, health care professionals, parents and teenagers can be articulate and compelling advocates for teen health programs. First-hand experience in helping young people build skills, education and motivation to make responsible choices about sexuality provides a remarkable body of expertise that can, and should, be more available to the policymakers.

This Advocacy Kit contains information on the basic components of an advocacy campaign. Specific sections address working in groups to achieve your goals (Coalition Building in Community Education and Advocacy), promoting your goals to the public (Education and Media Campaigns) and influencing the legislative process in your favor (Lobbying: the Art of Persuasion).

In addition, the Kit includes a list of organizations concerned with adolescent reproductive and sexual health, sample press materials, information for addressing criticism and opposition, a sample needs assessment and other materials about specific adolescent health issues.

The staff of Advocates for Youth hopes this information is useful to you in promoting teen health in your community. Please call (202) 347-5700 if you have questions, or require further information.
Organizations and Groups to Involve

- young people
- school faculty and staff, including health educators and nurses, teachers’ unions
- public and community health professionals and officials
- social service agencies
- adolescent pregnancy prevention organizations
- family planning providers
- youth-serving agencies
- religious leaders and organizations
- racial and ethnic associations
- civil rights groups
- gay and lesbian advocacy groups
- local chapters of national advocacy organizations
- civic groups
- elected officials
- AIDS prevention and service organizations
- school-based and school-linked health center staff
- child abuse and neglect groups
- women’s groups
General Advocacy Components
Coalition building and public education play vital roles in implementing policies and programs for adolescent reproductive and sexual health. Coalitions provide a structure for allied groups to pursue a unified goal, coordinate strategies, pool resources. Broad-based coalitions demonstrate wide support for particular policies or programs.

Coalitions can serve the purpose of educating policymakers and the public regarding adolescent reproductive and sexual health services. Coalition members act to lobby policymakers, write letters to the editor, speak with the press, attend community meetings and give public testimony. By so doing, policymakers and the public are afforded accurate and compelling information regarding adolescent health and are therefore more likely to demonstrate support for related policies and programs. Coalitions act to mobilize this support, demonstrating to policymakers that constituents care about improving or maintaining adolescent access to sexuality education and health services. Coalitions also provide a powerful counterpoint to organized opposition.

The following are some basic tips for creating and maintaining a coalition. Activities through which the coalition can promote adolescent reproductive and sexual health programs and policies are also included.

There are four steps to increasing community involvement and building support for adolescent reproductive and sexual health programs:

- Work in coalition
- Conduct research
- Prepare materials
- Conduct educational campaigns

The following explains each step in greater depth.

**Step 1: Work in Coalition**

Coalitions are invaluable because they bring people and resources together from all sectors of the community and provide visible signs of community support. Working in a group helps increase quality as well as the quantity of work, and prevents burnout by spreading responsibilities. Coalitions allow individuals and groups to contribute their unique expertise, as well as to educate and mobilize their particular constituents. Coalitions can help identify genuine concerns and engage in group problem-solving. Once a program is implemented, coalition members are ideal for providing services and resources for program operations.

Coalitions are hard work, however. Keep in mind the following pitfalls and work to minimize the usual problems found in coalitions:

- Coalition members’ interests may conflict
• Building consensus is a time-consuming process
• Logistics become more complicated
• Guidelines for Effective Coalitions.

**Develop a statement of purpose and goals.** The “statement of purpose” can be broadly worded to reflect the philosophy of the coalition and permit a wide range of groups to participate. “Goals” should be specific, achievable and measurable. An organization’s membership in the coalition symbolizes their commitment to the goals, and is indicated by endorsement of the coalition’s statement of purpose.

The statement of purpose should be broad, but not so broad that groups who would actively impede the overall purpose are eligible to be members. For example, if the coalition seeks comprehensive sexuality education, a group that opposed any discussion of abortion would not be an appropriate member. The coalition could work with non-member groups on other projects, but without jeopardizing the strategic work of the coalition.

The statement of purpose is also a place to clarify that your program is comprehensive and to address obvious criticisms. Highlight program components such as “involving parents” and “promoting abstinence” to forestall criticism and prevent misunderstandings. For example, a coalition seeking comprehensive sexuality education might adopt a statement of purpose that the coalition seeks sexuality education which includes information about abstinence and the full range of family planning options, as well as builds skills to communicate with parents and peers about sexuality.

**Establish a structure and leadership roles.** Coalitions are most effective when all members have a voice and know they will be heard. Creating maximum involvement does not negate, however, the need for organized leadership and structure.

**Select leaders.** Choose chairs and clearly define their responsibilities. It often helps to have co-chairs whose skills complement each other and who represent organizations willing to commit significant time and/or resources to coalition efforts. Roles can be shared or rotated.

**Create a broader leadership team** that includes representatives of the major interest groups. A diverse team will be more successful in providing effective leadership on an issue as complex and multi-faceted as teen reproductive and sexual health.

**Select spokespeople who will represent the coalition to the media.** These should be people with experience in interacting with the media, who are comfortable in that role. The spokespeople may or may not be the same people as the leadership team, but this may simplify communication. One of your spokespeople should be an articulate teenager. Agree on a process for handling media requests and opportunities.

**Share responsibilities for the work through task forces or committees.** These allow more people to become invested in the group, and can either be permanent or just for a specific project. Define responsibilities and the decisions that can be made without the broader coalition.
Create and follow a realistic timeline. Rome wasn’t built in a day. A realistic and strategically-developed timeline is one of the most important tools for a coalition. Some of the most successful programs take over a year to be implemented. A realistic timeline with targeted activities every month will help ensure the coalition remains focused and realistic in its expectations. Short term activities could include bringing 10-15 new organizations into the coalition; a medium-term goal could be the introduction of legislation supporting your program; a long-term goal is the passage of that legislation.

Establish a coalition identity. A coalition is more than the sum of its parts. To establish identity and generate excitement for the goals, members need to see how they fit in. Letterhead stationery listing coalition members and an updated membership list fosters ownership and the respect of those who receive coalition communications.

Be explicit about how decisions will be made. Coalitions often make decisions by consensus. This doesn’t mean that everyone has to agree on everything. Rather, a majority agrees and no one feels so strongly opposed that they would veto or publicly oppose the effort. Decide what will happen if consensus cannot be reached. Decide which decisions will be made by the leadership team and which are so important or sensitive that the entire membership needs to be involved. Determine in advance what issues must come before the entire coalition and how the coalition will make decisions quickly.

Hold regular meetings. Meetings should be held frequently enough to respond to current situations, and can be scheduled weekly, bi-monthly or monthly. Hold meetings at a convenient time and location; start and end on time. Consider whether meeting times should rotate between day and evening hours and between locations.

Keep people informed. Maintain up-to-date mailing, phone and fax lists of coalition members and key contact persons. Keeping members informed maintains trust, interest and involvement. It also minimizes misunderstandings and identifies points of disagreement before they become problems. Coalition members should receive minutes from meetings, updates, press articles and information on future events. Advance notice of meetings and other events encourages participation in important discussions and decisions.

Expand your base. The number and range of groups coalitions attract reflect their success. The public and politicians will judge the strength of the cause by the coalition list, both who is involved and who is missing. Teens are clearly the group most affected by this issue, yet they are often left out of the advocacy and planning process. Other groups to approach are listed in the box.

Ensure that these groups are aware of the problem. The coalition seeks to address and that they understand the need for action. Make clear how they will benefit from being part of the coalition effort. Give them an easy way to join the coalition and support your program as a part of the solution. Outreach through members’ organizational resources (newsletters, meetings, staff) to educate and enlist more support for your coalition goals. As each new group joins, add them to the coalition stationary and list of supporters.

Involve youth. Articulate and committed young people help the coalition
remain true to its mission. Moreover, youth are excellent spokespeople for programs designed to address their needs. Young people can also organize students and other young people to support the program. Many community groups already work closely with youth and should be targeted for involvement with the coalition. Teens know their peer opinions and needs better than most adults; be open to young people’s suggestions, and seek their input. Involve youth in meaningful ways, and encourage them to represent the coalition to the media.

**Develop materials.** Create 1-2 page materials describing the problem you are concerned about and the proposed program’s ability to address it. Compile a larger packet of materials that can be distributed to the community and to the media. See Step 3 (below) for more information on what types on information to create.

**Develop educational campaigns.** In order to win support for your program, you must be ready to advocate on its behalf. Survey the policymakers who will be involved in approving, funding and implementing your program, and start educating them. Start with firm supporters and move on to moderates and undecideds. Coalition members can testify at hearings, organize letter-writing campaigns, write letters to the editor, etc. Refer to the Lobbying and Media handout as well as the Public Education Campaign section below.

**Monitor planning and implementation of the program.** Once legislation has been passed, the expertise of coalition members can be useful in design and implementation. Members may be asked to sit on the design team or advisory committee, provide education in classrooms, train program staff, develop written or visual materials or accept referrals for other services.

**Step 2: Conduct Research**

Poll after poll shows that most Americans support adolescent reproductive and sexual health programs. Those who are not initially supportive usually need more information to convince them to be proponents. They may just need to understand why the program is important and what its components are in order to become supporters, or they may have specific questions or concerns that can be easily answered. Others need to feel that representatives from their community have been involved in developing the program in order to become its champions.

Three types of research are necessary in order to answer these questions and maximize public support.

**Prepare a needs assessment.** The coalition cannot build support for a program unless it can make a compelling case for why this program or policy is needed, and what its effect will be. This analysis is typically called a “needs assessment.” Research the situation in your community and make comparisons with national rates. What has changed over time? A list of needs assessment components is included in this packet.

**Asses the current political situation.** The coalition cannot work effectively for change without understanding the political environment and the players. Who does the coalition need as a supporter of the program, and
what is their background and viewpoint? What policymaking body will make this decision, and what is its structure for doing do? Who is running in upcoming elections, and how will their success affect program implementation?

**Know the opposition.** Strategic planning for program success must include an understanding of what opposition the program will face, and from where this opposition will come. Research the most likely concerns and criticisms to be raised and prepare in advance to respond with current research and facts. Answers to the most common questions about specific adolescent reproductive and sexual health programs are included in this packet.

It is vitally important to anticipate organized opposition from extremist conservatives. Programs designed to address sexual and reproductive health are a flash point for extremist groups, and may generate vocal and sustained criticism. The Extremists effectively publicizes misinformation about adolescent reproductive and sexual health which must be corrected if the public is going to support programs under attack.

Research any extremist group affiliates in your community and collect their materials on the issue at hand. Find out which decisionmakers are associated with these groups and what their arguments are likely to be when approached about proposed programs. Information on the Far Right’s most common misinformation tactics is included in this packet, along with an overview of extremist groups.

**Step 3: Prepare materials**

Advocacy is easier if the coalition has gathered or created information persuasive to groups being approached for support. Materials may be created for specific audiences whose concerns vary, since parents, the press, legislators, business people and teens will be interested in and/or concerned by different aspects of the problem at hand and the coalition’s suggested solution. Leave materials behind whenever coalition members visit policymakers or other interested groups.

Educational pieces should be short, easy to read and to the point. They should explain the need for the program as well as describe the program’s components and its intended effects. Educational materials are an appropriate place to respond to questions, concerns and misinformation about the program. (See the Media section for more information on press-related materials and the Needs Assessment for useful data.)

Materials to create:

- Information about the coalition: list of members, statement of purpose and goals
- National, state and/or local statistics on adolescent reproductive and sexual health connected to the proposed program or policy, such as rates of sexual activity, lack of access to medical care, rates of pregnancy, reported AIDS and STD cases
- Factual information that describes the local situation, explains why the proposed program or policy is necessary and describes its intended effects
Step 4: Plan and Conduct Education Campaign

A successful strategy for program implementation must include education targeting three distinct groups that, while distinct, influence one another: policymakers, the public and the media. Without public support, policymakers will be reluctant to back potentially controversial programs. Media coverage educates the public about the need for and structure of the proposal. An educated public is more likely to press for political support of the program. Without political support, the program cannot succeed, particularly when legislative approval is required. Specific educational activities are listed later in this section.

Ensure that factual information presented in clear and accessible language reaches the public BEFORE misinformation about a proposed program does. Communicate about why the program is needed, what the program goals are, how teens will benefit from it and how the public can observe and participate in the program. Never let a communication void be filled by misleading, inaccurate information; instead, reach out with information before there is a crisis of communication and public trust.

The best way to educate is to USE THE MEDIA. People who oppose adolescent reproductive and sexual health programs use the media, and program proponents must also. Use the media and other forums to challenge misrepresentation and ask for clarification. Never allow misinformation about a proposed program to stand unchallenged.

The Media section of this Kit gives tips on working with press to promote a program, but several points bear repeating. Use the media to respond to concerns about the program, particularly those originating in press arenas such as letters to the editor or op ed columns. Write articles for the local paper and promote coalition members for interviews on television and talk radio. Use press releases and news advisories to keep the media informed about the state of teen health in your community, and how the coalition goals will help improve the situation.

An educational campaign involves targeted advocacy. The Lobbying section gives specific tips but, in general, the coalition should plan to visit everyone involved in promoting, approving and implementing the program. Meet first with the most supportive individuals or agencies, and ask them to join the coalition. Their name on the coalition membership will invite others to join.

Coalition members should go directly to influential and supportive community members and groups, describe the program and why it is needed, and ask them to publicize the coalition’s goals. Providing materials for organizational newsletters and meetings is an easy way to provide information to a broad group of people. Speaking at meetings and other group activities is another effective way to get out the word on the coalition’s program.
Other Activities for Educating the Public

All of these events present opportunities to reach the public with detailed information about the proposed program. The following opportunities can be used to answer questions, respond to concerns or questions, and encourage broader participation in the group working to promote the program.

- Give a presentation at board or membership meetings of civic, professional and/or advocacy groups and ask them to endorse the coalition’s goals.
- Create and distribute materials targeted for a specific audience, such as parents; these materials can include questions and answers, reports, fact sheets, etc.
- Hold or participate in community forums or briefings for parent groups, PTAs, neighborhood associations, etc.
- Testify at meetings of policymaking bodies such as school boards, city councils, legislatures.
- Organize coalition members’ constituencies to engage in a letter writing campaign to policymakers and/or the papers.
- Conduct a petition drive among the general population or among specific groups such as students; then hold a press conference and present these petitions to policymakers.
- Conduct polls or surveys to gauge and/or illustrate community support.
- Write articles about the program for organizational newsletters.
- Hold speak-outs, protests or rallies to illustrate support for the program.
- Write letters to school boards, Department of Education and other government agencies concerned with the issue.
GENERAL ADVOCACY

COMPONENTS
Following are tips for working with young people and involving them in your advocacy efforts. By and large, these are simply the common-sense courtesies that make any group effort successful.

If you don’t have contact with any adolescents, contact peer education, youth service and youth leadership programs in the community, especially those focusing on youth and sexuality. Start with your local AIDS prevention, pregnancy prevention, health education and youth development programs.

**Integrate young people into coalition and group efforts.** Meetings should be scheduled when teens can attend, in an accessible location. Like everyone else, young people should be kept informed about plans and meeting times.

Enable young people to participate in coalition and group activities in meaningful ways. Youth should participate as much as possible in the coalition’s decision making process, and should have equal rights to vote and hold leadership positions. Be clear with other coalition members that young people are equals in the effort.

**Be open and nonjudgmental about young people’s insights and suggestions.** Let them know that their involvement is important. Guard against dismissing, or otherwise reacting negatively to, young people’s suggestions.

Many young people are intimidated by adults; they may not be accustomed to being included in planning or other strategy discussions. Be aware that it may take time and effort to get young people to participate fully in the coalition. Work to help teens feel comfortable. Don’t assume if a teen isn’t speaking up that he or she doesn’t have an opinion. Solicit contributions and opinions from teens during meetings and discussions.

**Take advantage of the expertise teens offer.** Young people know about their peers. Encourage them to share their knowledge about a proposal’s positive or negative impact on young people. Affirm teens’ input!

Be honest about your expectations for the project, the teens’ contribution, and the coalition’s benefit from teen participation. Keep your expectations realistic. Check in with coalition members to make sure people’s expectations and needs are being met.

**Be prepared to offer support for young people.** Think about kinds of support it may take to involve a broad variety of community members (including teens) in the project. Support can include financial assistance, transportation, training and information. Encourage coalition members to interact with each other to provide this support in order to maximize everyone’s participation.

**Make the work interactive and fun.** Like adults, young people are more likely to become and remain active in projects that are interesting and fulfilling. Volunteer work should be pleasurable!
Help build teens’ skills so they can become more involved. Young people may need information about adolescent health statistics, the overall political situation or the community’s need for a particular program. They may need help learning how to be effective communicators and to feel comfortable speaking with the media or with policy makers. Provide young people with opportunities to build their skills and you expand the coalition’s effectiveness.

Don’t make assumptions about what individual young people are like.

Things that teens could do (anything adults can do!)

- Petition drive
- Conference
- Media interviews
- Educate legislators
- Plan a program
- Evaluate a program
- Provide information to media, etc.
- Get other young people involved
- Plan strategy
- Design educational materials
- Educate the community, their peers, etc.
- Coordinate parts of the program
- Conduct research or needs assessments
- Fundraise
- Write letters to the editor
- Testify before government bodies
GENERAL ADVOCACY
COMPONENTS
Working with Communities of Faith to Promote Adolescent Reproductive and Sexual Health

Confronting Extremists

Advocates for progressive issues often meet opposition by determined conservative activists who claim to speak from the sole acceptable moral and religious perspective. Opposition based on religious issues is particularly likely when the issue at hand is adolescent reproductive health, since this combines two potentially explosive topics: the rights of young people and sexuality. Advocates working on behalf of young people’s reproductive rights desperately need the support of communities of faith in order to confront extremist opposition. Progressives especially need Christian clergy to stand up to the intolerant, bigoted and oppressive use of the faith by well-organized religious political extremist groups, such as the Christian Coalition.

Progressive advocates working together with supportive members of the faith-based community can successfully combat religious political extremists’ powerful rhetoric. Without any dissenting voices from within the religious community, public debate over adolescent reproductive and sexual health issues can become polarized between the “religious” and the “secular” point of view. The extreme political agenda of certain visible and vocal groups can become automatically associated with what is “holy” or “morally right”. The secular and progressive view, by disassociation, will be rendered “wrong” or “immoral” in the public’s eye.

By wedding social and political views to their religious affiliations, extremists have successfully characterized any criticism of their positions as anti-religious bigotry. They hypocritically seek protection behind the First Amendment while attempting to abridge the First Amendment rights of others. Advocates therefore need to work with members of the religious community to broaden the public definition of the “religious position” on various issues and to deny extremists the sole power to define what is “morally correct” for society.

When building coalitions, progressive advocates should not attempt to separate public health and spiritual issues. Too often, public health officials address an issue such as AIDS prevention from a purely medical angle without any acknowledgment that attitudes towards sexuality are often influenced by peoples’ religious/spiritual convictions. People tend to make decisions through a mix of pragmatism and moral conviction. It may well be that the success of progressive programs now rests on advocates’ ability to address peoples’ wish to integrate their spiritual and secular lives. Including vocal representatives from religious communities in advocacy and public education campaigns is essential to this goal.
Reaching Out to Religious Leaders

Be Patient

While it is vital to enlist the support of faith-based communities, it is necessary to have realistic goals and not expect overnight success. Coalition building is difficult, no matter the topic or audience. Adolescent reproductive and sexual health activists face unique challenges, especially when seeking religious support. Leaders in the religious community you most desire to involve in advocacy efforts may be reluctant to step forward when first approached. Clergy often face difficult decisions, being doubly charged with an expectation that they will offer guidance not only in nonspiritual matters but also maintain spiritual unity in a congregation which may be divided along political and social lines. Clergy may choose to avoid discussing political matters for fear of dividing their congregation. Like political figures, religious leaders may be attacked by extremists for their stands on issues. This is especially burdensome in denominations and faiths where the clergy is hired by the congregation rather than appointed by a higher governing body. An unpopular stand on a political issue like abortion or gay rights could cost jobs. Know that it may take time to encourage clergy to participate in adolescent health promotion efforts.

Show Community and Congregant Support

It is most effective for congregants to approach their own clergy when seeking support. Given the potential level of opposition around sexuality issues, clergy may need reassurance that a large number of their congregants favor activism on progressive issues before they will give support. It is also useful to work with groups such as sisterhoods, parent groups, youth groups, or social action groups already established within the religious community. Additionally, some clergy may need to feel that there is consensus among their clerical peers before they will be comfortable getting involved in an advocacy campaign.

Be Prepared to Educate

Clergy hear the same extremist rhetoric as everyone else: condemnations, exaggerations, and mistruths about progressive issues, particularly around sexuality. They may be influenced by the images of extremist propaganda and distortions of right wing candidates; even clergy sympathetic to progressive causes may unconsciously carry ideas of “seedy abortion mills,” “sex instruction,” and “sex clinics”. Prepare materials that provide information about the issue at hand in order to help make your case for the clergy’s involvement and commitment.

Be willing to meet clergy people “where they are” on an issue. Do not expect even sympathetically-minded clergy people to simply parrot progressive positions. Clergy have unique responsibilities and unique restrictions placed on them by their vocations. Respect the clergy’s position and the constraints which they may feel.

Clergy willing to speak publicly about adolescent reproductive and sexual health issues may still need education and resource materials. They may need help understanding the complicated issues today’s young people face around sexuality: STDs, AIDS, rape, pregnancy, incest, homosexuality, abortion. While teens, parents, and other concerned individuals may wish to seek counsel from
clergy on reproductive or sexual health issues, few seminaries address sexuality in practical terms or give clergy the skills to talk about reproductive health. Providing clergy with materials and support can help them become better counselors as well as advocates.

**Be Respectful of Time Commitments**

When approaching clergy remember that most have great demands placed upon their time. They may have little time to devote to other causes, between planning and leading services, visiting the sick, comforting mourners, welcoming newcomers, supervising staff, attending to church finances and property, and participating in community projects. Even clergy who want to help may feel unable to take on another obligation. Avoid requesting things that others could do just as well; make every effort to create specific (and time-limited) avenues of involvement and be prepared to work with clergy who only want to take limited roles.

Concentrate on asking clergy people to undertake activities that will have the most effect in helping policy makers and the public understand that many religious people support adolescent health programs. Delivering testimony before a policy making group, working with the media, conducting interviews, or speaking to parents’ groups are very specific—and very effective—ways religious leaders can help broaden public understanding of young people’s reproductive health needs.

**Finding Religious Support for Youth Programs**

It may seem overwhelmingly difficult to bring spiritual leaders into your advocacy campaign, but the energy and time will be well-invested. Here are some tips:

**Begin at home.** Progressive advocates need to speak out about their own spirituality, and the moral necessity of public health programs. Being vocal about your own religious and spiritual perspectives and practices is an important way to make clear that extreme conservatives do not hold the only perspective on faith. Speak out about the need to protect teen health, and how your commitment is connected to your personal belief system. Ask your own clergy member to get involved in promoting teen health in your community.

**Start with progressive religious leaders and communities.** Almost every community is home to at least one outspoken, progressive religious leader. As with any other advocacy campaign, begin your outreach to religious leaders by identifying those who are already committed. Reach out to religious groups which have passed policy statements in support of reproductive choice or other progressive issues. Many, many denominations support abortion and other progressive public health issues. The Resource List at the end of this article provides contact information for these groups.

**Contact national advocacy organization concerned with your issues.** National organizations can be very helpful in identifying organizations and individuals who are willing to get involved in advocacy efforts and countering religious extremists’ claims about morality. These organizations include the Religious Coalition for Reproductive Choice, the Interfaith Alliance, and Americans United for the Separation of Church and State (see the Resource List).
Know when to stop. You don’t need every religious leader in the community to actively participate in your efforts. The enthusiastic and vocal support of a few well-respected and committed individuals will aid your efforts immeasurably and help demonstrate that adolescent reproductive and sexual health is a mainstream issue.

At no other time has there been a greater need to involve members of the community of faith in advocating for adolescent reproductive and sexual health. The opposition is well organized and increasingly successful at electing legislators who are willing to pass regressive public health policies. Yet those legislators—and the groups who support them—do not speak for all Americans. They are an extremist minority. Broadening the progressive advocates’ base to include clergy and communities of faith is a crucial and realizable goal. Advocates for adolescent reproductive and sexual health are not alone in their view that young people need to make healthy and informed decisions about their lives. We must seek out allies from many communities, and stand united; together progress can and will be made.
The following national organizations support progressive reproductive health platforms. They can be of great assistance in building activist coalitions in your community as well as providing a starting point to reach other communities of faith for progressive issues.

Religious Coalition for Reproductive Choice
1025 Vermont Avenue, NW
Suite 1130
Washington, DC 20005
(202) 628-7700
(202) 628-7716 (fax)
info@rcrc.org (email)
www.rcrc.org (web page)

The Religious Coalition for Reproductive Choice represents forty national Christian, Jewish, and other religious organizations that support a full range of reproductive health options. Call for a list of the Coalition’s members.

Catholics for a Free Choice
1436 U Street, NW
Washington, DC 20009
(202) 986-6093
(202) 986-332-7995 (fax)
cffc@igc.apc.org (email)

Interfaith Alliance
1511 K Street, NW
Suite 738
Washington, DC 20005
(202) 639-6370
(202) 639-6375 (fax)
tialliance@intr.net (email)

Americans United for Separation of Church and State
1816 Jefferson Place, NW
Washington, DC 20036
(202) 466-3234
(202) 466-2587 (fax)
amerunited@aol.com (email)
www.netplexgroup.com/americansunited/ (webpage)

This article is based on How to Organize and Mobilize Religious Support for Choice from the Religious Coalition for Reproductive Choice. Call or write the Coalition for a complete list of their publications.
General Advocacy Components
Media coverage is important because it carries your message to a much larger number of people than can be reached independently. Carefully planned media strategies help identify supporters, answer people’s concerns and persuade those who are undecided. The media also can diffuse criticism by providing a forum to explain a program and demonstrate thoughtfulness, sensitivity and candor.

Luckily, adolescent sexuality is a story that will attract press attention. Unluckily, it is also a story too-often covered irresponsibly or without a great amount of depth. Given our society’s discomfort with adolescent sexuality, media coverage of the issue often fails to explore the complicated and inter-related aspects of teen health and the prevention programs designed to improve adolescent futures.

Successful media plans usually follow a four-step process:

1. Define the role of the media in outreach efforts. Be aware of media coverage of related issues (sexuality, HIV, adolescence) and provide copies of past coverage in briefing packets. Keep records on local and national press (both those who have been contacted and potential contacts). Keep accurate mailing, telephone and fax lists of the press in your area.

2. Determine what press activities to hold and which materials to have on hand as background or current information. Consider sending out press releases, creating a press packet, holding a press conference or using a variety of other techniques.

3. Be aware of the leading spokespersons for the opposition and the media strategies they employ; be prepared to respond.

4. Evaluate your press campaign. Keep track of stories, determining how the story was presented, who was quoted and what kind of follow-up may be necessary.

The Spokesperson and Interviews

The Spokesperson: Press calls should be routed to a designated spokesperson (or spokespersons) to establish a regular contact for the reporter and to allow for follow-up. This person should be articulate and well-versed on adolescent health and pregnancy prevention issues. They should be able to speak clearly and directly to the issue without using jargon or terms unfamiliar to the audience. If the respondent is not a spokesperson for the organization, but is providing background information, make the relationship clear and let the reporter know who to talk to for attribution.

When You Don’t Know: If the spokesperson does not know the answer to a question, it is important to say so. Reporters have the right to ask anything and expect that the spokesperson will answer to the best of his or her knowledge. The respondent has the right not to be drawn into issues that
are inappropriate for comment. ANY remarks made to the media are liable to be used. If you don’t want something published, don’t say it. If there is a subject on which you don’t want to be quoted, the safest rule is to not talk about it. Do not be drawn into criticism of colleagues or other organizations. Reserve criticism for real adversaries or for motivating public officials.

The Story: It is crucial that the spokesperson plan in advance what points to make and how to make them succinctly. Anticipate difficult questions and practice answering them in a role-play situation before interviews. Focus on two to three points, and stress these points in your conversation or interview. Short snappy sentences (15-20 words) that stand alone are “sound bites;” make it easy for the media to use your words by providing them in this format. Use a technique called “bridging” to ensure that your points are made. For example if the interviewer asks an irrelevant question, say “I think the real issue [or question] is...”

The Press Information Packet

One of the most important items for a media campaign is the press information packet. It contains basic background material on the program’s issues and describes the coalition. It can be used to insert press releases and advisories for conferences or briefings. A standard packet includes:

- Information about the coalition: a list of members, statement of purpose and goals;
- Contact information for the press spokesperson, including a phone number;
- Background (such as fact sheets) on adolescents and AIDS, STDs, sexual activity and pregnancy/birth/abortion rates;
- Information on similar prevention programs across the country;
- Favorable press coverage of the coalition or similar prevention programs;
- Information on how the proposed program can address a need in the community;
- Materials for a press conference, such as news advisories, news releases, statements from the coalition leadership, copies of their speeches or testimony.

When the Press Calls

Calls should be directed to a spokesperson who will either respond to the inquiry or refer the reporter to an appropriate person for additional information or an interview.

Respond to all media calls. Don’t avoid press calls. Leaving a “no comment” impression may arouse suspicion. Responding quickly will increase the chances of being quoted and cited in the final story. Practice making your 1-2 points before calling the reporter back.

Be aware of “sensationalist” journalists, those who have stated their opposition to your program, or those who work for newspapers with an editorial position against it. Be especially cautious when working with these journalists. Think about how to work with these journalists before they call; you may decide not to give interviews to these organizations.
When Contacting the Media

Develop a press list including contact information for the various departments you will be contacting (PSA, events listing, health writer). Your press list should contain the television, radio and newspaper outlets in your area, including university papers, community newspapers and radio stations, regional magazines and military press officers.

- Learn the deadlines for the media outlets on your press list and research the demographics of their target or primary audience (e.g. teenagers, sports fans, affluent). To be most effective in dealing with the press, also research the contact for your calls and materials. The following are some suggestions:
  - Newspapers and Magazines: Contact the assignment editor or the assignment desk.
  - Television: Start with the assignment desk. TV public service directors and editorial directors also are good contacts, particularly for public affairs programming. Some correspondents also take part in deciding which stories are covered.
  - Radio: Identify news directors and talk show producers to whom the interview may be suggested. Shows whose primary audience is teens are a particularly good place to call for coverage.

Evaluating Press Relations

Keep copies of press coverage that mention your efforts, as well as records of press materials, media contact information. The crucial factor in understanding and evaluating press experience is in setting realistic expectations.

A news story should present the proponents' side of the story fairly and evenly and present other viewpoints. It should incorporate at least one of the major points raised in the interview. It will quote spokespeople accurately. But most important, a press piece should not only educate the community about the program confronts but also lay the foundation for greater awareness and support.

Media Activities

**News Releases.** A news release is a one-to-two page (500-800 words) description of an event, program or activity. It can stand alone or be enclosed with additional materials and resources. News releases should be distributed with sufficient lead time and include the following: one or two quotes from spokespeople; date on which the information can be released; facts: who, what, where, when, why and how; contact name and telephone number. Make your point in the first few paragraphs. Distribute a news release by mail, fax, messenger or at conferences and press briefings.

**News Advisories.** A news advisory is sent to announce an event or specific news; it is a simple one-page document that invites coverage of an event. Include a description of what is happening, when, why, where and who is participating. Fax the advisory to your contacts 1-2 days prior to the event.
News Briefings and Press Conferences. Briefings should be reserved for announcements that cannot be communicated well in a press release. When possible, schedule the briefing to last up to half an hour between 12-2 pm. Use a location convenient to the reporters such as a press club or downtown site. Have press kits available at the event, and designate someone from the coalition posted at the door. A briefing on the overall issues of the program is appropriate at the beginning or after a great deal of change.

Public Service Announcements (PSAs). PSAs are a good way to publicize events. For radio, write a 15-to-20 second statement or announcement and submit it by fax or mail to PSA contact. Television PSAs will need to be produced, but your only cost is for production, not distribution. Many newspapers will print information from PSAs in their community calendars and announcements sections.

Local Cable Access Programming. Cable access channels offer access to equipment, air time and consulting and are an excellent venue for local issues. PSAs, panel discussions or other programming are possible; contact the local cable company for more information. In many areas, cable channels will film public forums or debates.

Buying Space or Time. Buy space for a prepared advertisement to appear in local newspapers or magazines. Newspapers and magazines have rate cards that explain ad sizes and prices. Buying time for radio advertisements is relatively inexpensive. Check with local stations for rates, listenership and technical requirements for submitting advertisements. Some stations allow radio personalities to read ad copy on the air; others use only advertisements that are produced on tape.

Letters to the Editor. Newspapers frequently print letters to the editor that address an issue which has been in the news recently. The letters to the editor section is one of the most-read sections of the paper, and an ideal place to respond to criticism or concerns. Letters should be persuasive, brief and use statistics from reputable sources. A prominent member of the community could be asked to write a letter, or sign a letter drafted by another coalition member.

Guest Editorials. Guest editorials, or “op-eds,” are brief opinion pieces or essays on topics in the news. Op-eds should be approximately 500-800 words in length and make one major point, backed up by reputable statistics and compelling stories. As with letters, a prominent member of the community could be asked to write an editorial or sign one drafted by another coalition member.

Letters to Media Professionals. Maintain press contacts through letters to reporters, editors, talk show producers and editorial boards. Use letters to suggest interviews or topics for press consideration, to acknowledge good coverage of an issue or to praise a reporter or editor.

Appearing on TV or Radio. TV and radio stations often look for community members to comment on current events. You and the coalition can call or send information suggesting yourself/the spokesperson as an appropriate guest for a specific show. Once you are invited onto a show, research the other guests’ views. To make the case more compelling, use stories to illustrate your points in addition to facts. Speak in short, crisp sentences. It’s harder to
provide background in these mediums than in print, so assume no prior audience knowledge when you make your case. On TV, wear bright solid colors, and avoid wearing glasses.

**Other Activities for Educating the Public**

All of these events present opportunities to reach the public with detailed information about the proposed program. The following opportunities can be used to answer questions, respond to concerns or questions, and encourage broader participation in the group working to promote the program.

- Give a presentation at board or membership meetings of civic, professional and/or advocacy groups and ask them to endorse the coalition’s goals.
- Create and distribute materials targeted for a specific audience, such as parents; these materials can include questions and answers, reports, fact sheets, etc.
- Hold or participate in community forums or briefings for parent groups, PTAs, neighborhood associations, etc.
- Testify at meetings of policymaking bodies such as school boards, city councils, legislatures
- Conduct a petition drive among the general population or among specific groups such as students; then hold a press conference and present these petitions to policymakers
- Conduct polls or surveys to gauge and/or illustrate community support
- Write articles about the program for organizational newsletters
- Hold speak-outs, protests or rallies to illustrate support for the program
- Write letters to school boards, Department of Education, and other policymakers concerned with the issue
General Advocacy Components
People use the voting booth to let their elected officials know how well they’re doing. But there are other opportunities to communicate with decisionmakers, and many different methods for doing so, such as visiting, calling or writing legislators or presenting testimony.

Advocacy can occur any time. Particularly in local policy bodies (such as school board or city council), many opportunities exist for sharing opinions. Advocacy can occur when you encounter a legislator in the hallway or the post office. You can sign up to speak at a public hearing or write to legislators about your viewpoint. There are also specific points in the legislative process when bills are most readily affected. The state legislative research office, League of Women Voters or the Secretary of State’s office can provide information on the legislative process in your state. Use this material to help decide upon the most effective strategy for making your views known to decisionmakers.

It is also useful to understand Parliamentary procedure, which is an operating system used by legislators. Parliamentary procedure is complicated, but well worth understanding. Little-known rules and procedures are often used to defeat or weaken proposals without generating public notice or allowing legislators much opportunity for negotiation. Likewise, rules and procedures can be used to advance legislation and bring it to a vote. Familiarity with the parliamentary procedure used by the targeted political body will increase advocates’ abilities to strategize for success under many scenarios.

General Tips for Advocacy

Target your efforts. Survey the policymakers who will be involved in approving, funding and implementing your program, and decide who you will approach, and in what order. Start with firm supporters and move on to those who are moderately progressive or undecided in their views. You may want to begin with legislators on the committee that will first hear the bill and members of a friendly caucus, such as the Women’s Caucus. Be certain your own legislator knows your position on the bill.

Be gracious. Always begin by thanking the legislator for providing the opportunity to hear your ideas, opinions, etc. Legislators who support adolescent reproductive and sexual health, in particular, receive a lot of negative attention from the opposition. A sincere “thank you” will be greatly appreciated.

Be professional. Be professional in both dress and manner; don’t say negative things about other legislators or public figures.

Be focused. Stick with one issue per call or letter. Information about more than one topic will only confuse the message and dilute your point.

Do your homework. As part of your preparation, research the legislator’s position on your issue. You can find out through voting records, speeches, newspaper articles, debates and other organizations that work on this area. Advocacy organizations, particularly those with Political Action

Advocates For Youth
Committees often track legislator’s votes, and can provide voting guides. Explore the legislator’s personal connections with the issue: do they have teenagers themselves? Frame your presentation for maximum effectiveness based on your knowledge about the legislator’s constituency, views, background, interests. Different arguments are compelling for different people; use the most persuasive argument for this person. It might help to role play what you want to say at the meeting, and practice responses to possible comments.

**Make a personal connection.** No matter how insignificant you may feel it is, if you have friends, relatives and/or colleagues in common, let the legislator know! In particular, let the legislator know if you are a constituent. The legislative process can be very informal and, although a personal connection makes no difference in your presentation, it may make the difference in your effectiveness.

**Consider yourself an information source.** Legislators have limited time, staff and interest in any one issue. They can’t be as informed as they’d like on all the issues—or on the ones that concern you. YOU can fill in the information gap. Encourage the policy maker to ask questions about the program or the issue.

**Tell the truth.** There is no faster way to lose your credibility than to give false or misleading information to a legislator.

**Know who else is on your side.** It is helpful for a legislator to know what other groups, individuals, state agencies and/or legislators are working with you on an issue. Providing this information also illustrates that your group represents many more voters. Bring coalition members and young people with on lobbying efforts. It is also important to keep in touch with your allies so that advocacy efforts are coordinated and relevant information is shared.

**Know the opposition.** Anticipate who the opposition will be, both organizations and individuals. Tell the legislator what opposition arguments are likely to be and provide clarifications and rebuttals. The ability to anticipate criticism and defend your position will make a difference.

**Don’t be afraid to admit you don’t know something.** If a legislator wants information you don’t have, or asks something you don’t know, tell them. Then, offer to get the information they are looking for, and DO IT!

**Be specific in what you ask for.** If you want a vote, information, answers to a question, signature on a petition; whatever it is make sure you ask directly and get an answer.

**Follow up.** It is very important to find out if the legislator did what they said they would. Send a thank you letter after your conversation, restating your position. It is also very important that you thank the legislator for a supportive vote, or ask for an explanation of an unsupportive vote.

**Stay informed.** Legislation changes status quickly and often. Amendments or other committee actions can radically change the effect of a bill without receiving much publicity. The sponsor or legislature’s research office can help identify where in the process the bill is currently located, and what it’s current language is.

**Don’t burn bridges.** It is easy to get emotional over issues you feel strongly about. That’s fine, but be sure that you leave your relationship with the legislator on good enough terms that you can return to them on that or another issue.
Don’t get into a heated argument with a legislator, and never threaten them. Your strongest opponent on one issue may be a great proponent on another!

**Remember, you’re the boss.** Your tax dollars pays legislators’ salaries, pays for the paper they write on and the phones they use. YOU are the employer and they are the employees. Be courteous, but don’t be intimidated. They are responsible to you and, nine times out of ten, legislators are grateful for your input.

### Communicating with Legislators by Letter

**Identify your target legislators.** You can send a letter to your own representatives, to all members of a committee dealing with your issue, or to the entire legislative body.

**Mention a specific issue and/or bill.** Your letter will be more effective if it concentrates on a specific issue or a particular bill. When referring to a bill, cite the sponsor, bill title and number. If possible, include the bill’s status: what Committee it has been referred to, when the public hearing was held.

> Dear Representative Jones:

> I am writing to urge your support of L.D. 2214, An Act to Ensure Safety for Workers, which was presented for public hearing before the Legislature’s Labor Committee last Tuesday, February 10th.

**Be brief and succinct.** A one-page letter has more impact than a ten-page letter. Outline your main point in the first paragraph and try to cover only one issue per letter. Make it clear how you want the legislator to vote. For background, you could also include a newspaper clipping or fact sheet that discusses the issue in greater depth.

**Make it personal.** Policymakers and their staff are more likely to pay attention and remember letters that include real life experiences. Explain why the issue is important to you, how the legislation will affect you and others in your area. Describe an experience you’ve had that illustrates your point. Organized campaigns do not impress legislators as much as heart-felt constituent communication; don’t let it appear that you are part of an organized advocacy effort.

**Identify your relationship with the legislator.** If you are a constituent or have another connection with the legislator say so at the beginning. Include your name and address. This enables the legislator to respond to your letter. Your address also indicates your voting district, and gives an extra incentive for the legislator to pay attention to you.

**Ensure that they receive the letter.** When the legislature is in session, send your letter to the state house; out of session, use the district (or home) address.

**Follow up.** Make a quick call to confirm receipt of the letter. You can simply say to the receptionist: “I’m calling Representative X to make sure she received my letter about L.D. 2214, the Act to Ensure Safety for Workers.” Leave your name and phone number. Call or write until you get an acknowledgment of your letter.

**Send a final reminder about the bill.** Find out when the bill will be voted on and, just before the vote, send a postcard (or leave a phone message) about your position. As before, include the bill number and title. This
will let the legislator know you are following this issue, and that the vote is still important to you.

Thank the legislator if he or she voted with your position.

**Face-to-Face Visits:**

**Schedule a meeting.** Call the legislator’s office and schedule a meeting enough in advance that you have time to prepare. Make appointments well enough in advance to prepare, confirm the meeting and invite other people working on this issue. Keep a record of who attended, what information was shared and any actions promised.

**Be flexible.** Expect interruptions, changes in schedule or staff availability. If you can’t meet with a legislator, try to meet with an appropriate staff member or reschedule for another time.

Staff people are extremely important, and may have great influence on a legislator’s views.

**Be prompt.** Don’t be late, as it sets a bad tone for the meeting before it has even started. If you are running late, call ahead and let the legislator’s office know.

**Be prepared.** Make the most of your visit: plan your presentation in advance and divide up roles for group members to take on, including a note taker. Plan a 5-minute presentation (10 minutes at the most) and expect to spend no more than 15 minutes with the legislator. Make your important points in a clear and succinct manner. Note personal relationships and constituents.

**Take advantage of opportunities.** Meetings with legislators can take place anywhere — in the state house hallways, the district office or the local grocery store. Take advantage of unexpected opportunities to speak with legislators.

**Leave something behind.** Develop a handout packet to leave with the legislator. It should include a short (1-2 pages) summary of your group, the issue you are working on and your request for action, background information about the issue, and press clippings such as editorial support for your position.

**By Telephone**

**Identify yourself** using your name and address. If you are a constituent, say so.

**Identify the issue** you want to talk about; when referring to a bill use its number and its title.

**State both your position** and how you would like the legislator to vote.

**Ask for the legislator’s position** on the bill or issue. If supportive, ask for a commitment to vote for your position. If opposing or undecided, thank them for the information—don’t argue with them on the phone. Ask what information would be helpful in helping the legislator become a proponent.

If the legislator is unavailable, **leave a detailed message** with a staff member. The staff member may be able to describe the legislator’s position.
Follow up by sending a note thanking the legislator for their time. Include any information that the legislator can use to solidify their position, or which may move them to support your position.

In Testimony

When committees and subcommittees hear views from constituent on a certain topic, it is called “testimony.” Arrangements for presenting testimony vary by state: the state legislative research office or your legislator will be able to describe the procedure in your state. In most areas, you can arrange to present testimony by calling the bill’s sponsor, the chair of the committee considering the bill, or your legislator. Once you’ve scheduled your testimony:

- Draft a 5-minute speech on the bill. Begin by thanking the committee for allowing you to present your views. Make the testimony interesting, personal and compelling.
- Include information about what the bill’s effects would be, as well as a few compelling statistics about the situation the bill is designed to address.
- Print your testimony, include your name, address, organizational affiliation and the bill number at the top of the first page. Find out from the committee staff how many copies of your testimony to bring to the hearing.
- Attach easy to read background information (such as a fact sheet or newspaper article) to each copy of your testimony.
- Practice delivering your testimony so you won’t be nervous. Time your delivery to ensure that you have enough time.
- Expect questions from the legislators, particularly from those opposing your viewpoint, and be prepared to address their concerns.

What to do if the Legislator:

Strongly agrees with your position:

Thank them.

Ask them to take a leadership role in the legislature, the media and/or the community.

It is appropriate to ask for any of the following, and more: an agreement to write an article for a newsletter; signature on a petition or letter of support; public use of legislator’s name; sponsorship of a bill; agreement to offer amendments to legislation; speeches at public forums; agreement to vote for or against a resolution.

Ask their advice about who else to talk to, what arguments best make the case for the bill, what media strategy will be most effective in gathering support for the bill.

Ask what information or constituency would be helpful in swaying additional legislators to your position. Then work to produce these materials or advocates.

Ask them to “lobby” undecided legislators, and give them a list of these legislators.

Thank them again.
Agrees with your position:
Thank them.
Assure them of your continued interest in the issue and your continued support for their position.
Ask if they would be willing to help in any way beyond their vote. If yes, refer to the tips above.
Thank them again.

Is undecided or noncommittal:
Inform them of your interest in the issue or legislation.
Present the case as clearly and concisely as possible, if possible have constituents and/or teens make the presentation.
Ask about their viewpoint to investigate whether their position results from personal or political factors, a lack of information, misinformation, or a combination. Adjust your strategy accordingly.
Ask if there are specific groups or individuals from whom they would like to hear.
Offer to provide information that will help inform them about the issue.
Follow up by providing information they requested, or information addressing their reservations.
Once they have indicated a position, thank them for their support, or send a letter stating your disappointment in their position.
Keep in touch to nurture the relationship.

Is opposed to your position:
Thank the legislator for the opportunity to discuss your views.
Determine how strong their opposition is, and upon what it is based. If the opposition is not vehement, it may be worth trying to change the legislator’s position.
If the legislator appears movable, present information that addresses his or her concerns. Make sure that the legislator hears from constituents who support your position. Strategize and present the case most likely to resonate with this particular legislator.
Stay in touch to nurture the relationship with the legislator.
If the legislator is not movable, ask them not to lobby their colleagues on the issue. With a close vote, where you cannot win unless the legislator cooperates, ask them to “walk” (be absent) when the vote occurs.
If the legislator’s opposition is strong, write and express your disappointment in their position (and/or their vote). Don’t waste your time and energy trying to move them.
GENERAL ADVOCACY COMPONENTS

RESPONDING TO OPPOSITION & CRITICISM
Every program has critics. Proponents of adolescent reproductive and sexual health programs must be prepared to address objections and opposition. Conflict is unpleasant but provides an opportunity to educate and communicate with the public. Responding to critics through open discussion allows everyone to be heard and competing ideas to be tested. Open communication often leads to compromise that maintains the integrity of a program while building the broadest possible support.

Addressing opposition effectively involves listening to many different interests and conflicting views and then cooperating to achieve agreement.

Since a debate of some nature is guaranteed when adolescent reproductive and sexual health programs are considered, proponents must prepare in order to succeed. The majority of Americans support programs to improve adolescent reproductive and sexual health, but too-often are not active and/or vocal about their support. Even those who initially oppose adolescent reproductive and sexual health programs can be made supporters if they receive information, have their questions answered and are invited to contribute to the debate. Provide information and the opportunity to hear differences, answer questions and respond to concerns, and most of the community will be supportive.

It is vitally important to know who opposes the program or proposal under consideration, why they do so, and what strategies and arguments these critics will use. Opposition can arise from many sources. Some individuals may oppose a program because they have questions about what is being proposed, what will be accomplished and how the plan will be implemented. These critics may be turned into supporters by providing information about how the local situation demonstrates that the program is needed, what the program’s goals and components are and how the program will be funded and evaluated.

Other individuals object to a planned program because they feel they have been left out of the development process. Program planners should make every effort to involve representatives from all areas of the community from the earliest discussions about a desired program. It is particularly important to involve supportive members of the religious community as well as parents. Documenting a large and diverse coalition whose members support the proposal assures those who might otherwise feel ignored that their community is involved in creating the program plan.

Other critics may think teen reproductive and sexual health programs are simply unnecessary. A broad public education campaign is an effective way to build public awareness about teen health issues. By highlighting relevant local teen health indicators and describing how they will be improved by the proposed program, proponents can persuade many people to support the
proposed program. A sample needs assessment, which serves as a guide for collecting information about the community, is included in this Kit.

Some people oppose school-based programs that target reproductive and sexual health as representing an effort to divert schools’ attention from providing the best possible education. Present facts about how school-based health programs can improve young people’s health and about the correlation between health and improved school performance. Additional information about the long history of public health and educational campaigns focused in the public schools can be effective in many communities.

Some people will never change their minds and become supporters of a proposed program, so don’t waste your time attempting to convince them otherwise. There are plenty of people who will listen to and benefit from an information campaign—concentrate on this audience.

The most important tool in fighting for a program is clear and concise information about the need for the program and the manner in which the proposed program will improve teen health. Engage the community in order to publicize this information and the program stands a good chance of being approved and supported by the public. By listening to people’s concerns, proponents can identify the most effective means to persuade the greatest numbers to support the program or policy under consideration.

How to Deal with Opposition and Criticism

Create a broad-based coalition of vocal supporters. Extensive community support and participation clearly indicates the popularity of your program. See the Coalition section for more information. Support one another when times are rough. Let young people remind you of what the issues are all about: their reproductive and sexual health!

Be prepared for opposition. Know in advance that there will be objections to your proposal, and watch for them. Know not only who the opposition is but also what objections will be raised. Read opposition materials, study the newspapers, watch and listen to talk shows, learn about area organizations that will oppose your program. Check the lobbies and parking lots of religious organizations, as well as religious bookstores, to see if opposition literature on the issue is being handed out: this type of literature has been used to misrepresent the goals and effects of progressive programs.

Explain the program to the public. Many Far Right successes come from their ability to twist the meaning of educational, public health and public policy terms that are unfamiliar to the general public. Move beyond Far Right descriptions by explaining why the proposed program reinforces families, will not corrupt children and addresses existing problems in the community. Use descriptive and accurate language: for example “contraceptive availability” is preferable to “contraceptive distribution,” since these programs do not force contraception on anybody, but rather make it available to those in need.
Defend your program. Prepare to answer criticism with data, statistics, anecdotes and other information. Ignoring opposition statements makes them appear to be more popular than they really are and permits distortions to be accepted by the public. Check opposition statements for truth and publicize any distortions. When terms are unclear, or appear to be manipulated into different meanings come up, ask for an explanation. Responding to opposition can be accomplished by writing letters or op-eds for newspapers, speaking out at meetings, calling radio talk shows, offering your position as a follow-up interview to TV or radio stations covering the issue.

Encourage open and civilized debate. Communication is essential to the democratic process and is the only way to address the fears of the general population and objections of the opposition. Investigate and participate in the mechanisms by which schools and other public organizations address questions about programs. Ensure that all public meetings adhere to rules to encourage order. Ask members of the press to sign in and show their credentials. Require speakers to sign up in advance, give their name and address (and, when relevant, how many children they have in the schools); set time limits; select a moderator who will control personal attacks or diatribes. Some communities hold hearings for specific groups: parents, health care works, teacher, students, etc. This is time-consuming, but can yield open discussion instead of heated exchanges in which only one viewpoint is expressed.

Don’t be afraid of threats. Urge policymakers not to be intimidated when faced with demands that programs be abandoned. Threats of lawsuits are common when communities consider progressive programs, such as contraceptive availability, but few carried out and/or successful. Holding community meetings in response to criticism can help generate broader discussion and answer the public’s concerns.

Follow the debate. Find out about the different news outlets in your area and watch for coverage of your issue. Participate in the debate by contacting these outlets with news, objections, clarifications, etc. Sometimes opposition groups spread misinformation about programs and policies through leafletting and flyers. If this happens, respond with correct information through the press or community and/or religious groups.

Be active in your campaign. Provide information and the framework for the discussion so that the real facts are made public and all have a chance to get involved. Set the tone of the debate by taking the lead. See the Media and Coalition sections for specific activities.
Religious Political Extremists

Some groups are not open to persuasion. Organized groups opposing progressive programs may be part of the Far Right movement, known for its extreme political agenda. Religious political extremist organizations (also known as the Religious Right) believe that their worldview and theology (typically fundamentalist) should be the dominant one in American culture and that the government should enforce Biblical law.

Almost universally, religious political extremist groups favor:

- limiting access to contraception
- denying women access to abortion information, counseling and services
- prohibiting equal rights for gay, lesbian and bisexual Americans
- abandoning multicultural and cultural diversity educational programs
- requiring abstinence to be taught as the only acceptable method of preventing pregnancy and sexually transmitted diseases
- denouncing sexual expression outside of marriage
- censoring books in public schools and libraries
- closing school-based and school-health centers

It is very healthy for a young girl to be deterred from promiscuity by fear of contracting a painful, incurable disease, or cervical cancer, or sterility, or the likelihood of giving birth to a dead, blind or brain-damaged baby (even ten years later when she may be happily married.)

Phyllis Schlafly, Eagle Forum

The extremists’ ultimate goal is to impose a narrow religious agenda upon the American people. Tactics used include misrepresenting evaluation data, lying about program components and goals and fomenting public hysteria about progressive organizations and programs. Adolescent reproductive and sexual health proponents must reveal and contest the religious political extremists’ agenda in order to succeed in promoting progressive programs.

The Pro-Life Action League opposes all forms of contraception.

Joseph Scheidler, Pro-Life Action League

Magic Johnson wants us to believe AIDS can happen to anybody. Sure, anybody with numerous homosexual partners, or several hundred heterosexual partners, or an illegal IV drug habit. It will not happen to you if you have one mutually faithful uninfected partner for life. That is the only “safe sex.”

“Quick Facts on Safe Sex,” Focus on the Family
Extremists typically utilize three tactics: stealth, demonization and misrepresentation.

**STEALTH** candidates attempt to win political office by concealing their agenda from all but their most ardent supporters. While everybody has the right to participate in the political process, extremists tend to infiltrate the political sphere rather than engage in the democratic process. The problem is not that these candidates have views or allegiances, but that they hide them. Certain extremist conservatives concentrate get-out-the-vote efforts on sympathetic organizations and hide from the general public. Stealth tactics keep turnout low, because voters don’t know enough about a candidate to know they would not support them. Because of reduced voter turnout, stealth candidates can win, particularly in a non-presidential election year (such as 1994) or in local elections that not coinciding with national elections.

We don’t have to worry about convincing the majority of Americans to agree with us. Most are at home watching Falcon Crest. They’re not voting.

*Guy Rodgers, Christian Coalition*

When we get an active Christian parents’ committee in operation in all districts, we can take control of all local school boards. This will allow us to determine all local policy, select good textbooks, good curriculum programs, superintendents and principals. Our time has come!

*Dl Bednark, Citizens for Excellence in Education*

**MISREPRESENTATION** is a tactic by which the extremists raise support for their cause by distorting and falsifying program goals, components and effects. Misrepresentation incites opposition by frightening and misleading the public. The religious political extremists manipulate statistics and research to support their agenda. They have fabricated and misrepresented quotations, program goals and evaluation outcomes in order to portray progressive programs as faulty, ineffective or offensive. For example, some extremists misrepresent psychological health, substance abuse prevention and self-esteem raising efforts as occult brainwashing programs. People who have not been informed or who feel they are prevented from getting involved are excellent targets for misinformation campaigns.

The feminist agenda is not about equal rights for women. It is about a socialist, anti-family political movement that encourages women to leave their husbands, kill their children, practice witchcraft, destroy capitalism and become lesbians.

*Pat Robertson, Christian Coalition*
DEMONIZATION is a tactic that channels public discontent into active opposition by blaming current social woes on a specific group such as program proponents, educators and political candidates. This tactic plays on people’s fears of change and of their social condition. Demonizing terms include: Feminazis, the homosexual lobby, secular humanists, Godless socialists and New Agers. Extremist materials often portray the target group as agents of Satan. These labels make reasonable people who care deeply about teens seem to be dangerous and subversive forces with an agenda of harm and control.

The separation of church and state is a foreign idea to God and U.S. history. It is found nowhere in Scripture or any U.S. Constitution or official documents. It is found in the Soviet Union Constitution.

*Bob Simonds, Citizens for Excellence in Education*

The humanism that is being taught in schools, media, and intellectual circles will ultimately lead people to the Antichrist, because he will be the consummate figure of humanism.

*Pat Robertson, Christian Coalition*

We have meticulously followed God’s plan and His biblical principals in CEE’s plan to redeem America’s children from the clutches of atheism, immorality and psychological brainwashing. Godless socialism and the plethora left-wing agenda items must be stopped.

*Bob Simonds, Citizens for Excellence in Education*
In its publication Winning Through Reason, Not Fear: Meeting the Challenge of the Religious Right, People for the American Way has designed ten rules for engaging in a debate with religious political extremists (Religious Right).

1. Do not focus the debate on the extent of the Religious Right’s strength or exaggerate the “threat” it poses. It is not the Religious Right’s existence—or its putative power—that Americans object to, but rather what it wants to do.

2. Always remember that this is a fight for the mainstream, which will be won by addressing the concerns and values of ordinary Americans. Voters often feel left out of today’s arguments between the Religious Right and progressives. This leaves both these sides on the margins, with the middle up for grabs.

3. When appropriate, criticize the Religious Right for trying to use government to impose its religious values on others, thereby mixing religion and politics in an inappropriate way. This is what most limits its appeal with voters.

4. Whenever possible, engage the Religious Right on fights over specific issue positions rather than general values, and force its leaders to defend their most extreme positions. Progressives can win on the issues, especially when they develop a competing agenda for change.

5. Speak to Americans’ strong conviction that the nation is experiencing a serious decline in moral values. Avoid getting positioned outside the mainstream on questions of core values.

6. Highlight the limited range of values advocated by the Religious Right, and challenge its claim to speak for all moral and religious Americans.

7. Do not allow the Religious Right to define political differences as a debate over the importance or value of religion. Although Americans do not favor government promoting particular religious views, they do want more religion in their society.


9. Reach out to less-educated and lower-income voters, who often do not have liberal social values.

10. Educate younger Americans about the Religious Right; they reject much of its agenda, but are also the least concerned about its influences.
RESPONDING TO CRITICISM AND OPPOSITION: 
Selected Bibliography

In addition to Advocates for Youth’s Fact Sheets and advocacy manuals, the following materials offer insight into dealing with opposition to adolescent reproductive and sexual health programs.


GENERAL ADVOCACY COMPONENTS

COMMON QUESTIONS ABOUT SEXUALITY EDUCATION
COMMON QUESTIONS ABOUT SEXUALITY EDUCATION

The following are some questions commonly raised by opponents of comprehensive sexuality education, along with responses that have worked for other communities. Other criticisms may arise and sexuality education proponents should decide in advance what their response will be.

**Shouldn’t parents be the ones responsible for teaching their children about sexuality?**

Open communication between parents and children is extremely valuable, and young people consistently say they want to be able to talk with their parents about sexuality. Unfortunately, most parents report that they do not know what to say, or when to say it. Parents often feel uncomfortable talking with young people about intimate issues: 67 percent of parents say it is hard for them to talk with their children about sexuality. Ninety-eight percent of parents say they need help in communicating better.

Supplementing education received by parents with sexuality education provided in the schools helps parents overcome the difficulties they face when they are the sole providers of information and guidance. Sexuality educators work in concert with parents to promote healthy sexual development by adolescents. Links between parents and schools can aid parents in their efforts and help them to build skills along with their children.

**What advantage is there in offering sexuality education in the schools?**

The goal of sexuality education is to promote positive sexual health. Quality sexuality education focuses on both factual information and skills development. Skill-building components address setting goals, communicating about whether to have sex, negotiating abstinence or contraceptive use, resisting peer pressure and other important abilities.

While sexuality is a normal, healthy part of being alive, too many families maintain a harmful silence about the issue, giving young people the message that sexuality is bad. Ignorance flourishes in such a climate, preventing teens from making informed and responsible decisions about abstinence, contraception, sexuality and relationships.

School-based programs can play an important role in educating young people about sexual health and decision-making. Age-appropriate comprehensive sexuality education (preferably from kindergarten through 12th grade) can reach young people before they start having sex and increase motivation to delay initiation of sexual intercourse and to use contraception consistently.

Comprehensive sexuality education also allows students the opportunity to examine behavioral values and norms in order to weigh the consequences of their decisions. School-based education helps young people learn to identify
their own and their families values, and to use these values to make healthy choices throughout their lives.

**What are the effects of sexuality education?**

Sexuality education, combined with access to contraception, can help teens delay sexual intercourse and to use contraception better. Other industrialized countries that have comprehensive education and confidential access to contraceptives have much lower rates of teen pregnancy, childbearing and abortion than does the United States. In fact, these European rates are 2-7 times lower than rates in the US, even though teen sexual activity is similar for US and European teens.

Research shows that young people who receive sexuality education in the schools are more likely to talk with their parents about sexuality. Comprehensive sexuality education enhances young people’s knowledge, clarifies their values, improves their communication skills and encourages sexually active teens to use contraception. Comprehensive programs have been found to help teens delay having sex and to improve their contraceptive use when they do have sex.

Because most contraceptive failure is due to error on the part of the user rather than a flaw in the product, sexuality education can decrease contraceptive failure. For example, correctly used condoms are about 98 percent effective. Comprehensive sexuality education can help reduce user error by improving communication about contraception, as well as educating people about correct use.

**Doesn’t sexuality education promote sex and lead to sexual experimentation?**

No, providing information about sexuality does not lead young people to experiment with sex. Age appropriate comprehensive sexuality education that begins early and is sustained can help teens delay sex and use more effective methods of birth control once they become sexually active.

In fact, a recent World Health Organization review of sexuality education programs from all over the world found that young participants engaged in neither earlier nor increased sexual activity. Studies consistently show that teens who receive quality sexuality education are more likely to report contraceptive use at first intercourse than teens without sexuality education.

**What’s wrong with teaching values?**

Sexuality education programs do stress values. The values-based components help young people identify their own values based on their culture, family and religious background. Comprehensive sexuality education programs do not attempt to replace family values, but rather to help young people identify them so they can be more aware of which decisions are right for them, and why.

Education which explores differences in American society fosters respect for diversity in our country while validating commonly held social values: honesty, dignity and responsibility.
What’s wrong with teaching abstinence?

All comprehensive sexuality education programs teach about abstinence, and help teens build their skills to remain abstinent if they so desire. These topics include decision-making, negotiating health care and contraceptive use, disease prevention and avoidance of peer pressure. When abstinence is taught as the only option for young people, however, teens are denied information and skills that will be vitally important to them at some point in their sexual lives.

Furthermore, sexually active teens feel stigmatized by messages that only abstinence is safe or appropriate, and may be less likely to use contraception when they have intercourse. After all, condoms provide 10,000 times more protection than no contraception at all. Withholding information does not help young people make informed and responsible choices.

How can you teach abstinence and contraception at the same time? Doesn’t that send a mixed message?

Teaching abstinence along with contraception does not send a mixed message. Instead, it realistically acknowledges the complicated nature of sexual relationships and the important decisions that being sexual people involves. Comprehensive sexuality education provides young people with facts about a wide range of behaviors and choices, including abstinence and contraception. This information empowers teens who are both having and abstaining from sex to make healthy decisions based on knowledge and their personal values. Research indicates that school programs that promote both abstinence and protected sex are more effective in reaching teens and help them make responsible decisions.

How can sexuality education be good if so many people oppose it?

Actually, most people (including most parents) support sexuality education. A recent study indicated that 85 percent of adults support comprehensive sexuality education in the schools, and 94 percent support HIV prevention education in the schools. Public health organizations recognize that sexuality education is beneficial; a list of organizational supporters appears on the reverse of this page.

Most opposition to sexuality education comes from a small minority of people, unusually conservative in their political and religious values. These critics usually fear that any discussion of sexuality will lead young people to have sex or that openness about homosexuality will somehow “recruit” teens into lesbian or gay relationships. Another misperception is that programs which are not comprehensive and only discuss abstinence can be effective. Not one of these beliefs is true. Educating the public about the real content and effects of sexuality education will help allay fears and make visible the overwhelming public support for comprehensive sexuality education.
GENERAL ADVOCACY COMPONENTS
COMMON QUESTIONS ABOUT SCHOOL-BASED AND SCHOOL-LINKED HEALTH CENTERS

The following are some questions commonly raised by opponents of school-based and school-linked health centers (SBHCs), along with responses that have worked for other communities. Other issues will probably arise and SBHC proponents should decide in advance what the response will be.

Isn’t adolescent health care parents’ responsibility?

It is, but in many communities medical services are limited and difficult to access. Parents often find it difficult to get needed health care for their children. Barriers of cost, scheduling and transportation may keep parents from being able to provide the health care their children need. SBHCs work with parents to help their children and young people obtain care.

Won’t SBHCs undermine parental authority?

SBHCs aim to provide comprehensive health services to young people, they do not seek to replace the family. If anything, SBHCs serve families by providing quality medical care to their adolescent members.

Furthermore, parents are involved in the process: before a student is allowed to use a school-based health center, he or she must produce a signed parental consent form. During the visit, center staff encourage young people to communicate with their parents, discuss their clinic visits with parents and inform their parents of illnesses, such as the flu, strep throat, etc.

With regard to family planning and treatment of sexually-transmitted diseases (STDs), if a center provides those services, the SBHC will follow legal procedures practiced by any health center in the state. In the majority of the 50 states, young people are entitled by law to confidential services associated with family planning, prenatal care and the screening and treatment of sexually-transmitted disease. At SBHCs, staff members urge students to talk with their parents about sexual matters, but health centers respect the law, and do not inform the parents directly about these matters. Check the laws in your state by calling the state health department.

Doesn’t the parental consent form confuse parents about the services actually provided?

Parental consent forms are straightforward. They describe the health center and often list the services available. If parents have questions regarding forms or center services, they are welcome to call or to visit the center for further information. In many locations, SBHC staff hold parent orientation meetings and information forums throughout the school year.
Shouldn’t schools focus on education and not try to provide medical care?

For more than one hundred years, in addition to their educational mission, America’s public schools have served as vehicles for reaching young people with critical health services and messages. From vaccines to vision and hearing tests, schools have been at the forefront of providing health-related services to young people.

Now, in response to the nation’s growing awareness of health — particularly for young people — health centers are extending and improving the services offered in the school setting. Because educational potential is significantly compromised by illness and absence from school, and because many young people do not receive adequate health services elsewhere, schools must continue to confront the health and social problems that profoundly impact students’ healthy transitions to adulthood.

SBHCs are a natural extension of traditional school health services and represent a collaboration between the school and health and social services agencies. Health center staff educate young people as well as treat them. SBHCs help students attain educational goals by detecting problems in vision or hearing. Moreover, SBHCs are able to intervene in conditions that interfere with academic performance, such as substance abuse or sexual abuse. Furthermore, since health center resources are used rather than educational resources, school budgets and curricula are not adversely affected by the presence of health services.

The National PTA, the National School Boards’ Association, the American Medical Association and many other professional organizations support the role of schools in providing comprehensive health services. These groups recognize that students cannot learn if they are not healthy.

Don’t SBHCs disrupt school by taking students out of class?

SBHCs do not disrupt the educational process. Rather, by keeping students healthy, encouraging healthy behavior and saving young people the time and inconvenience of traveling to distant physicians’ offices, health centers keep students in class. Students usually do not leave class randomly or at a moment’s notice, but rather schedule appointments at the health center for their free period or study hall. Students can also visit health centers before and after school, as most center hours extend beyond the official school day.

Don’t SBHCs create additional work for over-burdened school administrators?

Although health center staff cooperate with school officials and follow all school regulations, all SBHCs are sponsored and administered by an outside agency. That agency is responsible for obtaining funding, hiring and directing staff, establishing medical protocols, obtaining medical liability insurance and handling other aspects of the center. SBHCs are independent from the schools, and function as guests within the school setting.
Don’t SBHCs put school nurses out of business?

School nurses have several duties distinct from the center, such as those related to school records and serving students who are not enrolled in the SBHC program. Therefore, much of the nurse’s day remains the same as it did before the SBHC existed. Most school nurses and SBHCs work together to integrate the responsibilities of the nurse with those of the center. The school nurse should serve on the advisory board, help plan the center and counsel and refer students to the SBHC. Nurses typically welcome SBHCs because it enables them to not only to detect and diagnose, but also to treat and resolve student health problems.

Don’t SBHCs require students to use their services?

SBHC enrollment is not mandatory. Students and their families choose whether or not to use the facility. In every school there are students who have access to other sources of care and students who choose not to use the center for other reasons. Students have the right not to participate in the program and are never pressured to do so.

Don’t SBHCs provide lower quality care than private physicians, community and hospital clinics?

SBHCs follow the same procedures and protocols as other clinics and medical facilities. SBHC physicians either serve students directly in the center or establish protocols and handle referrals. They also provide oversight, acting as the program’s medical director. Every program differs and, as is the case with individual private physicians, styles vary. SBHCs can offer more individualized, age-appropriate care, with a longer amount of time spent with each client, than private physicians and community and hospital clinics are ordinarily able to provide.

Aren’t SBHCs expensive?

Health care is expensive all over the United States. SBHCs cost, on average, $150 to $200 per student served per year. This is not inexpensive, but neither is the loss incurred by the community when young people become ill, miss school, perform poorly and/or drop out due to undetected and untreated illness. In addition, health care costs are offset in the long run by the reduction of emergency room visits, births to teens, infants born with low birth weight, and STD infection.

Aren’t SBHCs wasting money by duplicating already-existing services?

SBHCs open when a significant amount of unmet need is discovered — where existing services are insufficient or not effectively reaching young people. Therefore, SBHCs do not duplicate existing services. Moreover, a good SBHC improves the effectiveness of existing services by linking with community agencies through referral and follow-up. In doing so, the SBHC helps broaden the outreach and impact of their own, as well as other, community programs.
Won’t a family planning component in the SBHC sanction promiscuity?

Studies indicate that SBHCs that provide reproductive health services do not increase sexual activity. In fact, most young people who use SBHCs or other clinics for birth control services have already been sexually active for several months — typically as long as nine months. SBHCs provide counseling that encourages students to reflect on their decisions about sexual activity, recognize the right to say “no” and abstain, and consider discussing their situation with their parents. If young people are engaging in sexual intercourse, the health centers work to provide safe and effective contraception and STD prevention.

Aren’t SBHCs really “sex centers”?

SBHCs are comprehensive health centers. They address the health needs of adolescents. Most of these needs are not related to sexual activity. In fact, 75 to 80 percent of SBHC visits are generally for reasons other than family planning; reasons such as chronic and episodic care. Still, young people have important questions and needs regarding their sexuality. They deserve access to services and/or consultation that addresses these important issues.

Don’t these centers “push” contraceptives?

SBHCs do not “push” birth control. Health center staff counsel students, examine them and, if students decide to engage in or are already engaging in sexual intercourse, educate them about birth control and disease protection. Centers then either refer students to a family planning clinic, suggest or prescribe a birth control method, or make contraceptives available. Staff members conduct follow-up to determine whether the student has any questions, has encountered any difficulties, is continuing to use the method and/or needs an additional check up.

Do SBHCs promote and perform abortions?

No school-based or -linked health center performs abortions. SBHC practitioners adhere to standards of medical ethics whereby pregnant patients are entitled to know about all of their medical options. Many centers refer pregnant students to other agencies for counseling.

Aren’t SBHCs overrated? Can’t you achieve the same results from other health programs?

SBHCs cannot solve all of the problems that beset adolescents — nor can any program. There certainly remains a need for other additional programs to serve youth.

Nevertheless, SBHCs represent an exciting concept with many advantages. Because of their convenient location in schools, their focus on adolescent health and their provision of comprehensive services, SBHCs effectively serve many young people. They provide access to primary and preventive care that is convenient and comprehensive. Health center staff develop positive and lasting relationships with teens, thus enabling them to provide high quality, consistent care in addition to education, counseling and support. SBHCs provide a readily available entry point into the health care system for young people who might otherwise be left without services.
GENERAL ADVOCACY COMPONENTS
RESPONDING TO ARGUMENTS AGAINST CONTRACEPTIVE AND CONDOM AVAILABILITY PROGRAMS

Because of the intense controversy surrounding contraceptive availability programs for adolescents, it is important to be prepared to respond to arguments raised by the opposition. The following are some typical arguments against contraceptive and condom availability for teens, and suggestions on ways to respond.

Abstinence is the only truly effective means to prevent pregnancy and sexually transmitted diseases (STDs); there is no such thing as “safe sex.”

Proponents must stress that abstinence is the only guarantee against unwanted pregnancy and infection with HIV or other STDs. All comprehensive plans include positive messages about abstinence. Teens who choose to be abstinent or to delay sexual activity despite biological, emotional and environmental pressures need to be supported. But almost everyone will become sexually active at some point. Information about reproduction and sexuality and access to services for prevention of pregnancy and STDs are also important components in efforts to ensure healthy sexuality.

Abstinence-based messages should always be part of prevention programs, but they should not be the only message. Abstinence-only messages have been shown to be ineffective with teens who are already having sex (estimated to be 70 percent of high school seniors). Teens who are sexually active ignore abstinence messages; without information about contraceptive methods and the need to act responsibly, these teens are likely to use no contraception at all.

Contraceptive “distribution” encourages teens to have sex.

Contraceptive availability programs do not cause teens to be sexually active. Program staff do not indiscriminately force condoms and other forms of birth control on teens who do not request them. Contraception is available only to those who ask for it, not distributed to all students.

Studies have found that contraceptive availability neither hastens the initiation of sexual activity nor results in greater frequency of intercourse among students. Such programs only offer protection to teens already engaging in sexual intercourse. Additionally, comprehensive contraceptive availability programs offer teens decision-making and negotiating skills as well as skills to resist peer pressure.

Contraceptive availability programs send the wrong message to teens.

By making contraceptive available to sexually active students, schools let students know that the community cares about their total health and well
being; that there are adults who are prepared to deal with the reality of their lives rather than deny adolescent sexual behavior; and that, while adults may prefer teens to refrain from sexual intercourse, it is of primary importance to help those who do not avoid the extreme negative consequences of unprotected sexual intercourse.

**Condom failure rates are very high. Telling teens they should use condoms gives them a false sense of protection.**

When used consistently and correctly, latex condoms are extremely effective. One study of 123 couples where one member was infected with HIV and the other one was not determined that none of the uninfected partners who reported consistent condom use during the study period became infected with HIV. Most condom failure results not because condoms break or leak, but because they are used incorrectly. Increased familiarity with family planning methods, and greater education about how to use them, will increase the likelihood that contraceptives are used correctly and consistently.

Teens must receive accurate information about the efficacy and side effects of every method including using no contraception at all. Information about the probability of contracting an STD or experiencing an unintended pregnancy with different methods, and with no method, will help teens make responsible decisions about whether to have sex, and the most appropriate way for them to avoid pregnancy and STDs.

**The number of adolescents with AIDS is small; the problem has been blown out of proportion.**

While the actual number of full blown AIDS cases in the teenage population is small, there are a sizable number of HIV-infected teenagers in this country, and adolescents are at risk of contracting HIV.

AIDS is currently the sixth leading cause of death among 15- to 24-year-olds. The number of reported AIDS cases among 13- to 19-year-olds increased by 20 percent between December 1993 and December 1994. Given the average latency period of 10 to 12 years between infection and the onset of symptoms, most of the AIDS cases among 20- to 24-year-olds probably resulted from infection during the teenage years. Research suggests that from 1987 to 1992 one quarter of those newly infected with HIV were under the age of 22.

America’s STD rates are among the highest in the world. Three million American teens contract an STD each year, indicating that many young people are at high risk for HIV infection.

**It is the parents’ responsibility to inform children about sexuality, not the schools’.**

Parents are the first and primary sexuality educators of their children. Optimally, parents provide the values and guidelines for all aspects of what they deem to be acceptable behavior — through both discussion and acting as role models. Yet most parents express the need for help in discussing sexuality and AIDS prevention with their children.
Further, many teens are not fortunate enough to have homes where they can seek information and guidance on these subjects. HIV prevention and sexuality education programs compliment and augment parents’ responsibility, not to replace or undermine it.

**Parents do not approve of these programs and will not support them.**

The majority of parents understand the risk adolescents face and support efforts to protect them. According to a 1988 poll by Louis Harris and Associates, 73 percent of adults favor making contraception available in schools. A 1991 Roper poll found that 64 percent of adults say condoms should be available in high schools. In addition, a 1992 poll of North Carolina residents found that 67 percent favored making contraceptives available in senior high schools.

**Condoms are available at drug stores, there is no need for them to be at school, too.**

It is true that since the 1977 Supreme Court decision, Carey v. Population Services International, unmarried teens have had a legal right to purchase condoms at any drugstore or convenience store, but that does not guarantee unimpeded access. A survey of drug stores in the Washington, D.C. area found teens had to overcome significant barriers in order to purchase condoms, including disapproving clerks and difficulty locating condoms on the shelves or behind counters.

The problems are more complicated for low income and rural teens who find the cost of condoms an obstacle, may not have transportation or fear encounters with friends or neighbors while in the store. While some family planning clinics attempt to be sensitive to teens’ needs by scheduling special hours or establishing outreach sites, it remains difficult for teenagers to this is not always the case.

School is where a majority of teens spend their non-home hours. A well-designed school contraceptive availability program does more than expand access to condoms; it teaches sexual decision-making and negotiation skills and signals to sexually active teens that the community cares about their future.
General Advocacy Components
A needs assessment is a study of youth health indicators within a defined community and an analysis of factors potentially contributing to any excess morbidity and mortality within that population.

Needs assessments that demonstrate high rates of teen pregnancy, sexually transmitted diseases (STDs) or HIV, and/or show limited adolescent access to reproductive and sexual health services provide the basis for advocacy and public education campaigns to promote new or expanded programs.

A complete needs assessment includes three phases:

1) comparing local rates of (or trends in) morbidity and mortality with state and national averages;
2) identifying and examining gaps and barriers to accessing mental, physical and reproductive health services in the community;
3) assessing state and local policies and / or laws affecting adolescent reproductive and sexual health information and service availability.

It is not necessary to collect all the information presented below. Access to all of these statistics may not be possible, but it is important to accumulate enough data to describe the state of adolescent health in the community. Further, the more information available, the better able planners will be to design effective and accessible programs that meet the real needs of the community’s young people.

When analyzing the data, examine whether local rates have changed over the past few years and / or if local rates are higher than national or state averages. The needs assessment should also identify groups or neighborhoods with higher than average rates of health problems and / or less access to services and information. These areas, having demonstrated the greatest need, should be targeted first for health promotion programs.

Based on what is discovered, the needs assessment analysis can be very effective in persuading policymakers to support, expand or implement programs and policies to improve teen health. Identifying the major problem areas will help this community design programs most likely to address these issues.

**Health Indicators:**

To assess the health status of youth in a given community, start by collecting existing data from state and local public health agencies, the school-system and other sources. If the information does not exist, gather it by polling youth directly. The following local, state and national data can be helpful when conducting a needs assessment:

- Teen pregnancy / miscarriages / abortion / birth rates
- Sexually transmitted infection rates
- Low birth-weight babies born to teen mothers
Adolescent Reproductive and Sexual Health

- Consistency of teen condom and other contraceptive use
- Percent of all adolescents that are sexually active
- Adolescent and adult substance use/abuse
- Child abuse and neglect reports
- Sexual abuse/incest reports
- AIDS cases among adolescents and adults 20-30 years of age
- Teen homicide and suicide
- Accident and injury
- Malnutrition, anorexia, bulimia and obesity
- Income of the community
- Children living with single parents
- Immunization status of children
- Juvenile incarceration
- School drop-out
- School absenteeism.

Assessing Gaps in Services

Examine the existence and quality of reproductive and sexual health information and services, as well as the availability of physical and mental health services by answering questions like:

- What primary health care services exist in the community?
- Are these services private or public?
- Are mental health and substance abuse services available for teens?
- What confidential reproductive health services exist in the community?
- Is confidential HIV testing, counseling and treatment available to teens?
- Is confidential STD screening, counseling and treatment available to teens?
- What percentage of teens have private insurance?
- What percentage are covered under Medicaid?
- What percentage are uninsured?
- What percentage have a primary care provider?
- What forms of insurance do the health care providers accept?
- Is comprehensive sexuality education provided by schools and/or other organizations?
- Starting at what grade level?
- What percentage of teens used the emergency room the last time they needed health care?
- Is transportation to services available?
- Are services offered at convenient hours for teens, such as on the weekend and in the evenings?
- What factors keep teens from using existing services?
- What services are not available?
Policies That Affect Adolescent Access to Services and Information

State and local policies can either enhance and protect or restrict and limit teenagers’ abilities to access health care information and services. Examine existing policies by answering the following questions:

- Do policies restrict health care referrals or services that may occur in school-based or -linked health centers?
- Are SBHCs permitted to make contraceptives available to clients?
- Are comprehensive sexuality education and AIDS prevention education mandated to be provided in the public schools?
- What information is required by these mandates?
- What grade levels are mandated to receive this education?
- Does the state or any school districts restrict discussing certain information, such as contraceptive methods, homosexuality, condom use or abortion?
- What is the reality of sexuality education and AIDS prevention education implementation in the area?
- Do state policies restrict teen access to abortion information and services?
- Does the state mandate provision of any specific services at school-based or -linked health centers?
- Do policies prohibit discussing contraception, condom use, homosexuality or abortion in school-based health centers?
- At what age does state policy allow adolescents to consent to their own health care treatment? For what services?
- Does the state fund abortions for women receiving Medicaid?
GENERAL ADVOCACY COMPONENTS
RESOURCE LIST

National Organizations Concerned about Adolescent Reproductive and Sexual Health

Advocates for Youth
Suite 200
1025 Vermont Avenue, NW
Washington, DC 20005
(202) 347-5700

Alan Guttmacher Institute (AGI)
111 5th Avenue
New York, NY 10003
(212) 254-5656

American Academy of Pediatrics
Division of Child & Adolescent Health
Suite 400N
601 13th Street, NW
Washington, DC 20005
(202) 347-8600

American College of Obstetricians & Gynecologists (ACOG)
Resource Center
409 12th Street, SW
Washington, DC 20024

American Foundation for AIDS Research (AmFAR)
2nd Floor
East Satellite
5900 Wilshire Boulevard
Los Angeles, CA. 90036
(213) 857-5900

American Public Health Association
1015 15th Street, NW
Washington, DC 20005
(202) 789-5600

American Red Cross
17th & D Street, NW
Washington, DC 20006
(202) 639-3016

Teen AIDS Hotline: 1-800-440-TEEN
American Social Health Association
P.O. Box 13827
Research Triangle Park, NC 27709
Herpes hotline: (919) 361-8488
AIDS hotline: (800) 342-2437
Spanish-speaking AIDS hotline:
(800) 243-7889
STD hotline: (800) 227-8922
For the deaf: (800) 344-7432

American School Health Association
P.O. Box 708
Kent, Ohio 44240
(216) 678-1601

Big Brothers/Big Sisters of America
230 North 13th Street
Philadelphia, PA. 19107
(215) 665-7747

Boys and Girls Clubs of America
National Headquarters
771 First Avenue
New York, NY 10017
(212) 351-5910

Bureau of Primary Health Care
Healthy Schools, Healthy Communities
9th Floor
4350 East-West Highway
Bethesda, MD 20814
(301) 594-4470

Camp Fire Boys and Girls
4601 Madison Avenue
Kansas City, Missouri 64112-1278
(816) 756-0258

Catholics for a Free Choice
Suite 301
1436 U Street, NW
Washington, DC 20009
(202) 986-6093
Centers for Disease Control and Prevention
Division of Adolescent & School Health
Mailstop K31
4770 Buford Highway, NE
Atlanta, GA 30341-3724
(404) 488-5358

Center for Reproductive Law & Policy
120 Wall Street
New York, NY 10005
(212) 514-5534

Council of Chief State School Officers (CCSSO)
Suite 700
1 Massachusetts Avenue, NW
Washington, DC 20001
(202) 408-5505

Girls Inc.
30 East 33rd Street
New York, NY 10016
(212) 689-3700

Latino Center for Reproductive Health
c/o HDI Projects
Suite 603
1000 16th Street, NW
Washington, DC 20036
(202) 452-8750

Making the Grade
Suite 505
1350 Connecticut Avenue, NW
Washington, DC 20036
(202) 466-3396

National 4-H Council
7100 Connecticut Avenue, NW
Chevy Chase, MD. 20815-4999
(301) 961-2800

National Adolescent Health Information Center
11th Floor
1388 Sutter Street
San Francisco, CA. 94109
(415) 476-5255

National Advocacy Coalition for Youth and Sexual Orientation (NACYSO)
Suite 200
1025 Vermont Avenue, NW
Washington, DC 20005
(202) 783-4165

National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850
(800) 458-5231

National Asian Women’s Health Organization
Suite 208
440 Grand Avenue
Oakland, CA. 94610
(510) 208-3171

National Assembly for School-Based Health Care
6728 Old McLean Drive
McLean, Virginia 22101
(703) 556-0411

National Association of State Boards of Education
1012 Cameron Street
Alexandria, VA 22314
(703) 684-4000

National Center for Youth Law
Suite 900
114 Sansome Street
San Francisco, CA. 94104
(415) 543-3307

National Coalition of Hispanic Health and Human Services Organizations (COSSHMO)
1501 16th Street, NW
Washington, DC 20036
(202) 387-5000
National Council of La Raza
Suite 300
810 First Street, NE
Washington, DC 20002
(202) 289-1380

National Education Association (NEA)
Health Information Network
1201 16th Street, NW
Washington, DC 20036
(202) 822-7570

National Family Planning and Reproductive Health Association (NFPRHA)
Suite 380
122 C Street, NW
Washington, DC 20001
(202) 628-3535

National Latina Health Organization
P.O. Box 7567
Oakland, CA 94601
(510) 534-1362

National Lesbian and Gay Health Foundation
1407 S Street, NW
Washington, DC 20000
(202) 797-3578

National Minority AIDS Council
Suite 400
300 I Street, NE
Washington, DC 20012
(202) 544-1076

National Network for Youth
Suite 401
1319 F Street, NW
Washington, DC 20004
(202) 783-7949

National Organization for Adolescent Pregnancy Prevention (NOAPPP)
4421 A East West Highway
Bethesda, MD. 20814
(301) 913-0378

National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722

National School Health Education Coalition (NaSHEC)
Suite 520
1400 I Street, NW
Washington, DC 20005
(202) 408-0222

People for the American Way
Suite 400
2000 M Street, NW
Washington, DC 20036
(202) 467-4999

Planned Parenthood Federation of America
810 7th Avenue
New York, NY 10019
(212) 541-7800

Religious Coalition for Reproductive Choice
11th Floor
1025 Vermont Ave, NW
Washington, DC 20005
(202) 628-7700

Sex Information and Education Council of the United States (SIECUS)
130 West 42nd Street
Suite 2500
New York, NY 10036
(212) 819-9770

Y.W.C.A. of America
725 Broadway
New York, NY 10003
(212) 614-2827
GENERAL ADVOCACY COMPONENTS

SAMPLE TESTIMONY: AFY STATEMENT BEFORE THE PRESIDENT’S COUNCIL
I am Margaret Pruitt Clark, President and Executive Director of Advocates for Youth (formerly the Center for Population Options). Advocates for Youth, a not-for-profit agency located in the nation’s capital, was founded 15 years ago with the mission of increasing the opportunities for and abilities of young people to make healthy decisions about their sexuality. We provide information, education and training about adolescent reproductive and sexual health to youth-serving professionals, policymakers and the media.

In light of Advocates for Youth’s mission and the work our organization does with and on behalf of young people, particularly in the field of teen pregnancy prevention, our organization has a strong interest in government policies directed at adolescents.

Since its inception in 1980, Advocates for Youth has studied the issues of teenage pregnancy and teenage childbearing and effective ways to address both issues. It is important to remember that just as teenage sexual activity does not automatically lead to teenage pregnancy, teenage pregnancy does not necessarily lead to teen childbearing. It is also important to remember that while many teenage pregnancies are reported as unintended by the young woman herself, not all are. I will return to both of these points shortly.

The causes of teenage pregnancy and childbearing are numerous and complex. Poverty, poor schools, inadequate health care, lack of access to family planning services, lack of knowledge about sexuality, sexual abuse, parental neglect and lack of hope for the future are some of the myriad causal factors underpinning this nation’s number of teenage pregnancies.

The first step in addressing the problems of adolescent pregnancy and childbearing is to acknowledge the reality of teenage sexual activity. Approximately one-third of 15-year olds in the United States have had sexual intercourse. By age 18, 70 percent of females and 79 percent of males have had intercourse. There has been a consistent upward trend both of first intercourse at younger ages and of more young people at any age reporting sexual activity for several decades now.

Looking at rates of sexual activity broken down by race and ethnicity we see the following trends. Among unmarried 15- to 19-year-old males, 81 percent of African Americans, 60 percent of Latinos and 57 percent of European Americans have had sexual intercourse. Among unmarried females ages 15 to 19, 61 percent of African-Americans, 49 percent of Latinos, and 52 percent of European Americans have had sexual intercourse.
The decline in the average age at first intercourse has coincided with a rise in the average age at first marriage. In 1950 the average age at first marriage for men was 23 and for women it was 20. Four decades later the average age for men is 26 and 24 for women. Reflecting the worldwide trend toward marriage at an older age (if at all), the likelihood that a young woman will have intercourse before getting married has almost doubled in the past thirty years.

In addition, for some young women, African Americans in particular, the prospect of marriage is rapidly diminishing due to high unemployment rates and the lack of educational and labor opportunities for African American men. Still, for some young women, enhanced economic independence along with changing gender roles has made the desirability of marriage questionable.

Research has shown that the younger a woman is at the time of her first sexual experience, the more probable it is that the encounter was forced, that is, took place without her consent. Seventy-four percent of women who had intercourse before age 14 and 60 percent of women who had intercourse before age 15 report that it was involuntary.

In light of these changes, it is highly unrealistic to expect young people to wait until marriage to become sexually active, and indeed, they do not. A more reasonable approach is to provide reproductive health information and access to services to ensure that unintended pregnancies and unwanted births do not result once they do become sexually active.

It has been estimated that 43 percent of all adolescent females experience at least one pregnancy before they reach the age of 20. In 1989, over one million young women under the age of 20 experienced a pregnancy. The pregnancy rate for females under 20 was 118.8 per 1,000 women up from 98.9 in 1973. Of the 2,800 adolescents who become pregnant each day, 1,300 will give birth, 1,100 will terminate the pregnancy, and 400 will miscarry. Three quarters of all unintended pregnancies occur to adolescents who do not use contraception. According to Child Trends, however, the adolescent birth rate (as opposed to the pregnancy rate) was 90.3 per 1,000 in 1955 and only 59.9 per 1,000 in 1990.

This country does not fare well when compared with other industrialized nations. In countries such as Sweden and the Netherlands, where the national governments have made philosophical and monetary commitments to family planning and comprehensive sexuality education, teen pregnancy rates and birth rates are significantly lower. Yet the level of sexual activity among adolescents in those countries is similar to that in the U.S., indicating the beneficial effects of social and financial commitment to prevention and education instead of punishment when addressing teen sexuality.

As I said earlier, although many young people have decided to engage in sexual intercourse prior to marriage, most do not want to become pregnant. In fact, 82 percent of teenage pregnancies are unintended, resulting from a variety of factors, including peer pressure, lack of self-esteem, poor communication between adults and adolescents, lack of understanding of reproductive health, lack of access to family planning information and resources, insufficient access to alternative constructive recreational activities, sexual abuse, or coercion arising from the significant age disparity between some young women and their partners.

As a nation, we could make significant strides toward reducing the number
of teen pregnancies by funding youth programs that are sensitive to and treat the multidimensional nature of the problem. While the majority of teenage pregnancies are unintended, as many as half of young women who become pregnant unintentionally are ambivalent about pregnancy and even about taking active steps to avoid pregnancy. That is, they take an alarmingly indifferent "shrug the shoulders" approach to some very important life decisions. Again, the key to dealing effectively with teen pregnancy and early childbearing is to address young women's indifference about the future by providing options for the future in the form of educational resources and employment opportunities.

Pregnancy prevention strategies should give young people the attention, services and resources they need to be self-sufficient before problems arise. The focus cannot solely be on young women because they are only half of the equation when it comes to making babies. Male involvement at all levels and ages must be part of the formula for addressing these problems.

Some of the steps we must take if we want to give all young women and men the chance to have healthy, productive futures are the following:

First, young people — male and female — should be encouraged to delay sexual activity until they are prepared to assume the obligations that it can bring. This means equipping adolescents with more tools than "just say no" phrases. We have to teach adolescents how to say no. At that same time, many teens need to be given reasons to say no to early sexual involvement. Particularly in economically-depressed neighborhoods, adolescents need alternative recreational activities and other incentives not to engage in high-risk behaviors. They need to believe that if they work hard and play by the rules, including delaying childbearing, there will be a job available that will allow them to support a family.

Second, we must encourage responsible behavior by those young people who do choose to be sexually active to reduce their risk of sexually transmitted diseases, HIV/AIDS as well as unintended pregnancy. As other industrialized nations have found, encouraging adolescents to delay having sex teaching them to protect themselves should they choose not to delay, are not contradictory goals. Rather, they complement each other because they respond realistically to the range of social behaviors in the adolescent population.

Third, if we are serious about reducing teenage pregnancy, we must commit additional dollars to solutions. Federal resources should be directed at comprehensive school- and community-based youth service programs. These are places where young people learn and receive social and academic skills, family-life education, family crisis intervention counseling, pre-employment training, conflict resolution and violence prevention skills, and participate in athletic and artistic activities. Examples of successful programs that could serve as model programs include: Meharry Medical College’s “I Have A Future” program in Nashville; The Children’s Aid Society, run by Michael Carrera in New York City; and Grady Memorial Hospital’s “Human Sexuality, Postponing Sexual Involvement,” run by Marion Howard in Atlanta.

Government resources are also needed to promote abstinence-based (but not abstinence-only) sexuality education beginning no later than the fourth grade; to fund peer-based and adult mentoring programs for young people at highest risk for pregnancy, STD and HIV infection; and to increase access to and acceptability of all methods of contraception, including condoms.
The federal government can make a difference in reducing the number of teenage pregnancies and births by increasing support for Title X; eliminating the “Gag Rule” and the Hyde Amendment restricting women’s access to abortion counseling and abortion, respectively; increasing support for school-based and school-linked health centers and their reproductive health services; removing restrictions on condom availability; and encouraging government support for both behavioral and scientific research and evaluation. How can we talk about changing adolescents’ risk-taking behavior if we do not know what it is? We also need to continue searching for alternative contraceptive methods, including more methods for males.

Finally, all adults, particularly those in entertainment and sports industries, must send consistent messages that say early childbearing (as opposed to teenage sexual expression) is not the route to take. The message should be that giving birth to/having a child for whom you cannot emotionally and financially care is wrong. Government officials should both play a leading role in this campaign and strongly urge the communications industry to do the same. A combination of laws and media messages can be powerful in changing behavior. Who, in 1980, would have thought that we would be using seat belts or designating a driver?

Those of us who work with and on behalf of youth urge policymakers to abandon the flashy and empty political rhetoric and pay attention to the real reasons adolescents become pregnant and give birth. Once this country makes a true commitment to invest in human capital, starting with our youth, we will see fewer births to young women and fewer unintended births to all women.

ENDNOTES

Adolescent Sexuality Education
The National Coalition to Support Sexuality Education (NCSSE) is committed to the mission of assuring that comprehensive sexuality education is provided for all children and youth in the United States by the year 2000.

NCSSE consists of more than 80 national non-profit organizations, many of which are noted role models and initiators in promoting health, education, and social concerns for our nation’s youth. These organizations represent a broad constituency of social workers, religious officials and lay people, educators, advocates, physicians, health care professionals, and child development specialists, whose combined work reaches more than 30 million young people.

NCSSE Goals are to:

- Advocate for sexuality education at the national and state level;
- Assist national organizations concerned with youth to establish policies and programs on sexuality education by the year 2000;
- Develop strategies for facilitating national and local implementation of sexuality education initiatives and efforts;
- Develop pro-active strategies to address the activities of those who oppose providing children with comprehensive sexuality education;
- Provide an opportunity for networking, resource sharing, and collaborating on a national level;
- Develop joint goals and objectives into the 21st century;
- Hold semi-annual meetings to discuss progress made toward achieving its mission.

Sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, affection, intimacy, body image, and gender roles. Sexuality education seeks to assist children in understanding a positive view of sexuality, provide them with information and skills about taking care of their sexual health, and help them acquire skills to make decisions now and in the future.

Sexuality education programs should emphasize that sexuality is a natural and healthy part of life. School-based education programs are most successful in a balanced curriculum that provides factual information for adopting health-promoting sexual behaviors. In order for such sexuality education programs for adolescents to be inclusive, they need to address both sexual abstinence and safer sexual behaviors. Ideally, programs would be offered from kindergarten through 12th grade in the context of an overall comprehensive health education program.

Comprehensive sexuality education underscores and supplements the role of parents in the sexuality education of their children and reinforces the notion that responsibility and obligation sexuality education must be shared on a community-wide basis.
MEMBERSHIP LIST
as of February 1995

Advocates for Youth
AIDS Action Council
American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Association on Mental Retardation
American Association of School Administrators
American Association of Sex Educators, Counselors and Therapists
American College of Obstetricians and Gynecologists
American Counseling Association
American Association of Family & Consumer Sciences
American Library Association
American Medical Association
American Nurses Association
The American Orthopsychiatric Association, Inc.
American Psychological Association
American Public Health Association
American School Health Association
American Social Health Association
Association for the Advancement of Health Education
Association of Reproductive Health Professionals
Association for Sexuality Education and Training
Association of State and Territorial Directors of Public Health Education
ASTRAEA National Lesbian Action Foundation
AVSC International
Blacks Educating Blacks about Sexual Health Issues
B’Nai B’Rith Women
Catholics for a Free Choice
Center for Policy Alternatives
Child Welfare League of America
Children’s Defense Fund
Coalition on Sexuality and Disability, Inc.
Commission on Family Ministries & Human Sexuality, National Council of Churches
Education Development Center, Inc.
ETR Associates
Federation of Behavioral, Psychological and Cognitive Sciences
Girls Incorporated
Hetrick-Martin Institute for Gay and Lesbian Youth
Human Rights Campaign Fund
The Institute for Advanced Study of Human Sexuality Alumni Association
The Latina Roundtable on Health & Reproductive Rights
Midwest School Social Work Council
National Abortion Federation
Adolescent Sexuality Education

National Abortion & Reproductive Rights Action League
National Asian Women’s Health Organization
National Association of Counties
National Association of County Health Officials
National Association for Equal Opportunity in Higher Education
National Association of School Psychologists
National Center for Health Education
National Coalition of Advocates for Students
National Council on Family Relations
National Council of State Consultants for School Social Work Services
National Education Association Health Information Service
National Family Planning and Reproductive Health Network
National Gay and Lesbian Task Force
National Information Center for Children & Youth with Disabilities
National League for Nursing
National Lesbian and Gay Health Foundation
National Medical Association
National Mental Health Association
National Minority AIDS Council
National Native American AIDS Prevention Center
National Network of Runaway and Youth Services

National Organization on Adolescent Pregnancy, Parenting, and Prevention
National Resource Center for Youth Services
National School Boards Association
National Urban League
National Women’s Law Center
Parents, Families and Friends of Lesbians and Gays
Planned Parenthood Federation of America
Population Communications International
Religious Coalition for Reproductive Choice
Sexuality Information and Education Council of the United States
Society for Adolescent Medicine
Society for Behavioral Pediatrics
Society for Public Health Education
Society for the Scientific Study of Sex
The Alan Guttmacher Institute
Unitarian Universalists Association
United Church Board for Homeland Ministries
United States Conference of Local Health Officers
United States Conference of Mayors
University of Pennsylvania, Graduate School of Education
YMCA of the U.S.A.
Zero Population Growth, Inc.

The breadth of the National Coalition to Support Sexuality Education reflects the widespread public support for the provision of sexuality education to the nation’s youth. If your national organization is interested in joining this important coalition, please contact SIECUS at (212)819-9770.
WHEREAS, the Adolescent Pregnancy Prevention Coalition of North Carolina emphasizes that parents are the primary source of sexual education for their children. Let’s Talk — National Family Sexuality Education Month — encourages individuals, community organizations and institutions to celebrate October by conducting special events promoting family education about sexuality; and

WHEREAS, Let’s Talk Month notes the importance of a strong partnership between the community and the family in helping young people foster responsible and positive attitudes towards their sexuality. Religious organizations and community agencies are assuming leadership roles in this effort by providing information, resources and educational programs for parents and children; and

WHEREAS, accurate education about sexuality will prepare today’s young people to educate their children. An honest approach to sexuality and an ability to inform children in an appropriate manner are elements that promote healthy sexual attitudes and behavior. Working together, parents and their communities can provide the information and support necessary to prepare today’s young people for their responsibilities as adults and parents of tomorrow;

NOW, THEREFORE, I, JAMES B. HUNT JR., Governor of the State of North Carolina, do hereby proclaim October, 1995, as “Let’s Talk Month” in North Carolina and commend this observance to our citizens.

JAMES B. HUNT JR.
SCHOOL OFFICIALS are acutely aware that America is in the midst of a new civil war over values. While there are skirmishes regarding school prayer, diversity, and other issues, the longest-running and most heated battles involve sexuality education. Regardless of whether a program is labeled family life, reproductive health, growth and development or comprehensive health education (which means it includes sexuality education), Bible-based traditionalists at the one extreme, secular humanists at the other, and those of every ideological shading in between vie with one another to influence policy and to define curriculum to suit their own ideological perspectives. These conflicts are not new to principals, superintendents, and school boards. Over the years, school officials have taken measured steps and followed low-key approaches to minimize disruptions regarding the sex education curriculum. However, two new factors may force educational leaders to make precise, controversial, and high-profile decisions. First, all regions of the country are facing local lobbying efforts orchestrated by well-funded national coalitions of special interest groups. Second, parents and government agencies are increasingly pressuring schools to address adolescent health problems that involve sexuality, such as teen pregnancy, AIDS, and sexually transmitted diseases.

Given increases in teen sexual behavior and its negative consequences, groups that were totally opposed to sex education in the 1960s and 1970s now strongly support a new brand of sex education “abstinence only.” Because proponents of abstinence-only programs believe that dealing with any aspect of intimate sexual behavior sends children mixed messages, they vehemently oppose curricula that include such topics as condom and contraceptive use, abortion, masturbation, homosexuality, and other matters of sexual behavior. The goal of abstinence-only education is to convince teens that the only morally acceptable sexual behavior takes place within marriage. Other groups call for “abstinence-plus” sexuality education. While they encourage students to postpone sexual intimacy, they support a wider range of education, including coverage of the topics mentioned above. They also advocate for skills development—providing students opportunities to rehearse, with adult coaching and supervision, communicating appropriately.
and making sound decisions. Finally, there are other groups that oppose abstinence instruction because it produces debilitating fear and shame. But these groups tend to be underrepresented in public meetings about sexuality issues. Consequently, most of the debate over sex education takes place between advocates of conservative and moderate positions, rather than between advocates of conservative and liberal positions.

As pressure groups have gained sophistication in their methods of persuasion, they have begun to cite research to substantiate their arguments. And the past decade has produced a bumper crop of well-documented scientific studies regarding sexuality education and the sexual behavior of adolescents and adults. Some of the most significant findings were derived from government-sponsored Title XX programs that examined the effectiveness of abstinence education. More recent studies, examining the effectiveness of condoms in preventing HIV transmission from infected to uninfected partners, have come from Europe.

Special interest groups, however, tend to be myopic when examining scientific data. Results from credible research are taken out of context, misinterpreted, or partially reported. Both sides of the debate may even cite the same study as the basis for opposing recommendations. In other cases, older data or outlying findings are presented as conclusive, while many newer studies that consistently show differing results are ignored. Some researchers with philosophical and financial connections to ideological factions have circulated studies that have not been subjected to peer review. Indeed, many of these studies have serious methodological flaws that invalidate their conclusions.

School leaders need to make good decisions based on reliable and valid information. Yet the time it takes to work through the research in this single area is prohibitive for most administrators. Consequently, we present here the 17 arguments most frequently put forth by groups that oppose comprehensive sexuality education, and we examine the scientific literature to determine the validity of those arguments. The first four arguments concern the effectiveness of abstinence instruction, including specific programs that have been studied under controlled conditions. Next we take up concerns about intimate sexual behavior, including the effectiveness of condoms and contraceptives. Finally, we deal with abortion as a resolution to unintended pregnancy.

1. **Abstinence-until-marriage curricula work.** In 1981 the American Family Life Act was passed, creating Title XX funds. The intent was to establish a variety of abstinence-based sexuality education programs and to test their results in delaying sexual intercourse among teens. In five studies of the three major abstinence-until-marriage programs, students who had taken part in the programs one to two years earlier showed no significant gains in maintenance of abstinence over a control group not exposed to a program. The three programs investigated were Sex Respect, Success Express, and An Alternative National Curriculum on Responsibility (AANCHOR).

2. **Abstinence-plus curricula with skills development, followed by lessons about contraception, give students a “mixed message” and encourage sexual behavior** in studies of seven abstinence-plus programs that were followed by lessons on
contraception, students surveyed one and two years after the program maintained abstinent behaviors longer than a control group. Among the successful programs were these three: Postponing Sexual Involvement, Reducing the Risk, and Skills for Life. Two new programs in this category, Be Proud! Be Responsible! and Get Real About AIDS, have also proved effective.

3. Researchers from the Institute for Research and Evaluation in Utah have shown that Sex Respect works. While behavior research on Sex Respect was completed in 1989 and 1991, to date the researchers have not submitted their studies for peer review or publication in professional journals. The report to the Office of Adolescent Pregnancy Programs (OAPP), which administered the Title XX funds, showed that Sex Respect made no significant and lasting differences in attitudes or behaviors after one and two years. In a new study, submitted in 1991, the researchers claimed a slight behavioral difference in favor of the Sex Respect group, but the OAPP reported that the research methods were flawed and that such conclusions could not be reached on the basis of the data analysis.

4. TEENAID is a highly successful abstinence-until-marriage curriculum; in San Marcos, California, teen pregnancy was reduced by 86% when TEENAID was taught. To date, the TEEN AID curriculum has not been investigated in a scientific study for behavioral effect. The “San Marcos miracle” has not been substantiated by scientifically collected data or by the counselors at the school. Advocates and detractors have described the benefits and drawbacks of TEEN AID and Sex Respect. Both programs are involved in litigation in several states.

5. Sex education encourages students to become sexually active at younger ages. The World Health Organization recently reviewed 35 controlled studies of sexuality education programs in the United States and Europe and found that in no cases did students who took part in the programs initiate sexual intercourse at an earlier age than students in the control groups exposed to no programs. One 1984 retrospective recall study found that girls who took a sex education course were “slightly more likely” to have had intercourse at ages 15 and 16, but the authors reported the factor “weaker than virtually every other variable found to have a significant relationship with first intercourse at these ages.”

6. Teaching students about contraception causes students to initiate sexual activity. Studies show that American teenagers initiate sexual intercourse and have unprotected sex for between six and 18 months or longer before they seek contraception. They typically seek contraception because of a pregnancy or a pregnancy scare.

7. Teaching students about contraception increases the likelihood that they will become pregnant. There is evidence to the contrary. European educators include contraception in family life education throughout the middle and high school grades. In a 36-country
study, it was found that, while U.S. girls initiated first sexual intercourse at the same ages and with the same frequencies as European girls, the rates of pregnancies were two to seven times higher among U.S. girls.11

8. **Because contraceptives fail so frequently, we should teach teenagers to abstain from sex.** While teen sexual behavior has increased significantly over the past two decades, the rate of pregnancy among 15- to 19-year-olds has declined by 19%, due to more effective use of contraceptives.12 The overall number of pregnancies among 15- to 19-year-olds has risen 23% since 1972, because of the large increase in the numbers of sexually active young people.13 With more effective contraceptive instruction and the introduction of Norplant and Depo-provera (which are as effective as vasectomy but completely reversible), teen pregnancy levels could be significantly reduced in the United States, as they have been in other industrialized countries.14

9. **Contraceptives do not protect against AIDS and sexually transmitted diseases (STDs).** Other than total abstinence from risky behaviors, only condoms can provide significant protection against STDs. If teens choose not to abstain, it is recommended that the male always use a condom and that the female use a reliable method of contraception until they are ready to parent a child and are determined to be free of STDS.15

10. **Condoms have a failure rate of 12% to 40%.** The failures of condoms can be attributed mostly to the people using them rather than to the product. For instance, some people who claim that they use condoms for contraception don’t use them every time, put them on after they have had intercourse but prior to ejaculation, don’t hold onto them during withdrawal, or use petroleum-based lubricants that dissolve the latex.16 The lack of knowledge about how to use a condom effectively and the lack of motivation to use one every time mean that condoms fail much more often than they otherwise would. The Centers for Disease Control and Prevention, the National Institutes of Health, and the Food and Drug Administration have issued a joint report on condoms that sets the failure rate at less than 2% for consistent and correct condom use.17 For comparison, one might ask how often people who intend to practice abstinence fail and thereby expose themselves and their partners to the risks of unprotected sex.

11. **Condoms break frequently.** The quality of condoms does vary. Triple-dipped latex condoms that are less than two months old and treated with nonoxynol 9 are considered the most reliable.18 In an eight-country study of condom breakage, an average of 4% of the participants experienced breakage over a year’s time (range 0% to 13%). Interviews with those who said that condoms broke indicated that many users had damaged condoms by stretching or inflating them before they put them on, had reused them, had used petroleum-based lubricants, had cut them with fingernails, and so on.19
12. **Condoms do not prevent HIV from passing through the latex.** There is some evidence that the pores in certain condoms are larger than HIV, the virus that causes AIDS. However, in laboratory studies, non-defective latex condoms have been 100% effective in stopping the passage of HIV, according to the Centers for Disease Control and Prevention.

13. **Condoms are not effective in preventing the transmission of HIV.** An eight-country study of condom failures among couples in which one partner had HIV and the other did not, reported that “no uninfected partner acquired HIV from an infected partner with consistent use of condoms in approximately 15,000 acts of intercourse.” However, the rate of infection in couples who used condoms inconsistently was reported to be 4.8%. No transmission rates are available for couples who did not use condoms at all.

14. **Contraceptives like the pill, Norplant, and the IUD (intrauterine device) are dangerous and unsafe.** Most contraceptives have side effects that vary in severity. However, mortality studies of contraceptives show that using contraception is four times safer than becoming pregnant and having a baby. The oral contraceptive, in fact, is much safer for younger women than for older women.

15. **Abortion is a dangerous procedure.** Studies of complications arising from abortion indicate that legal abortion is seven to 25 times safer than becoming pregnant and having a baby, and comparative mortality statistics show that legal abortion is safer than playing football, driving a car, or using a tampon.

16. **Abortion prevents a young woman from having a baby in the future.** Multiple abortions may indeed jeopardize subsequent pregnancies. However, studies show that infertility, miscarriage, low-birth-weight babies, and other conditions were no more prevalent among women who had had an abortion than among those who had not.

17. **Abortion causes mental anguish and psychiatric problems.** Former Surgeon General C. Everett Koop’s report on abortion found inconclusive evidence to consider abortion a physical or mental health problem. Small numbers of women do experience post-abortion stress syndrome, but the American Psychological Association concluded that abortion brings women so much mental relief and there is so little evidence of psychiatric problems following abortion that abortion does not cause more psychiatric problems than unwanted pregnancy.

In this article, we have sought to bring credible scientific information to the argument over whether schools should provide comprehensive or abstinence only sexuality education to students. Most experts believe that comprehensive sexuality education, taught within the framework of health education, is the most effective strategy.

The Division of Adolescent and School Health of the Centers for Disease Control and Prevention has recently established a system (called RESEARCH to CLASSROOM) for evaluating school curricula and encouraging the
dissemination of those found to have a positive behavioral impact. Evaluation, program, and teaching experts work together to evaluate materials, update and revise them for classroom use, and then support teacher training and technical assistance through the comprehensive school health training network. The training network works with state departments of public instruction.

A program is deemed successful if it brings about one or more of the following results: 1) delaying initiation of sexual intercourse, 2) decreasing the frequency of unprotected intercourse, and 3) increasing condom use. Three curricula have qualified thus far: Reducing the Risk, Get Real About AIDS, and Be Proud! Be Responsible!

While there is encouraging news about sexuality education, helping youths adopt risk-reducing behaviors, and the effectiveness of various preventive strategies when used correctly, the moral and ethical implications posed by those who argue on both sides of these issues are legitimate and need to be addressed. Therein lies the special responsibility of the family (as the primary sex educator of children) and of religious institutions to put human sexuality into context.

However, it is certainly the school’s role, even its moral obligation, to meet the needs of learners. The research justifies making recommendations for accurate and age-appropriate information, for skills development, and for instruction designed to motivate young people to protect their health and the well-being of others.

END NOTES


3. "Programs That Work: HIV Prevention for Youth," a video conference as a part of the "RESEARCH to CLASSROOM" program, Division of Adolescent and School Health, Centers for Disease Control and Prevention, 28 April 1994.


5. Blake, op. cit.


12. Ibid., p. 41.

13. Ibid.


16. “Update: Barrier Protection Against HIV Infection and Other

17. Ibid., p. 591.


23. Ibid., p. 343


25. Ibid., pp.221-27.

26. Ibid., p. 146.


LINDA A. BERNE is a professor in the Department of Health Promotion and Kinesiology at the University of North Carolina. BARBARA K. HUBERMAN is director of training at Advocates for Youth, Washington, D. C
ADOLESCENT STD/AIDS PREVENTION
I appreciate the opportunity to be here today. I am Margaret Pruitt Clark, President and Executive Director of Advocates for Youth, a Washington D.C. based national and international organization dedicated to the prevention of adolescent pregnancy and STD/HIV. Prior to joining Advocates four years ago, I served three terms in the Maine House of Representatives. In my final term, I chaired the Human Services Subcommittee of the Human Resources Committee. I got involved in this issue in 1985 when then-Governor Joseph Brennan asked me to serve on the state Task Force to Prevent Adolescent Pregnancy. In other words, I know firsthand how difficult it is to deal with this sensitive issue from a policy perspective.

For those of you who are not familiar with my organization, Advocates for Youth (formerly the Center for Population Options) works to increase the opportunities for and abilities of youth to make healthy decisions about sexuality. Since 1980, Advocates for Youth has provided information, education, and advocacy to youth-serving agencies and professionals, policy makers, and the media.

I’ve come here today specifically to talk about the impact of HIV/AIDS and other STDs on young people, especially young women. While recent media coverage has stressed the susceptibility of the heterosexual population to HIV/AIDS and high rates of infection have been widely reported among gay males and intravenous drug users, little has been done to dispel the lingering impression that AIDS is a disease which mostly affects adults. HIV though, is increasingly contracted by teenagers and AIDS has become a leading killer of young adults. Rather than their youth being a boon in fighting the disease, adolescents are more susceptible to HIV/AIDS because of the risks they take during the course of their maturation. They chance behaviors before comprehending the consequences and before having the skills to manage the risks, they test boundaries by experimenting with sex, drugs and alcohol, and often with a sense of invulnerability, that “nothing bad can ever happen to me.” Too often, we adults do them a disservice by giving them conflicting, ambivalent advice about sexuality. The figures I am about to give to you are an indictment of our failure to better educate and protect our nation’s young people in the face of this growing epidemic.

One quarter of all new HIV infections in the United States are estimated to occur in young people between the ages of 13 and 20. By December 1995, 2,354 cases of AIDS among 13 to 19 year olds were reported to the Center for...
Disease Control. Among 20 to 24 year-olds, the figure was much higher: 18,955 cases, cases which due to HIV’s long incubation period, were incurred while most of these 20 to 24 year-olds were in their teens. Between June of 1993 to June of 1994 those figures represented a 28 percent increase in the infection rate among all 13 to 24 year-olds. The rate of infection among female adolescents especially is on the rise. The percentage of female adolescent AIDS cases in the U.S. has more than tripled from 14 percent in 1987 to 43 percent in 1994 of all adolescent cases.

The rate of other STD infections has grown among the teenage population as well, with females the most susceptible. Gonorrhea was the most frequently reported STD in the United States between 1981 and 1992. In 1992, 15 to 19 year old women had the highest rate of gonorrhea infection of all female age groups. Male teenagers as a group had the second highest rate of infection among males. Approximately 4 million cases of chlamydia occur each year among people in of all ages. The CDC estimates that 20 to 30 percent of sexually active teenage women are infected. Syphilis rates rose 41 percent among 15 to 19 year-old males between 1986 and 1992 and 112 percent among females in the same age group. Of the 12 million STD cases reported annually one quarter occur among adolescents. Roughly 25 percent of sexually active adolescents become infected with an STD every year.

The reasons for these statistics can be quickly discerned by viewing the relatively high rate of teenage sexual activity with a relatively low rate of condom use, the use of alcohol prior to sexual activity and an attitude that downplays or discounts the risk of sexual activity. Nationwide, more than half of all high school students (54%) reported having sexual intercourse. Of this group, 53.6 percent reported that they or their partner had used a condom during last intercourse. Alcohol use was reported by 25 percent of adolescents during last intercourse and five percent reported using alcohol and other drugs. The likelihood of a condom not being used or being used improperly increase when people are under the influence of alcohol and other drugs.

The progress of these diseases and the nation’s response can be charted with statistics; marshaling graphs and tables we can direct our efforts apply for funding, lament or celebrate the results. Often however, the reasons, the forces underlying the numbers are unquantifiable and yet just the same, central to understanding why the spread of HIV and STDs among adolescents persists. When teenage girls attending one hospital-based clinic were asked, the overwhelming majority responded they felt safe from STD infection, a level of confidence not in keeping with the figures for STD infection already mentioned. Between reality and perception a disparity exists, one with grave consequences to the health of young people. Many said they felt they had made a careful choice in their sexual partners, that he was in effect “clean” and that they maintained a monogamous relationship with him. A third felt that condoms weren’t necessary if one chose one’s sexual partner carefully. Another study showed that the perception of STD risk depended more on an individual respondent’s “anxiety” over contracting an STD rather than any concrete knowledge about STDs or the number of sexual partners that person had had or the frequency with which condoms were used.
“Feeling” and experiential knowledge greatly influence a teenager’s decisions. Researchers have noted a consistent belief among teenagers, participating in a wide range of surveys, an often repeated attitude that they are personally invulnerable. Bad things—STDs, drug addiction, car accidents—happen to other people, never to them. With HIV specifically, the long interval between infection and the onset of the illness serves to lessen the apparent impact of risky behavior. Looking around them, teenagers may see no one dying from AIDS, no rash of deaths among their peers. Adult admonitions to refrain from certain behavior may seem groundless. Strident warnings may even backfire as the propensity towards rebelliousness finds direction in adults’ seemingly overheated prohibitions.

Yet clearly there is a huge problem in the number of teenage STD cases and clearly a responsibility on the parts of adults to do something about it. Some argue the best approach is to demand abstinence of adolescents, but closer examination suggests that this approach is too simplistic. Appeals to abstinence may be sufficient to dissuade some young people from early, unprotected sex but appeals based on biblical morality will likely only resonate with teens who acknowledge biblical authority, those who are from a religious background and have a supportive, stable family who actively practice that faith. Fear-based messages linked to health or emotional risks will backfire if teens fail to see the dire consequences predicted by adults. What is needed is a more comprehensive, multi-faceted approach that acknowledges the different developmental stages of adolescents and crafts specifically-suited interventions to meet those needs. The response of teens in the aforementioned surveys are indicative of a lack of knowledge, one which poses serious risks to themselves as well as their partners.

The teenage years are filled with experimentation and movement away from family and toward friends. Adolescents engage in normal risk-taking behavior as part of a developmental process which moves them toward adulthood. We also know that the age of puberty has decreased over the decades while our expectation of years of school increases, thus placing teenagers “at risk” of non-marital sexual activity for more and more years.

Poverty, educational attainment of parents, family structure and level of dysfunction, and whether mothers and/or sisters experienced an early birth are all correlated to early unprotected sexual activity. Policies which address these systemic issues are obviously needed.

Beyond those, teens need information to make responsible decisions about their sexual activity. They need motivation and skills to act on the information they have been provided and finally they need access to affordable, convenient, and confidential health care services.

Contrary to some people’s fears, there is good data suggesting that teens who have comprehensive sexuality education, including values clarification and not just biology, are more successful at postponing sexual activity and using contraceptives when sexual activity does begin than those who do not have comprehensive sexuality education. A recent in-depth assessment of pregnancy prevention programs and their evaluations done by Child Trends, a well-respected Washington-based research organization, suggests that
“programs that combine factual information with assertiveness training and instructions for improving decision-making and communication skills also appear more promising for affecting adolescent sexual behavior than fact-based sex education alone. In general, these programs focus on helping teens develop specific skills to negotiate difficult or risky interpersonal situations.” (p 22)

Two promising and evaluated programs are Teen Talk, a 12-15 hour sex education course conducted as a collaborative effort between school and community health centers in Texas and California and Reducing the Risk, a 15-session health education curriculum developed by California-based Educational Training Resources Associates (ETR) for 10th graders. Girls, Inc., has also developed age-appropriate materials for use outside of the formal classroom. The National Junior League Association has developed and evaluated material for high school-age adolescents which also includes a community service component.

Even the conservative American Enterprise Institute for Public Policy Research was forced to conclude that “the weight of evidence from the national surveys indicates that sexuality education programs do somewhat increase the use of contraceptives and HIV education programs do somewhat increase the use of condoms.”

Peer education programs also work. Teens can successfully provide each other with information, legitimize the discussion about sexuality, and teach negotiating skills to refuse sex or to engage in safer sex. Since most teens perceive that their peers are more sexually active than they actually are, peer programs also provide teens a reality check on “normative” behavior. Postponing Sexual Involvement, another evaluated program, is a 10-lesson curriculum developed by Emory University School of Medicine for 8th graders, lead by trained male and female teams of older students.

Fostering communication between adults and teenagers and between teenagers regarding sex is important. Teens who reported previous discussion of sexual matters with their parents were 7.5 times more likely to feel able to communicate with a partner about AIDS than those who had not had such discussions. And adolescents who felt able to talk to a partner about AIDS-related issues are 10 to 17 times more likely to use a condom when engaging in sex.

In addition to education, adolescents need access to reproductive health services that are confidential, affordable, and convenient. Contraceptive availability programs aim to improve access to family planning for sexually active teenagers, thereby shortening the period between initiation of sexual activity and the acquisition of contraceptives.

There is no indication that punitive approaches or scare tactics have worked with young people. The decision to have intercourse and the decision whether to contracept are seldom rational enough for the threat of long-term consequences to affect behavior.

Let me conclude by suggesting some specific things you as policy makers can do to decrease the spread of STDs including HIV/AIDS.

Advocates For Youth
• Mandate comprehensive sexuality education throughout the K-12 curricula and in community-based programs

• Fund mentoring programs. Some researchers have suggested that one caring adult can make a difference in a child’s life.

• Improve economic opportunities. I won’t go as far as Marion Wright Edelman of the Children’s Defense Fund, who says that the best contraceptive is hope, but we do know that young people who believe that they have a future make better decisions about their sexuality than those who don’t.

• Expand STD and HIV/AIDS prevention programs. Used correctly and consistently, condoms prevent both conceptions and infections. Only abstinence works better.

• Increase access to health services, including mental health care and substance abuse treatment.

• Expand child sexual abuse prevention and intervention programs. Research is increasingly confirming what program people have known for some time — children who are sexually abused lack the skills to establish boundaries about their sexuality and are often victimized not only by family members but also by other older males. A recent California study of birth records suggested that many fathers of teen’s babies are NOT teenagers themselves.

• Increase access to and acceptability of teen contraceptive use.

As elected officials and policy makers you may be caught in a difficult position, attempting to pass responsible public health legislation concerning an issue that also falls under the traditional scope of morality. There are political and economic concerns to contend with, and conflicting advice as to what should be instituted policy-wise. The position you may be in though, no matter how complex politically or constrained fiscally, pales when compared to that of a young person dying of AIDS; it amounts to little next to a teenager who must acknowledge her life has nearly ended, at a time when the lives of so many others are about to truly begin.

I urge you to consider carefully the problem that lies before us and implement the policy measures I’ve advocated. I thank you for your time this morning.
This article explores how religious political extremists build opposition to comprehensive HIV/AIDS prevention programs. It addresses the mistruths raised by those who oppose HIV/AIDS prevention education, and counters them with facts. Religious political extremists groups—often referred to as “Far Right” or “Religious Right”—are well-organized and politically-active fundamentalist and evangelical groups. In general, they are ideologically opposed to gay rights, comprehensive sexuality education, abortion rights, school-based health care, feminism, and other progressive ideas. Prominent religious political extremist groups include the Christian Coalition, Focus on the Family, Concerned Women for America, the Eagle Forum, and the Family Research Council.

The philosophy of these organizations (and their discomfort with today’s society) can be illustrated by the following quotation, taken from a Focus on the Family publication. “At one time, our society explained the universe, humanity and the purpose of life from the Judeo-Christian tradition: a belief that truth existed, and everyone could know and understand it. A clear standard of right and wrong gave society a moral compass to measure crime and punishment, business ethics, community values, character and social conduct. It became the lens through which society viewed law, science, art, politics—the whole of culture.”1 This standard was “God’s standard of truth.”1 Religious political extremists fear that unless American society is based on, and limited to, a literal interpretation of the Bible, the U.S. will crumble and our nation’s world prominence will fade away. These groups further believe that sexual expression is acceptable only within marriage for procreation, and that secular sexuality education leads to immorality and promiscuity. To support their beliefs they have published a wealth of literature on HIV/AIDS which misstates facts and, in some cases, invents statistics.

These organizations firmly oppose providing HIV/AIDS prevention education in the schools and increased federal HIV/AIDS prevention funding. Extremist organizations argue that sexuality and AIDS prevention education curricula and programs should be discontinued because they promote sexual activity, endanger teens’ lives by encouraging condom use, condone homosexuality and advance the gay rights movement. Cumulatively, they fear that HIV/AIDS prevention curricula create sympathy for sexual “deviants” who they believe are responsible for the creation and spread of HIV/AIDS, and to whom, extremists believe, the disease is mostly confined.

Extremists’ fear HIV/AIDS prevention education materials will “normalize homosexuality, masturbation, and extramarital sex; pretend that condoms are reliable and abortion-risk free; and include pornographic illustrations.”2 The Christian Coalition has charged that “social engineers...developed the ‘safer sex’ notion so that people could continue being promiscuous with impunity.”3
At the root of extremists’ discomfort with HIV/AIDS prevention education (and other AIDS programs) is an intolerance of any non-marital sexual expression. Religious political extremists believe that “[t]he only safe sex is heterosexual and monogamous for life (a.k.a. marriage).” Further, they object to information which acknowledges that most people will become sexually active before they are married: “Teaching abstinence as merely one alternative among many is irresponsible on the part of the educator and hardly the kind of direction and guidance our children deserve.”

Extremists reject the theory that homosexuality is a natural expression of sexuality, and assert that it is a behavioral choice characterized by sexual deviancy and promiscuity. Some argue that homosexuality might be a “pre-disposition” but cannot “turn into” homosexuality without environmental support such as that offered by HIV/AIDS prevention and sexuality education. Thus, they oppose any form of comprehensive sexuality education. What differentiates extremists’ views on homosexuality from mainstream ones is their contention that all homosexuals are deviants who engage in extreme and outrageous behavior.

Religious political extremists’ methods for presenting their views are clever. They present moral admonitions with a veneer of scientific authenticity. Some statements are out-right lies. While all people are entitled to their opinion about what constitutes morally correct behavior, the misuse of scientific evidence to raise public support for fundamentalist doctrine is unacceptable. By misinforming the public and policy makers, extremists threaten the public’s health.

### Myth:
HIV prevention and sexuality education cause sexual activity

### Fact:
No research has found any connection between comprehensive sexuality education programs and increased rates of sexual activity.

“’Safe sex’ programs increase the number of sexually active teens’”

Focus on the Family and other extremist groups claim that sexuality and HIV/AIDS prevention education courses “increase teenage promiscuity.” The organization misuses a 1986 study, published in Family Planning Perspectives, which found a mere two percent increase in reported sexual activity among 15-year olds who had had sex and had taken a sexuality education course compared to those who did neither. The authors caution that this finding was “based on global measures of course instruction that do not take into account the quality and quantity of the sex education received... Consequently, we are unable to determine as well as we would like how factors related to the design of sex education programs may influence sexual behavior.” The authors themselves noted that their study is inconclusive.
In the same 1986 issue of Family Planning Perspectives, another study noted that “exposure to formal sex education appears to have no consistent effect on the subsequent probability that a teenager will begin to have intercourse.” Interestingly, religious political extremists do not quote the results of this second study. Both studies show an increase in contraceptive use among sexually active students who received some sort of sexuality education. Both studies also noted the disparity in types of sexuality education courses provided. Different types of courses are more effective than others; the sexuality education cited in the first study might have been an abstinence-only curriculum, thus far proven to have little effect on preventing sexual initiation or increasing contraceptive use. Extremists imply the proof of sexuality and HIV/AIDS prevention education’s “failure” is overwhelming, based on the partially-reported findings of a single study conducted a decade ago.

In fact, the World Health Organization (WHO) reviewed 35 controlled studies of sexuality education programs in the United States and Europe and found that in no cases did students exposed to sexuality education courses initiate sexual activity earlier than students in control groups who did not receive sexuality education. Other reputable evaluations have found that HIV/AIDS prevention education lowers teens’ reported intentions to engage in risky sexual behavior.

Some conservative organizations maintain that sexuality and HIV/AIDS prevention education have failed because they have not lead to increased, or more effective, condom use. The Family Resource Council cites the 1988 National Survey of Family Growth, which found that, of 1,887 never-married, sexually-active women aged 15-49, only 13 percent used condoms “consistently”; 59 percent of these women had never used a condom. The Family Research Council maintains that low condom use in this population indicates the failure of HIV/AIDS prevention education. Such a wide age range, however, makes the data on safer sex education’s effect on condom use meaningless. HIV/AIDS prevention education is implemented and presented haphazardly, is found predominantly in public schools and is, moreover, a fairly recent health strategy. Women at the end of the upper age range studied would not have received HIV/AIDS prevention education in school, and may never have received it elsewhere. Most importantly, the study did not compare rates of condom use between women who had received HIV/AIDS prevention education and women who had not, or between those in monogamous relationships and those who were not.

Focus on the Family cites another study published in Family Planning Perspectives as proof that “Planned Parenthood’s own data shows that educating teens about sexuality and contraceptives does not result in increased contraceptive use” and “Planned Parenthood’s own data...indicate that teenagers are almost inevitably ineffective users of contraceptives.” The article describes Postponing Sexual Involvement, a sexuality education course sponsored by Atlanta’s Grady Memorial Hospital which combines information with skills-building exercises. The study found that “Students involved in the program were more likely both to postpone sexual involvement and to use contraceptives when they did have sex than were the non-program group.” The study notes that information sessions alone are not effective in changing
behavior—not, as Focus on the Family maintains, that informational programs are useless. The researchers note that young teens learn differently than older teens, and therefore educational programs must be age-specific, address teens’ needs, and use experiential learning. They urge, however, that “young people also need...detailed information about reproduction, family planning and sexually transmitted diseases.” \(^{12}\) Nowhere do the authors recommend discontinuation of sexuality education.

With respect to young teens’ general ability to use contraceptives effectively, the authors merely note that young teens do not change their behavior because of information alone (e.g. increase their contraceptive use), but that peer education and skills-building activities about communication, decision making, and contraceptive negotiation can help them change their behavior. The authors do not write that young teens are “inevitably” ineffective users of contraception, nor do they examine effective contraceptive use in their research. As noted, however, the study did find that program participants increased their contraceptive use.\(^ {12}\)

Research actually shows that condom use is currently higher among adolescents than adults, refuting the extremists claim that teens are incapable of effective contraceptive use. Twenty-six percent of 15-to-19-year old sexually active females rely on condoms compared with just over 13 percent of all American couples.\(^ {13}\) Among sexually-active 17-to-19-year olds living in metropolitan areas, condom use at most recent intercourse more than doubled from 21 percent in 1979 to 58 percent in 1988.\(^ {14}\) Furthermore, adult women have most of the unintended pregnancies in the United States, not teens. If teens invariably used contraception less effectively than adults, this finding would be reversed.\(^ {15}\) As in other extremist materials, the Family Resource Council presents an incomplete picture to argue for ending all education and prevention efforts rather than increasing or expanding them. This is akin to suggesting that, while wearing seat-belts is good protection, since not every American does so each time they’re in an automobile, we should all stop driving—or at least remove seat belts from the cars.

Another study cited by the Family Research Council examined patients at a state-funded sexually transmitted disease (STD) clinic.\(^ {16}\) Although 51 percent of the male clients and 64 percent of the females had an STD in the past, and 47 percent of those surveyed were diagnosed with an STD the day of the survey, only 25 percent of respondents said they used a condom at last intercourse. According to the survey, most appeared to understand the benefits of regular condom use. The Family Resource Center uses this study to argue that condom use is low even among “high risk” individuals; therefore HIV/AIDS prevention education fails even those most in need of it, and therefore should be discontinued.

The clinic clients are, in fact, at “high risk” of STD infection because they do not use condoms. If they had used condoms consistently and correctly, they most likely would not be at an STD clinic. The population studied in this article is not intended to represent the general public, but a sub-group at increased risk for STDs. The problem is not that condoms fail, but that people do not use them correctly or consistently. By broadening and improving education efforts, sexually-active adolescents and adults will gain the skills and motivation to use condoms properly each and every time they have sex.

---

*Advocates For Youth*
Focus on the Family maintains that “safe sex” programs “increase peer pressure, curiosity and the sense that ‘everyone else is doing it.’” In fact, teen who complete effective AIDS prevention education programs have the skills and information to resist peer pressure, get answers to their questions, increase their ability to delay sexual intercourse and/or use condoms correctly if they are sexually active. Studies show that teen in comprehensive sexuality education programs—which include information about both abstinence and contraception—delay initiation of sexual activity and use contraception more than teens in programs that stress abstinence alone.

**MYTH:**
Condoms are ineffective at preventing HIV transmission

**FACT:**
Properly used, latex condoms are 99.9 percent effective in preventing transmission of STDs, and 97.5 percent effective at preventing pregnancy.

Want to get pregnant? Use a condom! Want to die? Trust a condom?

Extremists almost universally questions the reliability and effectiveness of latex condoms in preventing HIV transmission. They cite the maximum standardized failure rates for condoms as a basis for the argument that teenagers should not be encouraged to use condoms at all. The extremist viewpoint is that, unless every condom is 100 percent reliable, condoms are not effective enough and should be neither discussed nor used. Their conclusion is that public health agencies and educators endanger teens by telling them about condoms, and they should instead only provide information about abstinence. Many extremists imply that condoms cause or increase pregnancy and STD infection. One abstinence-only promoter noted: “We don’t give kids the false hope of ‘all you need is a condom’...That’s simply fooling them and postponing the problem.”

Often extremists twist several true statements to lead readers to the conclusion that condoms are dangerous. Religious political extremist materials consistently provide unconnected facts to support their contention that condoms will not prevent HIV transmission. Focus on the Family’s 1993 pamphlet, Why Condoms Aren’t Safe, states: “Over the course of a year, chances of getting pregnant while using a condom are 1 in 6 (like Russian roulette). But unlike pregnancy, you can get AIDS any day of the month, 365 days a year.... The HIV virus (sic) is 1/25th the size of sperm. The smallest detectable hole in a condom is one micron. The HIV (sic) virus is one tenth the size of that hole. Researchers studying surgical gloves made out of latex found ‘channels of 5 microns that penetrated the entire thickness of the gloves.’ The HIV virus measures one-tenth of a micron.”

In this particular pamphlet the author makes no explicit linkage between these facts, but the implication is clear: if condoms sometimes fail to prevent
pregnancy, and HIV is so much smaller than sperm, than condoms will fail to prevent HIV transmission. If latex gloves have holes in them and the smallest hole in a condom is 10 times larger than HIV, then the virus could be transmitted even with condom use.

The point is presented less ambiguously in another Focus on the Family publication, AIDS: Facts vs. Fiction. "Condoms have a proven record of failure—as high as 20 percent among teens trying to prevent pregnancy. HIV is 30 times smaller than the width of a human sperm cell. All it takes is a tiny hole in that latex, or a tear, or possibly slippage—and you could be on your way to the grave."20 The Christian Coalition charges that "condoms, as presently manufactured, are inadequate from the point of the individual for life-time protection for the AIDS epidemic, even with training and high motivation."3

To build the case for condom ineffectiveness, Focus on the Family’s "Quick Facts on Safe Sex" pamphlet cites a 1987 study reported in the Journal of the American Medical Association (JAMA). The JAMA study involved 24 married couples who used condoms, where one partner was HIV positive and one was HIV negative ("serodiscordant"). Focus on the Family reports that 17 percent of the HIV negative partners became infected within a year and a half.4 This information is not contained in the article, and may have been invented. The study actually states that out of ten couples using condoms, one couple seroconverted (transmitted HIV). Of the 14 serodiscordant couples who did not use condoms, 12 individuals became HIV positive.21 Another study, with the same parameters and a greater number of subjects, was conducted in Europe. Among 123 couples who reported consistent condom use, none seroconverted. In contrast, among couples who reported inconsistent condom use, 12 out of 122 seroconverted.22 Compared to using no protection, condom use clearly prevents transmission of HIV and other STDs.

Research simply does not support the extremist position that condoms are ineffective in preventing HIV transmission. Those who oppose information and availability of condoms base their conclusion on exaggerated, falsely implied, or flatly misstated information about the degree of risk in using latex condoms. Laboratory tests indicate that latex condoms, used with a contraceptive spermicide during vaginal intercourse, have a projected effectiveness rate of 97.5 percent in preventing pregnancies and 99.9 percent effectiveness in preventing STD transmission.23 Reliable studies show that condoms, when used correctly, fail as a contraceptive measure only two percent of the time.13 For example, in a British study of almost 18 thousand acts of intercourse where the couple used condoms, only one pregnancy resulted.24

HIV is smaller than sperm, but it is five times larger than a water molecule.25 The Food and Drug Administration has established an official acceptable quality level (AQL) specifying that if more than four out of 1,000 condoms fail a water leakage test, the entire lot must be recalled and withheld from sale. All latex condoms sold in the U.S. must meet this quality level, and the average condom failure rate among batches meeting the AQL are 2.3 condoms per 1,000.26 Despite the extremists’ dire warnings of holes and rips, condoms with such flaws are not sold in the U.S.
Magic Johnson wants us to believe AIDS can happen to anybody. Sure, anybody with numerous homosexual partners, or several hundred heterosexual partners, or an illegal IV drug habit.4

Religious political extremists repeatedly assert that HIV/AIDS happens almost exclusively to “homosexuals and bisexuals, IV drug users, their sexual partners and their children.”27 Extremists present HIV/AIDS, in effect, as a disease that only happens to “bad people,” and one that they usually discuss in the context of behavior-linked transmission routes. One publication suggests that HIV/AIDS is not a threat to the general public by noting (incorrectly): “Most Americans have never even met an AIDS victim.”28 Extremists create a false dichotomy between “bad people” at risk of AIDS, and good people who are safe; this strengthens their idea that people with HIV/AIDS did something to deserve their infection and counters the suggestion that everyone should practice safer sex. This outlook rationalizes a lack of investment in prevention, diagnosis, treatment, research and services.

Homosexuals are presented uniformly as drug-addled, perverted sex fiends. Nearly every extremist discussion of HIV/AIDS includes lists of pleasure-enhancing drugs “they” take, descriptions of specific practices “they” enjoy and the number of sexual partners homosexuals are presumed to have. Concerned Women of America describes gay men living the “fast track” lifestyle, “averaging 10 to 1,000 partners per year...[who] regularly swallow the semen and ingest the urine and feces of their partners”.27 A publication distributed by Citizens for Excellence in Education reports that “male homosexuals use ‘poppers,’ cocaine, amphetamines, heroin, ethyl chloride, and hundreds of other drugs as sexual stimulants during bathhouse and sex-club orgies.”28

The descriptions of homosexuals in religious political extremist writing do not emphasize that homosexuals are attracted to, and form relationships with, their own gender but rather stress the myth that they “choose” their orientation out of insatiable lust. One publication complains, “the homosexual movement successfully created the notion of ‘safe sex’ as a way of preventing AIDS while preserving for its members the possibility of satisfying their sexual desires.”29 Extremists display their homophobia by exclusively linking HIV/AIDS with homosexual behavior and using examples of the wildest

<table>
<thead>
<tr>
<th>MYTH:</th>
<th>FACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only certain (“bad, gay”) people get AIDS</td>
<td>Anyone can be infected with HIV: in the U.S., the fastest-growing group of new HIV infections is among adolescents, particularly young women; AIDS is now the leading cause of death for men aged 25-44, and the third leading killer of women that age. In Asia and Africa, heterosexual sex is the leading cause of the HIV transmission.</td>
</tr>
</tbody>
</table>

Adolescent STD/AIDS Prevention

Advocates For Youth
and most promiscuous individuals to represent all gay men and lesbians. Likewise, they manipulate information about condoms and the risks of HIV transmission to represent their views that monogamous sex between married heterosexuals is the only acceptable form of sexual expression. As the Family Research Center noted, “The debate...is at heart not one about the meaning of data, but the nature of sexuality, the family, and society.”

One extremist publication argues that “the most obvious message of an AIDS education program would be to warn the public of the life-threatening nature of homosexual behavior.” Here again, the assumption is that HIV/AIDS is the immediate and natural consequence of “homosexual behavior.” In fact, there is nothing about a gay man or lesbian, per se, that makes him or her more likely to contract HIV. HIV is a virus. It has no brain. It has no predilection for a certain kind of host. The white blood cells of a gay man, a heterosexual woman, and a child all look alike to a virus.

Some extremists view the entire study of HIV/AIDS with suspicion, maintaining that “HIV does not cause AIDS.” One publication charges: “AIDS is not contagious. Nine of every ten cases are men, and over 90 percent are either “fast track” male homosexuals or heroin addicts...What do these groups have in common? Unbelievably heavy drug abuse, much more so than in the rest of the population...Male homosexual drug abuse is so severe that most homosexual activists have deliberately concealed this fact from the American public, fearing that the ‘gay rights’ cause might lose support.” This publication concludes that “long-term drug abuse and AZT do cause the epidemic.”

Many extremists cite the work of University of California at Berkeley professor Peter Deusberg, who argues that drug use and anal intercourse among homosexuals cause AIDS, not HIV. Deusberg puts a scientific stamp on the notion that AIDS is different from other diseases: inseparably linked to groups who participate in “immoral” behavior, especially homosexuals, promiscuous heterosexuals, and drug abusers. Deusberg has been widely criticized within the scientific community. A scientific review panel found one of his articles contained “misleading arguments,” “misrepresentations,” and “non-logical statements.” Yet, his message is still quoted by some extremists who seek scientific validation for their opinions.

While extremists reveal a sense that HIV/AIDS only happens to “bad” people, there is also a lingering suspicion that AIDS can be transferred casually, which would put “good” people, at risk. For example, Citizen’s for Excellence in Education describes two scenarios for public education in the 1990’s based on the supposed casual contagiousness of AIDS. Either “AIDS victims will be given special protection by law. This will expose children to this fatal disease. Thousands of children could die of AIDS in the next ten years” or “Anyone (school staff or students) testing positive with AIDS or HIV virus (sic) will be immediately removed from the school grounds to protect both staff and students.”

Concerned Women for America objects that there is no law preventing “homosexuals—with or without AIDS—from working in food-handling professions or with the elderly and young children who are especially...
vulnerable to illness.” The implication is that homosexuality and AIDS are inextricably linked and spread by casual contact, and that homosexuals are selfishly refusing to quarantine themselves and protect others (who don’t engage in “deviant” behavior) from contracting HIV/AIDS.

Even if one could accept the idea that terminal illness among any group is inevitable and acceptable, religious political extremists have confused their facts about HIV/AIDS infection in the U.S. These groups largely ignore the increasing numbers of infections among heterosexual women, and little mention is made of the teenage infection rate. Teenagers are now the fastest growing group of new AIDS cases, with teenage girls especially at risk. According to the World Health Organization, in many countries 60 percent of all new HIV infections are among 15-24 year olds, with a female to male ratio of two to one. In Africa and Asia particularly, heterosexuals account for the majority of HIV cases. Research indicates the strain of HIV which exists in these continents (and has recently been found in Britain and the United States) is more easily spread through heterosexual sex.

Needless to say, some homosexuals, like some heterosexuals, have multiple sex partners and use drugs. Religious political extremists use these statements for their shock value. When accompanied by descriptions of gay activists’ efforts to gain “special treatment” or funding for HIV/AIDS research, any acceptance or added funding to study AIDS sounds outrageous and unjustified.

**MYTH:**

AIDS prevention is a plot of the “Gay Agenda” designed only to advance social acceptance of homosexuality

**FACT:**

HIV/AIDS prevention is an important public health priority because most Americans are at some risk of HIV infection. Promoting tolerance, ending discrimination, and fighting bigotry is the agenda of many organizations, not only those with gay and lesbian constituents.

AIDS and the public concern over it is being used as a tool for winning public recognition of the legitimacy of homosexual conduct and for neutralizing those who object to such conduct.

Conservatives are often critical (and seemingly resentful) of gay rights organizations’ political power. Certainly, groups concerned about prevention and treatment have successfully increased the federal government’s commitment to fund badly-needed HIV/AIDS research and prevention programs. Organizations which focus on issues affecting the gay, lesbian, and/or bisexual communities—such as ACT-UP and Gay Men’s Health Crisis—have played vital and on-going roles in moving HIV/AIDS to the forefront of the nation’s consciousness.

Extremists’ charge that gay rights groups are “exploiting” HIV/AIDS to advance a political agenda which includes the normalization and acceptance
of homosexuality. For example, the Free Congress Research and Education Foundation’s publication, Gays, AIDS, and You, charges that “[f]or the leadership of the homosexual movement, stopping the spread of AIDS—at least within the nonhomosexual movement— is apparently not a high priority. As a matter of fact, AIDS and the public concern over it is being used as a tool for winning public recognition of the legitimacy of homosexual conduct and for neutralizing those who object to such conduct.”

Extremist move from their portrayal of HIV/AIDS as primarily a disease affecting homosexuals and then categorize any discussion of HIV/AIDS as a covert attempt to advance the “homosexual agenda.” No distinction is made between groups that advocate for AIDS prevention education, lobby against discrimination, or seek increased AIDS research funds. Extremists fear discussion of homosexuality or AIDS prevention will lead to tolerance of gays and lesbians, which they believe undermines the “traditional” family. For example, Citizen’s for Excellence in Education describes a teacher training on integrating lesbian history into the curriculum, and concludes that “Homosexuals Vow to Destroy the Family.”

The belief that any mention of AIDS prevention will advance the cause of gay people appears again and again in extremist literature, with disastrous results foretold. For example, the Family Research Council’s President has commented on the subject of a gay and lesbian civil rights march: “Homosexual activists want to use the power of law to force acceptance of behaviors that destroy family life and individuals...Behavior has personal and social consequences. No culture in history has cut the bonds of sexual restraint and devalued marriage and the family—and survived.”

Extremists cannot recognize gay and lesbian peoples’ right to live without harassment in this society because that is simply incompatible with extremists’ understanding of the family. They set up a dichotomy wherein mentioning homosexuality, or discussing AIDS prevention, is anti-family and a threat to the entire culture. Therefore, Citizens for Excellence in Education generalizes from a school program to provide information on lesbian history to bemoaning that “Left wing organizations [are] bent on destroying Christianity, Christian children and the Church of our Lord Jesus Christ.”

The level of homophobia extremists display is startling. “A closer look at the...political goals of the ‘gay rights’ movement shows that homosexuals are not an oppressed minority, that opposition to special protection for homosexuality is not bigotry and that extending such protection is dangerous to individuals and society...Homosexuals are pressing for government-enforced approval of activities that have been condemned in all successful cultures as immoral, unhealthy and destructive to individuals and societies...Homosexual activists realize that when people become aware of...homosexual practices such as inserting arms inside each others bodies and ‘sports’ involving bodily excretions—they will see that these behaviors do mot merit special protection in our laws.”

Extremists do not make clear which societies have tolerated homosexuality and “failed.” By misrepresenting gay and lesbian people, the social benefits of living in a non-discriminatory society, and the effect of tolerance on the
institution of marriage, extremists attempt to fuel homophobia and opposition to any and all HIV/AIDS programs. Extremists actually consider the fact that they are bigoted, but excuse themselves: “If pro-family concerns were not based on fact, logic and careful thought, we might indeed be guilty of prejudice. But we know that homosexual behavior is unhealthy. We know that homosexuals are much more likely to contract AIDS.”

Some groups suggest that HIV/AIDS is part of an enormous plot to consolidate governmental power over the individual. Citizens for Excellence in Education has distributed materials claiming that the federal government invented and publicized the story that HIV/AIDS is a contagious disease because “the fear of contagious epidemics could make almost anyone accept emergency controls by the government ....Although ‘Public Health’ sounds like a harmless and common term, the truth is that the Public Health movement is working to replace our traditional Judeo-Christian morality, which is based on Biblical teaching, with a new code of behavior. Public Health justifies overriding traditional morality on the excuse that diseases and other ‘public health threats’ must be prevented. This is a way of disguising religious humanism in scientific clothing.”

The sordid goal? “Money for researchers, unconditional endorsement of homosexuals and drug addicts, and increased government control are the end result of this nation’s present AIDS policies. Furthermore, these have led to mandatory ‘AIDS education’ for civil servants and schoolchildren, in which same sex relations, promiscuity and abortion are upheld.”

Some groups maintain that others, besides gays and lesbians, benefit from the AIDS epidemic. Focus on the Family believes that other organizations actually gain from the AIDS epidemic and public health encouragement to use condoms: “Pharmaceutical companies make their fortunes by creating and selling you medications to treat the disease you’ve contracted because the condoms you bought didn’t protect you.”

Certainly, AIDS has brought the lives and lifestyles of homosexuals to the attention of many whose only previous awareness was in the form of locker room jokes or bent-wrist stereotypes. To assert, however, that gay rights activists are willing to put anyone at risk of infection to combat homophobia, or that all HIV/AIDS prevention advocates are taking orders from some secret homosexual cabal, is both incorrect and grossly irresponsible.

While it is true that, in the United States, AIDS first appeared in gay men and intravenous (IV) drug users, the disease has long since spread to broader populations. Public health recommendations about HIV/AIDS prevention are based upon the recognition that many Americans are at risk of HIV infection, whether they know it or not. There are several ways to avoid being infected. First,
abstain from sexual intercourse and IV drug use. Second, engage in mutual monogamy with an uninfected partner. Finally, if either partner is HIV positive, or their HIV status is unknown, use condoms or clean needles, and avoid other behavior which might allow exchange of bodily fluids. To be safe, most Americans will need to follow the third recommendation for at least part of their life.

Extremists misunderstand the need for comprehensive HIV/AIDS prevention education because they believe that only having sex within marriage is the way to prevent HIV transmission. Even if every American were heterosexual and remained a virgin until they married, however, people would still be at risk for contracting HIV. In fact, for many women, “the major risk factor for HIV is the behavior of their spouse.” Public health officials would agree that only having sex in a mutually monogamous relationship minimizes the probability of infection, everyone needs comprehensive HIV/AIDS prevention education to assess their own level of risk and engage in appropriate risk reduction behaviors. This skill is vitally important whether one is gay or straight, married or unmarried, sexually active or abstinent.

To date, over $22 billion has been spent on AIDS research, and more than 77,000 academic papers have been churned out. Yet, the cause of the disease is still disputed, and no vaccine or cure is in sight. In addition, spreading the fear of heterosexual AIDS has been used by the homosexual lobby to support their claim that ‘we’re no different from anyone else.’

While few still publicly call AIDS “divine retribution” for homosexual behavior, many claims about HIV/AIDS in extremist literature reflect this sentiment more subtly. As noted, extremists promote AIDS as a mostly (if not exclusively) “gay” disease. This viewpoint is used to argue for decreased federal AIDS funding and resistance to the “gay agenda” which simply seeks tolerance.

Extremists argue that federal government funding for programs to prevent and treat HIV/AIDS should be reduced. The Family Research Council testified before the U.S. House of Representatives that funding for HIV/AIDS prevention and research should be redirected in ways commensurate with the threat to the entire population. In an article posted on their Internet site, the organization claims that AIDS ranks near the bottom of the top 10 mortal diseases and accounted for about 42,000 American deaths in 1995. In contrast, heart disease claimed 730,000 and cancer 520,000 lives. Yet AIDS, they point out, “enjoys” the highest per-victim-expenditure of any of the top 10 mortal diseases, with the Department of Health and Human Services alone spending $5.35 billion in 1996.

---

**MYTH:**
Few people are at risk for AIDS, so the U.S. should limit its prevention and treatment efforts.

**FACT:**
AIDS is a contagious and incurable disease which primarily strikes young people; it is one of the most serious threats to any nation’s productivity and public health.
It is true that AIDS is not the leading cause of death for the entire U.S. population. AIDS is, however, the number one cause of death for males between the ages of 25 and 44; AIDS is the third leading cause of death for women in the same age group. AIDS is an incurable disease which primarily strikes young people. As noted, adolescents are now the fastest-growing group of new HIV infections in the U.S. In terms of potential years of individuals’ lives lost, AIDS is more devastating than any other leading cause of death. And, unlike heart disease and lung cancer, AIDS is contagious. Around the world, nations that have ignored or belittled the threat of AIDS have watched in horror as the number of infections increases exponentially. The extremists’ attempt to create competition and conflict between different diseases is disturbing and unethical. The wealthiest nation in the world is perfectly able to fund research and programs to address all its public health problems without squabbling over which is the most deserving.

The Need and Purpose of AIDS Prevention

Extremists’ misunderstand the point of HIV/AIDS prevention education, which is not to promote sex but to promote health. AIDS prevention programs strive to provide accurate information about sexuality and build individuals’ skills to make responsible decisions— including refusing sex or negotiating effective condom use. The remedy to unprotected sexual activity and insufficient condom use is better education, increased access and skills that help increase condom use, condom negotiation, and refusal of unwanted sexual activity. Extremists threaten public health and display their intolerance by pretending that AIDS isn’t a threat, that condoms are ineffective, that homosexuality is akin to HIV infection, and that the “gay rights” movement is a threat to the nuclear family and the United States.

Religious and political extremists are fully entitled to advocate in favor of abstinence until marriage if they so chose. Progressives and conservatives agree that the best way to prevent HIV transmission is abstinence from sexual intercourse and from IV drug use. Many choose to abstain from, or delay initiating, sexual activity. But individuals must make their decisions about sexuality based on accurate medical information; every individual deserves to receive accurate and complete information about sexuality, STDs, and contraception. Many will choose abstinence when given all the information, but they will do so by choice and not in response to fear and lies.

In 1991, a Roper poll found that 80 percent of Americans believe that “AIDS is a major problem facing this country, and a similarly large proportion believe it should be one of the nation’s highest health priorities.” The poll revealed that “an overwhelming majority of Americans believe that children as young as 12 should receive information about AIDS from their schools.” Sixty-seven percent of respondents said that is appropriate to discuss condom use with 12-year-olds. The poll also found that “many doubt sexual abstinence is a realistic solution to the AIDS problem.” Religious political extremists who oppose AIDS prevention education are out of step with the mainstream and endangering the public’s health.
To save ourselves from HIV and AIDS, we must shake ourselves as a nation from our fears of what too many of us associate with HIV/AIDS, and move toward a confrontation with HIV/AIDS that sees the disease for what it is—a mindless, indiscriminate killer that we allow to thrive only as a result of our own unconfronted prejudices, fears and ambivalence.40

REFERENCES


2. Mel Gabler, “AIDS Roulette,” received from Citizens for Excellence in Education


28. Inside Story Communications, The AIDS Scandal that Medical Authorities are Trying to Hide, Inside Story Communications, 1994. Received from Citizens for Excellence in Education.


School-Based Health Centers
When statistics on child welfare and education are published, Louisiana often finds itself at the bad news end of the list—but not always. In our innovative and growing network of school-based clinics, we are positive leaders.

Ten years ago, there were fewer than a dozen school-based clinics in the United States. Now there are 600. In Louisiana, nine clinics serve 17 schools and more than 120,000 children. Nine more are about to open their doors and more than 20 are in the planning stages.

Located in a middle school, a high school or even an elementary school, these primary health care centers serve all the children, regardless of ability to pay. They are funded by grants, donations, insurance and Medicaid and, most importantly, by the collaborative and in-kind efforts of other health and social service agencies interested in children’s well-being.

In Louisiana, the Adolescent School Health Initiative, a statewide program that focuses on middle schools and high schools, provides funding, collaborates health and education services and sets standards to ensure high quality, comprehensive mental and physical health care.

Most students visit the clinics for colds, tummy aches, bumps and scrapes. Counseling and health education for everything from grief and anger control to diet and self-image are the second most-cited reasons for visiting a clinic.

The rest of the time, the clinic’s staff treat chronic illnesses or performs physical exams for students seeking employment or hoping to play sports.

These routine physical have discovered many undiagnosed conditions, including dental problems, vision defects, asthma and scoliosis, a curvature of the spine. One middle school boy was found to have high blood pressure caused by a narrowing of the aorta, a major blood vessel. This was repaired, his high blood pressure cured and he is back on the football field. At one middle school, more than 60 percent of the students were immunized for free against Hepatitis B. This immunization series costs from $150 to $300 in a private [doctor’s] office.

A Baton Rouge high school clinic saved taxpayers thousands of dollars by offering prenatal care to young women through the school clinic. The care helped the women stay in school, reduced medical expenses and led to healthier infants.
Placing a clinic staffed by health care professionals in a school keeps students at school. The first year a clinic opened in one Baton Rouge high school, the number of students checking out during the day dropped 50 percent.

If health centers keep kids in school, provide immunizations and assist in the early detection of chronic conditions, why is there any opposition?

Usually it comes from misunderstanding. Some are concerned that health centers focus on issues of sex. This is not the case. In Louisiana it is not legal to make condoms available in schools. Moreover, fewer than 10 percent of the health center visits concern reproductive health. The national figure is under 20 percent. Contraceptive counseling is provided only if local school systems approve, and parental consent allows a parent to withdraw or limit counseling for his or her child.

Others worry that the health center will drive a wedge between children and parents. While our services are confidential, that often encourages adolescents to seek counseling that may reduce tensions and increase communication at home. Every staff member realizes that students spend far more time at home than in school, and they involve parents often and whenever possible.

No student can receive treatment without parental consent, except in life-threatening situations. The clinics often counsel parents, hold parenting classes, arrange home visits and refer families to outside agencies for further assistance. Parents serve on clinic advisory boards and are among our strongest supporters.

A few educators, concerned that they are overburdened already, are way of clinics. But a child with physical or emotional problems is a poor student.

The clinic often requires nothing more from the school system than space and non-financial collaboration. In return, they not only serve the students, but also function as part of a comprehensive health education program.

Health care providers may see clinics as a financial threat. In reality, most clinics serve children who have no regular health care providers. These children get their care, if they get any at all, sporadically and expensively at the local emergency room.

Finally, there are those who question a focus on adolescent health.

Yet adolescents are the one age group in the United States with an increasing illness and death rate. Every school day in Louisiana, at least one high school student will die by homicide, suicide or motor vehicle accident; four high school students will contract HIV; 35 young women will give birth; and nearly 27,000 adolescents will be at serious use for abusing drugs.

Our children face many problems. School health centers are part of the solution. They keep children in school, teach them to walk away from fights, to say no to activities they learn are risky and to use health resources wisely. [School-based clinics] are a place of caring in our often frightening world.
The rise of extreme conservative political groups and their public cries for a renewed emphasis on “family values” has shifted public debate to the right. As a result, proponents of adolescent reproductive and sexual health programs such as school-based health centers (SBHCs) face increasingly harsh rhetoric in opposition to these initiatives. Extreme conservatives misstate facts, distort research and invent negative outcomes in order to generate opposition to progressive health programs. Advocates for young people’s health care must be prepared for these attacks and ready to replace misrepresentation with fact in the public arena.

Religious political extremist groups are known for their extreme and intolerant political agenda. They believe their worldview and theology, typically fundamentalist, should be dominant in American culture and that government should enforce scriptural law. Religious political extremists seek to impose a narrow religious interpretation of what is right, moral and spiritual on all Americans. These organizations are also sometimes referred to as the “Religious Right” or the “Far Right.”

Why Does the Far Right Oppose SBHCs?

There are two reasons religious political extremists oppose the provision of health care in schools.

- Mistrust of the secular government, especially the public schools.
- Rejection of any sexual expression outside of heterosexual marriage.

Public Education, Health Care and the Secular Government

Religious political extremists think the government’s public programs intrude too far into the family, thereby usurping parental control. From family structure to curricula, non-traditional ideas are viewed with distrust and suspected to contribute to the nation’s moral downfall. Religious political extremists are particularly wary of the public school system, believing that it challenges traditional family authority, and many extremists favor abolishing it altogether. The Family Research Council states that “with the rise of public education, and its enforcement through compulsory education laws, the education of children has been taken from the family...In the process, the state school system has proved an incompetent substitute for the family. It has also had devastating effects for society as a whole.”

Education programs that address values, self-esteem, sexuality education, decision-making and mental or physical health are viewed by extremists as an invasion of family sanctity and privacy, and a threat to parental authority. Such a program would represent “an attempt...by the state school system to
become ‘the’ parent for all children. And it represents a radical departure from the past which threatens the centrality and autonomy of the family.”

Religious political extremists believe that parents should have complete control over their adolescents. The public health view that adolescents are individuals capable of making health care decisions is ridiculed as the “children’s liberation movement,” believed to be in league with “extreme feminism.” Together, extremists fear, public health and women’s rights advocates attempt to “break with tradition. In their radical stages, [these movements] advocate an irresponsibility that seeks autonomous rights, no matter the cost.”

These extremists oppose school-based health centers because they believe that public health efforts to address sexual issues and teen health are an attack upon the family. So, when a health care provider asks a client about discussing sexuality, critics complain that this “utter disregard for basic honesty, parental authority and the integrity of the family unit...is cause for great consternation.”

Expression of Human Sexuality

The second root of opposition to SBHCs is the rejection of sexual expression outside of heterosexual marriage. Religious political extremists reject the public health view that sexuality is an innate, normal and healthy aspect of the lifecycle. Opposition documents, in fact, equate expressions of sexuality with drug addiction, prostitution and rape. Non-marital teen sexual behavior is particularly feared by extremists as a threat to “traditional” values, since they believe that “escalating teenage sexual activity and its appending consequences are clear signs that the subversion of individual character and of the family is well underway.”

On the subject of sexually active teens, The Family Research Council states: “the fact that some individuals will engage in immoral and self-destructive behavior should not discourage society from promoting moral and constructive behavior. It certainly doesn’t excuse us from our responsibility to promote the virtues of self-control, respect for others and submission to both temporal and divine authority.”

By discussing sexuality with unmarried teenagers, extremists believe that SBHCs validate sexuality as normal, thereby encouraging increased sexual activity and sabotaging family traditions.

With fears this profound, it is no wonder that these extremists oppose SBHCs and other programs that acknowledge the individuality of adolescents and address sexuality as a normal part of human development and experience. It is inconceivable to these critics that public health proponents strive for accessible health care, excellent educational systems, increased personal responsibility and expanded personal opportunities. Right-wing extremists fear that a silent power is undermining the American family; SBHCs are but one representation of the corruption of “family values.”
What Religious Political Extremists Say About SBHCs

Those who oppose SBHCs usually raise four very specific objections, regardless of the type of services to be offered:

- SBHCs undermine the role of family and the authority of the parent (the Family Objection)
- SBHCs unnecessarily replicate health care available other places, thereby detracting from the primary mission of the schools (the Education Objection)
- SBHCs encourage promiscuity and tolerance of non-marital sexual activity by mentioning reproductive health, and inevitably increase rates of sexual activity, pregnancy and abortion (the Immorality Objection)
- SBHCs promote abortion (the Abortion Objection)

According to the Family Research Council, a prominent critic of SBHCs, “[s]chool-based health clinics should not be funded because they usurp parental authority and involvement, fail to instruct in principles of morality and character development, are promoted under the pretense of providing general medical care when their primary focus is on family planning, and represent unnecessary duplication of existing services at added cost to the taxpayer.” Fortunately for SBHC proponents, none of these claims is true. Unfortunately, these criticisms have taken on a life of their own and are often repeated as fact by those who oppose SBHCs.

Tactics of Religious Political Extremists

Opposition documents used to support objections to SBHCs are very often opinion pieces presented as hard scientific evidence rather than research published in professional, peer-reviewed medical and public health journals. Although Advocates for Youth staff reviewed all available sources quoted in opposition documents, many of these publications did not include references or footnotes, making it difficult to locate the research used to support their claims. Our review of the available citations reveals massive distortion by these extremists of the research’s text, data and meaning.

In addition to outright fabrication, these opposition sources often “confuse” their terminology — a process known as slippage. For example, one publication maintains that condoms should not be made available to teens because they are flawed. Failure rates for non-latex condoms are then presented as proof that all condoms are ineffective. In fact, the Centers for Disease Control and Prevention (CDC) has issued a public report stating that, correctly used, latex condoms offer near perfect protection from STDs — including HIV, the virus that causes AIDS. Where teenage sexuality is concerned, the opposition moves freely between statistics on premarital sexual activity, teen pregnancy, teen birth rates and unmarried birth rates in order to make their point. Slippage of terms is a frequent ploy that all advocates should expect, correct and publicize whenever found.
These materials were gathered from religious political extremist organizations in 1995. Many of these documents date from the late 1980’s, and refer to research as old as the 1970s. Nonetheless, this report is based upon an examination of the opposition’s sources and documents, regardless of how dated they are. Where appropriate, the report presents recent information about SBHCs. Many opposition misstatements are based on documents produced by Advocates for Youth when the organizational name was The Center for Population Options. For clarity, this report uses Advocates throughout. Critics prefer the acronym “SBC” to “SBHC” because it downplays the centers’ goal of providing health care. This report uses “SBC” when quoting directly from opposition sources and “SBHC” in all other instances.

The Family Objection:

SBHCs Undermine the Family and Parent by Providing Information and Services Without the Parents’ Knowledge or Consent

These criticisms result from the mistaken fear that SBHCs actively attempt to usurp the parental role. The National Right to Life complains that health centers have a “missionary zeal to act as stand-in parents. SBC staffers do not perceive a teenager as part of a family unit, but quite separate from her or his parents.” The Family Research Council states: “many parents believe that in-school clinics usurp their authority and responsibility for helping children make decisions about sex.” Finally, school-based health centers are accused of encouraging parents to “abdicate that trust of rearing and nurturing children by surrendering the moral development of our children to an assortment of bureaucrats and health care ‘professionals’ and [that] is nothing short of immoral.”

MYTH:

SBHCs Keep Parents Out

Opponents believe that school-based health center staff and advocates want to keep parents out of the process and away from the facility. The National Right to Life maintains:

It is abundantly clear that SBC promoters will not let the parents have any meaningful input into the process unless they will lend support to the clinic. For example, when the important work begins with the selection of members for an advisory committee, [Advocates for Youth] recommends that the representatives “[i]nclude only people who are basically supportive of the idea.”

In fact, the document recommends that SBHC Advisory Committees “be sure to include people representing various political viewpoints in the community.... Include people representing the school, the students, the medical community,
parents, the clergy...” It also counsels: “Each year, keep parents informed and obtain their consent.” Far from wanting to keep parents and other community members away from SBHCs, Advocates stresses that parents should be involved in planning and implementing SBHCs, and that clients should involve parents in their health care decisions whenever possible.

### MYTH:

**SBHCs Keep Confidential Information from Parents**

Another criticism is that SBHCs “drive a wedge between the parent and the child” because some services may be offered confidentially. Opponents claim that health centers “may maintain two sets of records on each student who visits the clinic — one set for parents and officials to see, and the other with information the staff wants to keep hidden.”

This statement refers to the two sets of records kept at schools: one by the school nurse and the other by the school-based health center. Education and health systems each have different laws pertaining to confidentiality and release of medical records. School personnel and parents may access the school nurse’s records because the nurse is part of the educational system. SBHCs, on the other hand, are part of the health care system and follow the same legally-mandated protocols to protect client confidentiality as other licensed medical providers. Even school personnel cannot access a student’s SBHC records unless they are specifically listed as part of the student’s medical team on his or her original consent form. This arrangement is not an attempt to circumvent rules, mislead parents or be surreptitious, but to maintain the same quality of care as in any community or hospital-based health center. SBHC opponents are being alarmist over what is, in fact, a standard medical protocol.

Opponents object that, “[e]mploying what could be called a ‘public health’ point of view, SBCs regard a teenager as an independent patient capable of giving informed consent to receive reproductive health services without parental knowledge or consent.” Focus on the Family complains that teenagers can obtain family planning services and information “without parents’ direct knowledge under the guise of participating in health programs.”

Proponents of SBHCs know that confidentiality is essential in ensuring that young people seek information and services, particularly around pregnancy and sexually transmitted diseases. Confidentiality is so vital that the American Medical Association’s Council on Scientific Affairs recommends the AMA “reaffirm that confidential care for adolescents is critical to improving their health” and “encourage physicians to allow emancipated or mature minors to give informed consent for medical and psychiatric care without parental consent and notification.” Recognizing the need for confidentiality, state and federal laws guarantee adolescents’ privacy regarding certain health care services. For example, the federal government mandates that Title X, the federal family planning program, must target sexually active teenagers and provide services without requiring the consent or notification of adults.
School-based health providers and parents both want young people to be healthy and able to lead productive lives full of opportunity. To the greatest extent possible, SBHCs work with parents and the community. Where an individual’s health or future is at stake, however, health care providers have a responsibility to provide confidential services to the young people who seek their help.

- 23 states and the District of Columbia (DC) give minors the authority to obtain contraceptive services without their parent’s consent.
- 27 states and DC allow young people to consent to prenatal care and delivery services.
- 49 states and DC allow teenagers to consent to diagnosis and treatment of sexually transmitted diseases.

The Educational Objection:

SBHCs Detract From the Educational Mission of the School and Replicate Health Services Already Available in the Community

**MYTH:**

SBHCs Detract from the Mission of Schools

A second, frequently raised, argument is that school-based health centers detract from and dilute the schools’ primary mission of education. The National Right to Life maintains that “schools cannot effectively do their most important mission of achieving excellence in education and at the same time be a ‘one stop center’ for all of the social problems a community may have.” Opponents perceive health care to be readily available throughout most communities. The school-based health center is feared to be “the latest step in a growing movement to transform public schools into social welfare agencies which provide a wide range of peripheral services that interfere with academic pursuits. This movement has arisen despite a dramatic decline in scholastic achievement during the last decade — a decline largely caused by the inability of public schools to give proper attention to equipping young people with basic educational skills.”

Health care programs enhance rather than interfere with education. The interconnection between health and education has been clear since 1911, when the American Medical Association and the National Education Association created the Joint Commission on School Health Policies to help expand school health programs. It is for this reason that health services (including immunizations, eye exams and health assessments) have been delivered through the educational system since the late 19th century. Common sense indicates that students learn better when they are not ill, depressed or hungry.
The tradition, of increasing educational ability by improving health, continues today in SBHCs. A survey of students at a North Carolina school found that, compared to students not registered at the health center, SBHC users were significantly more likely to stay in school, to graduate or to advance a grade. Many SBHCs offer additional services such as clothing banks, job training, tutoring and child care, that improve students’ lives and help them learn better. Whatever woes exist within the educational system, they are not caused by attempts to safeguard students’ health and well-being.

School-based health centers are funded and staffed separately from the schools. SBHCs are usually administered by health agencies which exist outside the public school system, such as a local hospital or the local department of health. This arrangement allows health care providers to care for young people and frees teachers to focus on educating students. SBHCs do not draw upon the schools’ time or money, nor do they interfere with the provision of education.

**MYTH:**

**SBHCS Duplicate Existing Community Services**

In addition to claiming that SBHC services are harmful to the moral fabric of the community, opponents maintain that they are unnecessary. A common argument is that “SBHCs may be duplicating services that are already available in the community.” At a time when federal budget cuts are eliminating services (and the country debates the need for expanded health care coverage), Focus on the Family maintains that “most of the services of SBHCs are already available in their communities through family planning clinics, municipal hospitals and private physicians.”

In fact, school-based health centers are developed based on community needs assessments which reveal a lack of access to health services. SBHC clients are typically young people who are most in need of health care; nearly 40 percent of SBHC clients are completely uninsured. At one California school-based health center, 93 percent of clients reported no other source of health care.

Analysis of the study cited to support claims SBHCs duplicate medical services reveals yet another example of misrepresentation. The opposition cites a 1976 study indicating “only 3 percent of teenagers who did not use birth control said it was because they did not know where to obtain it.” The study, which examined sexual behavior of teens from 1971 to 1976, does not specify the percentage of sexually active girls who failed to use contraception because they knew of no family planning sources. The study actually examines the relationships between race, class, family structure and other demographic variables on premarital sexual activity and birth; the three percent statement appears to be fabricated.

This study does identify a population of “around 70 percent of the sexually active [teens] who are not being reached through organized services.” The researchers conclude that “privacy and independence” influence whether a
teen will seek contraceptive services, and note that, by offering “low cost and anonymity”, health care providers could reach sexually active teens more effectively. The authors conclude that sexuality education, abortion and contraceptive services are necessary components of pregnancy prevention programs for sexually active young people. In these conclusions, the oft-cited study recommends exactly the reverse of that claimed by the opposition.

Furthermore, research indicates that even if adequate medical care exists in a community, the cost may be prohibitive, insurance or medical coverage may be nonexistent, and transportation services and hours of operation may be inconvenient. Availability cannot be confused with accessibility in the context of health care provision. The issue is less one of knowing where to get services and information, than of being able to do so. The outcry about unnecessary duplication of services is an unfounded attempt to argue against SBHCs. Those who oppose SBHCs on principle reject an efficient way to provide health care to a needy population to gain an ideological point.

The Immorality Objection:

SBHCs Foster Promiscuity by Addressing Reproductive or Sexually-oriented Services, and Thereby Increasing Sexual Activity and Pregnancy; Promiscuity is Further Increased Because Providing Contraception Does Not Prevent Pregnancy

Opponents believe that most SBHCs actively provide family planning services yet hide this service from the community. They use three quotations to support their myth that reproductive health services are the primary reason for student visits.

The first quotation, from an Advocates for Youth’s publication, is taken out of context as: “80 percent of the clinics write birth control prescriptions, 50 percent refer for birth control prescriptions, and 50 percent actually dispense birth control in the clinics.” While many publications use this quotation, only one includes a coy footnote clarifying that “the survey was somewhat skewed in that clinics had to facilitate family planning to be included.” The 80 percent figure is based on a survey of only those SBHCs which provide family planning. Advocates’ 1993 survey reveals that only 33 percent of SBHCs provide even one family planning method.

The second Advocates for Youth quotation often miscited is “by definition, all of the clinics are involved in family planning.” Quite a different point was being made in the original statement that “reducing the number of student pregnancies is often one of the most pressing needs of the schools, and by definition all of the clinics are involved in family planning.... If students are sexually active, or planning to engage in sexual relationships, they are encouraged to think through a number of issues and options, including absti-
nence. Clinic staff do not encourage sexual activity.” An abbreviated quote is taken out of context and misused in order to argue against SBHCs.

The third “proof” that “the only service which is universally provided [by SBHCs] is reproductive health services” is derived from descriptions of available SBHC services which are compiled annually by Advocates for Youth. These lists are routinely misused for evidence that SBHCs concentrate on family planning. Sometimes, when describing SBHC services, the opposition lists only reproductive services and neglects to include the majority of services provided, such as immunizations, nutrition, suicide prevention and sports physicals. In another tactic, when Advocates’ research indicates 72 percent of SBHCs offer STD tests or family planning services, the data are misrepresented to imply over 70 percent of the students receive these services. There is a vital difference between an SBHC offering a service and a client using the service. Contrary to critics’ fears, Advocates for Youth’s 1993 survey indicates that an average of only 19 percent of client visits were for reproductive health services, including pelvic exams and information about abstinence and STD prevention. Preventive care, acute care and treatment of chronic problems accounted for over 60 percent of client visits in 1993.

**MYTH:**

Presence of Family Planning Increases Teen Sexual Activity

By far the most irresponsible criticism of SBHCs is that the provision of reproductive health services or information has been “shown” to be counterproductive. Critics maintain that the more information and contraception provided to teens, the greater their pregnancy rates and likelihood of engaging in sexual activity.

The opposition often claims that teens involved in contraceptive programs show a higher rate of pregnancy than their non-involved peers. One of the most widely-quoted studies about the effect of teen access to contraceptives is a 1985 report by Weed and Olsen, which purports to show that “pregnancy actually increases among teenagers participating in...family planning programs, and that birth rates decrease only through increased teen abortion.”

The Weed study states that “greater teenage involvement in family planning programs appears to be associated with higher, rather than lower, teenage pregnancy rates” and “birth control-oriented programs actually have the opposite of their intended effect. Pregnancies actually increase amongst adolescents involved in the family planning programs, compared with adolescents who were not involved.” Further, Weed and Olsen cite a supposed correlation between family planning funding and pregnancy rates, maintaining that federal funding levels increased 20 percent, causing an increase in both the number of teen clients and rate of teen pregnancy.

In letters to the editor of the Wall Street Journal, which covered the study, both the Alan Guttmacher Institute (AGI) and Planned Parenthood...
Federation of America set the record straight, noting: “Mr. Weed claimed to have proved a number of things which cannot be proved.” While Weed claims teen pregnancies are rising, this assessment was not based on the pregnancy rate for sexually-active teens, but on the rate for all teens aged 15 to 19. Using the former (more valid) pool, “both the number and the rate of teen pregnancies have been declining.” In fact, “[b]etween 1972 and 1982 the pregnancy rate among those adolescents who were sexually active decreased.” The decrease in the pregnancy rate among sexually-active teenagers continues to this day.

Where dollars are concerned, Planned Parenthood notes that Weed’s estimates of services provided to teens includes those not generally targeted at adolescents. Moreover, public expenditures for all family planning programs peaked in 1981 at $377 million. Funding levels have since declined. Between 1971 and 1981 the constant dollar increase for federal family planning programs for all women was 2.5 percent, nowhere near the 20-fold increase the Weed study claimed. In constant dollars, funding for Title X (the federal family planning program) declined over 70 percent from 1980 to 1992.

The Weed study is used to argue that, since some family planning clients seek abortions, abortion must be caused by family planning services. Since most teens wait to visit a family planning clinic for almost a year after becoming sexually active, and most make an appointment because they suspect they are pregnant, it is not surprising that many teens discover they face an unwanted pregnancy. “Since about eight in 10 pregnancies are unintended, higher pregnancy rates are associated with higher abortion rates.” As AGI notes, “Weed claims that clinics apparently are more effective at persuading teens to avoid birth than to avoid pregnancy. In fact, like older women and men, adolescents use contraceptives because they are trying to avoid having children. If their efforts are unsuccessful and they do become pregnant, many, but by no means all, turn to abortion.” “Using birth control, whether the government helps make it available or not, is not what causes pregnancy. Sex does.”

The reason pregnancy and birth rates in the United States are high is not because of contraceptive availability. What differentiates the U.S. is that American “adults and teenagers, in comparison to people in other industrialized countries, make less use of contraception, use less-effective methods, and are not very efficient regular users of whatever method we choose. As a result, we have high rates of unintended pregnancy and relatively high rates of abortion.” Factual data notwithstanding, the implication that family planning programs cause pregnancy occurs again and again in criticisms of SBHCs.
The supposed correlation between availability and funding of family planning programs and increased pregnancy rates appears in many other examples as well:

- “[f]rom 1971 to 1981 there was a 306 percent increase in federal expenditures on family planning with a corresponding 48.3 increase in pregnancies and a 133 percent increase in abortions for women 15-19.”
- “[t]he federal government spent nearly $2 billion in 11 years, from 1971 to 1981, on family planning programs in an effort to reduce teen pregnancy. Nevertheless, during that period, teen pregnancy climbed 48.3 percent, while teen abortions skyrocketed 133 percent.”

As with Weed’s report, there are several problems with these allegations.

1. Abortion was generally illegal before 1973, so reported abortion rates naturally increased swiftly after legalization.
2. All research indicates that family planning programs prevent pregnancy rather than cause it.
3. The figure given for family planning expenditures is far too large, as it includes broad federal programs, including non-family planning and non-adolescent-specific programs.
4. The data used to make these claims carelessly intermingles rates of sexual activity, premarital pregnancy and out-of-wedlock births: all of these figures are used indiscriminately as the “teen birth” rate.
5. The statements are incorrect: both the pregnancy rate for sexually active teens and the adolescent abortion rate have been declining for years.

**MYTH:**

School Sexuality Education and Other Prevention Programs Increase Sexual Activity

The opposition often claims that teens who received sexuality education and who have access to contraception have higher rates of pregnancy than teens without sexuality education and/or contraceptive access. Religious political extremists often cite a comprehensive study of teen sexual behavior by Zelnick and Kantner to argue that information and services cause sexual activity.
Neither the cited article nor the comprehensive research by these authors addresses this relationship. The report connects premarital sexual activity with indicators such as a girl’s educational dreams, accomplishments, age, race and socioeconomic status. No connection is made between the presence of sexuality education or contraception with premarital sexual activity, nor does the study even mention this possibility. The authors note that “many conceptions occur among young women early in their sexual careers, when they are not adequately protected” by contraception. The authors, contrary to extremists’ allegations, concur that contraception prevents pregnancy rather than causes it. Interestingly, frequency of premarital sexual activity was found to be positively related to “variables that reflect the maturity of the relationship,” including plans to marry.

Focus on the Family further asserts a 1986 Harris poll found sexuality education emphasizing contraception increases teenage sexual activity by one third. The poll does not address this issue at all, nor make any connection between sexuality education and the likelihood of sexual activity. Not only did Focus on the Family misrepresent the data, they drew a connection that was neither investigated nor mentioned by the original researchers.

The Harris poll actually reveals that 40 percent of teens who received comprehensive sexuality education at school report using contraception all the time, compared to only 25 percent of teens who received no sexuality education. Young people surveyed for this poll also reported that confidential, free and accessible family planning services were most likely to influence teens to prevent pregnancy.

**MYTH:**

School Sexuality Education and Other Prevention Programs Increase Sexual Activity

The opposition frequently falsely applies Advocates for Youth’s analysis of pregnancy rates at schools with and without SBHCs to claim that SBHCS cause pregnancy rates to rise. Some critics maintain there is “no statistical difference” in pregnancy rates between most of the SBHC schools and non-SBHC schools compared by Advocates. Other critics admit differences between these schools, but use flawed statistics to determine that SBHC schools had higher pregnancy rates. The opposition claims that this data shows “the SBC may actually have increased the pregnancy rate of teens.” Finally, critics also seize upon the fact that school-wide pregnancy rates did not decline as an admission that SBHCs are ineffective. These allegations are untrue.

While Advocates and SBHC opponents agree that there are methodological problems with the original report, it is impossible to construe the data as indicating SBHCs’ presence increased student’s pregnancy rates.
School-Based Health Centers

The principle researcher and author of the report argues that the presence of a SBHC was associated with an increase in the percentage of students who had ever been pregnant (or caused a pregnancy) in only one of the six schools surveyed. In a separate analysis, the researcher found no association between the presence of an SBHC and a higher pregnancy rate over the past 12 months. Chi-square tests for statistical independence were used in both analyses and results were significant at p<.05.33

Critics have asserted that “marginally” significant differences in pregnancy rates were found in two of the six schools in the two analyses described above. To draw this conclusion is to disregard the Chi-square test results since the assessment of the data clearly identified p-values greater than .05 for these two schools. Based on these results, one cannot make the claim that SBHCs contribute to higher pregnancy rates among student clients.

The criticism that SBHCs do not prevent pregnancy because they did not affect school-wide rates is illogical since the school-wide population includes students who did not use the SBHC. There is no reason that a health center would affect the behavior of non-clients; indeed, it would be a remarkable program that affected the behavior of those who did not participate in it.33

Zabin’s landmark study on the effectiveness of Baltimore’s teen health centers is also prey to criticism. Zabin examined a three year teen pregnancy prevention program in which a social worker and a nurse provided education, counseling and medical services in the school and at an adjacent clinic. Compared to teens from schools without this program, the evaluation showed participants had a greater knowledge of contraception and pregnancy risks; sexually-active participants had a higher attendance at birth control clinics, greater contraceptive use and lower pregnancy rates.34 The opposition claims that “the alleged pregnancy reduction...was computed by disregarding all pregnancies among girls in the 12th grade and girls who dropped out of school before graduating...the Baltimore program actually produced an increase in pregnancies instead of a reduction.”28 The opposition also claims Zabin’s results are flawed because one school with family planning services’ dropout rate was three times higher than non-center schools.14

Zabin calls both allegations “ridiculous.”34 She notes that the program evaluation lasted for three years; the data therefore reflect the fact that the largest number of students were exposed to the program for one year, the fewest number for three years. The variations in subjects may be the basis for the claim that drop out rates affected the data.34 Although some students had to be dropped because they were unavailable for the final survey, the researchers compensated by excluding all 12th graders who had participated in the evaluation for three years in both the program and control groups. Rather than skewing the data, this corrected for any bias.34

**MYTH:**

School Sexuality Education and Other Prevention Programs Increase Sexual Activity

The principle researcher and author of the report argues that the presence of a SBHC was associated with an increase in the percentage of students who had ever been pregnant (or caused a pregnancy) in only one of the six schools surveyed. In a separate analysis, the researcher found no association between the presence of an SBHC and a higher pregnancy rate over the past 12 months. Chi-square tests for statistical independence were used in both analyses and results were significant at p<.05.33

Critics have asserted that “marginally” significant differences in pregnancy rates were found in two of the six schools in the two analyses described above. To draw this conclusion is to disregard the Chi-square test results since the assessment of the data clearly identified p-values greater than .05 for these two schools. Based on these results, one cannot make the claim that SBHCs contribute to higher pregnancy rates among student clients.

The criticism that SBHCs do not prevent pregnancy because they did not affect school-wide rates is illogical since the school-wide population includes students who did not use the SBHC. There is no reason that a health center would affect the behavior of non-clients; indeed, it would be a remarkable program that affected the behavior of those who did not participate in it.33

Zabin’s landmark study on the effectiveness of Baltimore’s teen health centers is also prey to criticism. Zabin examined a three year teen pregnancy prevention program in which a social worker and a nurse provided education, counseling and medical services in the school and at an adjacent clinic. Compared to teens from schools without this program, the evaluation showed participants had a greater knowledge of contraception and pregnancy risks; sexually-active participants had a higher attendance at birth control clinics, greater contraceptive use and lower pregnancy rates.34 The opposition claims that “the alleged pregnancy reduction...was computed by disregarding all pregnancies among girls in the 12th grade and girls who dropped out of school before graduating...the Baltimore program actually produced an increase in pregnancies instead of a reduction.”28 The opposition also claims Zabin’s results are flawed because one school with family planning services’ dropout rate was three times higher than non-center schools.14

Zabin calls both allegations “ridiculous.”34 She notes that the program evaluation lasted for three years; the data therefore reflect the fact that the largest number of students were exposed to the program for one year, the fewest number for three years. The variations in subjects may be the basis for the claim that drop out rates affected the data.34 Although some students had to be dropped because they were unavailable for the final survey, the researchers compensated by excluding all 12th graders who had participated in the evaluation for three years in both the program and control groups. Rather than skewing the data, this corrected for any bias.34
When all else fails, the opposition flatly refuses to admit these results could occur anywhere else: “The Baltimore student population and other variables were unique. Therefore, the study cannot be replicated anywhere.”

MYTH:
Teens Do Not Use Contraceptive Services

Finally, critics maintain that increased sexuality education and contraceptive services do not help teens protect themselves against pregnancy. A study is quoted as finding that 9-12th graders consistently used contraception 50 percent of the time they have sex, while 6-8th graders used contraceptives 65 percent of the time. The purported decline in contraceptive use is blamed on the presence of sexuality education and contraception.

In fact, the report indicates that 9-12th graders report not using contraception between 49 and 55 percent of the time; 6th graders report not using contraception 61 percent of the time. The opposition has removed the negative “not” in order to make 6th graders appear more effective contraceptive users. Nothing in the study indicates whether the young people—sexually active or not, effective users of contraception or not—received sexuality education or had access to contraception.

Recent research on a SBHC offering condoms to sexually-active clients found that these programs do not, in fact, increase teen sexual activity. Evaluation of a Colorado program revealed that “the benefit of the [condom availability] program by aiding a sexually-active student was found to be more than three times as great as the risk of encouraging a non-sexually active teen to have sexual intercourse.” Although almost 100 percent of the students knew about the condom availability program, only 26 percent had used it. Not being sexually active was the most common reason cited for not using the program. The study “implies that rates of sexual activity are not significantly impacted by the availability of condoms.”

Another recent study of SBHC clients who receive contraceptive services found that “[b]oth contraceptive use and abstinence increased over the course of the program,” which lasted 11 months. The authors describe schools as “potentially ideal locations for providing reproductive health care for adolescents” because SBHCs remove barriers to health care and facilitate follow up.

While SBHC opponents present a wealth of information claiming to prove that reproductive health information and services cause teens to be more sexually active and to have more pregnancies, none of their data stand up to close examination.
The Abortion Objection:
SBHCs Really Exist to Provide Patients For Abortion Providers

It is almost inconceivable to most opponents that SBHCs exist to provide health care to a vulnerable population. Instead, the opposition is sure that health centers’ goal is to increase revenues by creating contraceptive “addicts.” Concerned Women for America asks: “could Planned Parenthood and its allies be more interested in rendering our children dependent on their contraceptive and abortion services than they are in reducing teen pregnancy?” Contrary to this irresponsible allegation, health care workers seek to improve the health and opportunities of young people.

MYTH:
SBHCs Funnels Teen to Abortion Providers & Options Counseling Encourages Abortion

Extremists suspect that “the principle aim of the SBC is to lure students into the clinic for reproductive health services.” The real objective, critics claim, is “offering unrestricted abortion counseling and referrals.” “SBHCs represent a wish come true for abortion proponents and others who for decades have dreamt of direct access to the mind and bodies of impressionable teenagers.” These critics claim that: “school-based clinics exploit the authority of the schools to funnel a captive clientele of pregnant teens into abortion mills.”

Although SBHC opponents maintain that health centers are ineffective at reducing teen pregnancy, they also claim any decrease in childbearing resulted from abortion rather than prevented pregnancies. Any mention of abortion as a legal option is ammunition for this claim. For example: “School-clinic proponents attempt to put this fact [that pregnancy tests and referrals are available] in the best possible light by not describing specifically why or how these services promote abortion.” Confidential access to information is also seen by these critics as a mechanism for promoting abortion: “The availability of health services often provides the smoke screen needed to provide minors access to contraceptives and abortion services without the knowledge of either peers or parents.”

These critics are opposed to the health practice of educating a client about all available options, and helping them make informed decisions. For example, the National Right to Life’s mistaken view of what happens when a client seeks information about pregnancy counseling is the following: “SBC staff will counsel the girl by initially performing a pregnancy test on her and then, if she is pregnant, inform her that she has a constitutional right to abort without her parents knowledge or consent. The girl will then be given directions (‘referred’) to a local abortionist.” “The rhetoric of terms such as ‘non-directive’ merely disguises the real agenda,” maintains the National Right to Life.
Since the opposition cannot prove their belief that SBHCs are a front for activities such as abortion, these extremists insinuate. For example, Advocates for Youth “indicates that 98% of the SBCs surveyed performed ‘assessment and referral to community health care system,’ which probably means abortion referrals.” Actually, only 35 percent of SBHCS even offered pregnancy options counseling to their clients in 1993. These critics recast the purpose, goal and activities of SBHCs through vague accusations, to stir up opposition to SBHCs where none may exist.

Not one SBHC in the U.S. provides abortions. Like any responsible health care facility, SBHCs talk to clients about their legal choices if a client seeks that information. The opposition, however, implies that talking about abortion is the same as performing an abortion, and that informing individuals of their legal rights is tantamount to coercion. Extremists prefer to withhold information and services from young pregnant women, telling her that she must have a baby. That is not the law of the land, nor is it good medical care.

The Extremists’ Solution:
Abstinence Until Marriage

The primary criticism of programs that provide information and help young people decide their best course of action is that these programs are “immoral.” These critics bemoan programs that discuss sexuality and sexual activity because teens “are not told that they ought to say ‘No.’” Without providing information and services to sexually active teens, how would religious political extremists address the issue of pregnancy prevention and too-early childbearing? They would impose their beliefs by insisting on abstinence and ignoring serious health issues such as HIV/AIDS and too-early childbearing. Their goal is “reducing the level of sexual activity among our youth through adherence to and promotion of an acetic moral code both in private and in public.” And the opposition believes that it would work, that “moral admonitions to refrain from sexual activity lead to a decrease in pregnancies.”

These critics insist programs that provide information only about abstinence (abstinence-only) are effective and, in support, references Postponing Sexual Involvement (PSI), an effective Atlanta program. PSI refers participants for contraceptive services and provides comprehensive sexuality education, including education about contraception as well as abstinence. In reality, plentiful research proves abstinence-only programs are not effective. Research also shows that several “abstinence-plus” programs — which include information about decision-making, abstinence and contraceptives — are effective in delaying teens’ initiation of sexual activity and increasing their contraceptive use when (or if) they become sexually active.
Conclusion

The root of extremist conservatives’ discomfort with SBHCs is a rejection of sexuality as a natural part of the human experience. In this view, providing information about sexuality corrupts the innocent. “Given man’s natural propensity toward evil, a certain level of sinful and deviant behavior will always be with us,” intones the Family Research Council, acknowledging that sexual expression can never be wholly stamped out.² “It is quite true that we will always have sexually active teenagers, and consequently, unintended premarital teenage pregnancies. It is equally true that we will always have prostitutes, drug addicts, alcoholics, wife abusers, rapists, tax evaders and thieves. The fact that some individuals will engage in unhealthy behavior should not discourage society from promoting healthy conduct.”² Failing total abstinence for those who are not married (adults included) religious political extremists would prefer sexual activity to be “controlled” to the greatest degree possible.²

The Family Research Council notes: “[t]een pregnancy is merely the symptom of a greater problem — premarital, adolescent sexual behavior.”⁴ Critics care not about young people making healthy and responsible decisions about whether or when to engage in sexual activity. Nor are they truly concerned about preventing unwanted pregnancies or sexually-transmitted diseases. The Far Right is indifferent to the public and personal costs of too-early childbearing, so long as these pregnancies occur within marriage.⁴ In their world, the wedding ring is a panacea for all social ills.

Whether extremists like it or not, teens need information, skills and services to make decisions about sexual activity. Sexually-active teens need to be able to protect themselves from sexually-transmitted diseases and unintended pregnancy. People in all industrialized nations are marrying later in life, if at all; confining sexual expression to married individuals is not a viable public health policy. Even married people need information, skills to make responsible decisions and access to contraception.

The facts reveal that SBHCs meet the health needs of countless young people with the attention, information and services too-often unavailable in our communities. When the opposition suggests, “inquire about the existence of a family planning clinic on school premises...there are close to 200 school-based clinics currently operating”,¹⁸ please do so. What you will find is NOT a family planning clinic, but a health care facility staffed by trained and concerned professionals who reach out to the entire community, including parents, and care for all students, to improve the health and future of America’s young people.
END NOTES

Note: Center for Population Options’ publications are referred to under the organization’s new name, Advocates for Youth.


See also Allan Carlson, “Pregnant Teenagers and Moral Civil War,” same volume. Note: The Family Research Council is the DC office of Focus on the Family.


25. Alan Guttmacher Institute, Sex and America's Teens (New York: AGI, 1994).
32. Robert Armacost, “Evaluation and Interpretation of Pregnancy Impact of Six School-Based Clinics,” (Received from the National Right to Life without publishing date or other information).

33. Telephone conversations between Advocates for Youth staff and Dr. Douglas Kirby and Dr. Cynthia Waszak, summer and fall, 1995.


School-Based Health Centers: Primary Care in High School

David W. Kaplan, MD, MPH

School-based health centers are best differentiated from traditional school health services through the provision of on-site primary and preventive medical and mental health diagnostic and treatment services.

During the past decade, school-based health centers (SBHCs) have expanded rapidly. The most recent SBHC survey done by Advocates for Youth (formerly the Center for Population Options) documented a significant increase in the number of SBHCs from 31 in 1984 to 327 in 1991. By 1992, 415 school-based and 95 school-linked health centers had been identified. Of these, 214 were located in high schools, 53 in junior high and middle schools, 79 in elementary school, and 69 centers served a combination of kindergarten through high school students. This expansion of SBHCs reflects the lack of access to primary physical and mental health services for medically underserved youth, the increasing prevalence of health-compromising behaviors and the growing awareness of the interconnectedness between child and adolescent health and education. The recognition that the complex problems youth face in society contribute to poor health, education, and social outcomes is exemplified by the numerous reports, position statements and documents focused on these issues.

What explains this concern and attraction to the SBHC model for delivering comprehensive health to the adolescent population?

Adolescents as an age group in the United States have experienced a significant deterioration in health, mental health, and social well-being. Suicide among 15- to 19-year-old males has increased 400% since the 1950s. Between 1983 and 1990, the homicide rate increased 2.5 times for African-American females and 2.7 times for African-American males. Alcohol and substance abuse remain highly prevalent; nearly one third of high school seniors report smoking within the past month. The percentage of never-married 15 to 19 year old females who were sexually active rose from 42% to 51.5% between 1982 and 1988. Two and one-half million adolescents are infected with sexually transmitted diseases annually, and from 1960 to 1988, the prevalence of gonorrhea among 15 to 19 year olds increased by 170%. Reported cases of acquired immunodeficiency syndrome (AIDS) among adolescents increased 29% between July 1990 and July 1991. Of the AIDS-infected young adult population, 20% probably became infected as adolescents. In 1990, more than 1 million females under the age of 20 years experienced a pregnancy.
Between 1986 and 1991, the rate of births for 15- to 19-year-old girls rose 24%, from 50.2 to 62.1 births per 1000 females.24

As adolescent health problems have become more complicated, the barriers adolescents face to accessing health and mental health services also have increased. Of the 31 million Americans without health insurance, minors comprise nearly one third, and adolescents are more likely to be uninsured than any other age group.25 Many more adolescents are underinsured with health insurance that does not include preventive care, counseling, substance abuse treatment, or other needed services.26 In addition to the lack of insurance coverage, adolescents face a number of other obstacles to receiving services (Table).

As the health status of adolescents has deteriorated, schools have been faced with an increasingly difficult mission to educate students who bring complex health and mental health problems into the classroom. Over the past two decades, there has been little improvement in academic performance. In science and mathematics, US students score lower than their peers in other industrialized nations.27 Forty percent of Hispanic, 22% of black, and 13% of white adolescents do not graduate from high school.28

As a reaction to the decline in health and educational status, and the desire to establish effective prevention and early intervention programs, there has been a resurgence of interest in the school as a focal point for integrating comprehensive health education with basic primary and preventative health and mental services. Many of the most significant and costly national health problems are caused by behaviors established during youth: behaviors that cause unintentional and intentional injuries; drug and alcohol abuse; sexual behaviors that increase the risk to sexually transmitted diseases; unintended pregnancy; tobacco use; inadequate physical activity; and poor dietary patterns that relate to disease.29

HISTORY OF SBHCS

School-based health is not a new idea.30 During the past century, school health programs were used in public health initiatives as a response to the most pressing morbidity and mortality of the times. In their earliest appearance in the United States, the first school health programs were introduced in New York City in 1892 to detect children with contagious diseases. As school health programs expanded in the early 1900s, health screening and communicable disease control remained their primary emphasis.

In the late 1960s and early 1970s, SBHCs were established by the Cambridge Health Department, which began providing medical services to elementary school children. In Dallas, the West Dallas Youth Center at Pinkston High School was federally funded as a part of the Children and Youth Program through the University of Texas Health Sciences Center Department of Pediatrics. Nurse practitioners, physicians, social workers, nutritionists, and health educators provided services to the adolescent population.

In the late 1970s and early 1980s, The Robert Wood Johnson Foundation funded SBHC projects in Chicago, Illinois; Kansas City, Flint, Michigan; and Houston, Texas. In response to rising rates of unintended teenage pregnancy, in 1973 the Maternal and Infant Care Program at St. Paul-Ramsey Medical
Center opened a comprehensive health center in Mechanic Arts High School to provide pregnancy prevention programs and prenatal and postnatal care. In 1987, The Robert Wood Johnson Foundation funded eleven SBHC projects to provide health services to medically underserved students in urban areas.

<table>
<thead>
<tr>
<th>TABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barriers to Adolescent Health Care</strong></td>
</tr>
<tr>
<td><strong>Financial</strong></td>
</tr>
<tr>
<td>Low rate of insurance coverage</td>
</tr>
<tr>
<td>Cannot afford the cost of care—high rate of poverty among minority youth</td>
</tr>
<tr>
<td>Low rate of Medicaid eligibility</td>
</tr>
<tr>
<td>Cannot bill private insurance for confidential care</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
</tr>
<tr>
<td>Most urban, suburban, and rural areas lack public transportation to access care</td>
</tr>
<tr>
<td><strong>Confidentiality</strong></td>
</tr>
<tr>
<td>Major morbidity in age group due to issues which many adolescents do not want parents to know about</td>
</tr>
<tr>
<td><strong>Developmental</strong></td>
</tr>
<tr>
<td>“Magical thinking”—denial that a problem may exist, e.g., pregnancy or sexually transmitted disease</td>
</tr>
<tr>
<td><strong>Self-Esteem</strong></td>
</tr>
<tr>
<td>Threatening to self-esteem to admit the presence of health and mental health problems, e.g., depression, substance abuse, human immunodeficiency virus, or sexually transmitted disease</td>
</tr>
<tr>
<td><strong>Lack of Knowledge of Health-Care System</strong></td>
</tr>
<tr>
<td>Do not know where to go for care, e.g., pregnancy test or treatment for sexually transmitted disease</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
</tr>
<tr>
<td>Adolescent visits require more time—often a hidden agenda</td>
</tr>
<tr>
<td>Low rate of reimbursement</td>
</tr>
<tr>
<td>Often difficult to communicate with adolescents</td>
</tr>
<tr>
<td>High “no show” rate and poor compliance</td>
</tr>
<tr>
<td>Adolescents rarely say “thank you”</td>
</tr>
</tbody>
</table>
WHAT IS AN SBHC?

School-based health centers are best differentiated from traditional school health services through the provision of on-site primary and preventative medical and mental health diagnostic and treatment services. The term “school-based health center” is usually reserved for those programs that are physically located in a school or on school ground and usually only serving students in that school. The term “school-linked health center” (SLHC) refers to health programs that have a formal written agreement with a school to provide health services to students at a site off school grounds. The SLHCs should have a visible presence in the school such as the co-location of staff in the school building. School-linked clinics may provide health care to students attending a variety of schools, as well as to out-of-school youth.

During the past two years, the School Health Policy Initiative of Columbia University School of Public Health organized a series of national work group meetings to further define complex administrative issues for SBHCs. The staff of a typical comprehensive SBHC includes a nurse practitioner/physician assistant, clinical social worker, receptionist/clinical assistant and part-time physician. The SBHC staff is often in addition to the school health staff, which may include a full or part-time school nurse and social worker. Staffing patterns are determined largely by funding, student population (school size), and school system school health program design. Additional staff might include an administrator who may be responsible for a number of clinics, a health educator, a substance abuse treatment psychologist, and a dental hygienist.

WHAT SERVICES ARE PROVIDED BY SBHCS?

Health and mental health services provided in most high school and middle school school-based clinics differ from the range of services provided in traditional health settings. Typically, the services are focused on basic, primary, and preventive physical and mental health care. Physical health services include health maintenance examinations; health screenings and psychosocial histories; immunizations; diagnosis and treatment of minor and acute illnesses and injuries; acute management of chronic conditions such as asthma, diabetes, and epilepsy (this management is usually coordinated with the student’s “medical home”); treatment of common adolescent concerns such as acne and weight management; basic reproductive health care; and diagnosis and treatment of sexually transmitted diseases, including testing and counseling for the human immunodeficiency virus (HIV).

The most controversial aspect of establishing SBHCs, remains the provision of reproductive health services. Eighty-two percent of middle and high school SBHCs provide counseling for reproductive health issues, 69% perform pelvic examinations, and 35% write prescriptions for contraceptives; however, only 15.5% dispense oral contraceptive on-site. Sixty-eight percent dispense prescription medications. Most programs provide basic dental screening, but only 14% offer restorative dental care.

The provision of mental health services is critical because of the high prevalence of emotional issues during this age period. Emotional problems common during this age period include depression, stress and anxiety, post-traumatic stress disorder, parent/adolescent conflicts, and physical and sexual abuse.
Basic mental health services include mental health assessment and consultation; individual, group, and family counseling; and crisis intervention. Most SBHCs do substance abuse assessment and prevention, and a number of programs have included substance abuse treatment services. Because of the close working relationship of physical and mental health providers, SBHCs are especially well configured to diagnose and manage teenagers who present with psychosomatic symptoms.

Social services usually include identification of basic needs and referrals for food, shelter, clothing, legal and employment services, and public assistance. Health education promotion services include one-on-one patient education as well as classroom and community health education on a broad range of topics such as sexually transmitted diseases, HIV/AIDS, substance abuse, pregnancy, violence, intentional and unintentional injury prevention, and chronic disease management.

HEALTH EDUCATION AND THE ROLE OF THE SBHC

Health education is conceptualized differently by school professionals and health-care clinicians. School professionals think in terms of primary prevention while health clinicians are clinically focused and more experienced with secondary and tertiary prevention. In the school setting, most health education is classroom-based with age-specific curricula. Comprehensive health education programs are much more common in elementary schools and focus on basic knowledge and primary prevention, e.g., to prevent initiation of particular behaviors such as smoking and using drugs and alcohol, as well as delaying the onset of adolescent sexual activity. At middle and high school levels, primary prevention is less appropriate because many students are already smoking, sexually active, drinking, and using drugs. There are few comprehensive health education programs at these levels. Secondary prevention becomes paramount because by the 9th grade, 65% of students smoke cigarettes, 17% regularly; 40.9% use alcohol, 22.6% heavy users; and 39% have had intercourse. The goal of secondary prevention is early detection and intervention, for example, to prevent sexually transmitted diseases, HIV, and unintended pregnancies in sexually active adolescents; to assist adolescents who are smoking or chewing tobacco to stop; to reduce heavy alcohol and marijuana use; and to identify seriously depressed adolescents who may be at risk for suicide.
The potential strength of the SBHC model is this comprehensive, integrated approach to primary, secondary, and tertiary health education, drawing on the strength of both classroom and clinical prevention techniques (Figure 1). This approach has potential for reducing health-compromising behaviors in a school setting. For example, school-based teenage pregnancy prevention would include comprehensive sex education with primary prevention at the elementary school level, emphasizing abstinence. At the middle and high school levels, when an increasing number of students become sexually active, secondary prevention becomes more important. The classroom curriculum should include sexually transmitted disease and HIV prevention and use of contraception. Clinical services can dispense contraception and diagnose and treat STDs. At the high school level, tertiary prevention programs should identify pregnant students for early prenatal care; help reduce risky behaviors for low birthweight births and assure optimal pregnancy outcome; support the teenage mothers to complete their high school education; and prevent further unintended pregnancies.

**UTILIZATION OF SBHC SERVICES**

Our experience with the three high school SBHCs in Denver serves as a good example of the frequency of physical health and emotional problems. The Denver SBHCs opened in April 1988, and data were collected for each visit using a computer-based management information system designed for monitoring school-based health data. After the first 3 years, 73% of the student body was registered with signed parental consent. As of June 1993, the health centers had provided 35,475 visits. Sixty-three percent of the registered students used the health center at least once annually, and each user average 5.5 visits annually. Sixty-five percent of female students and 60% of the male students used the health center. Utilization by race paralleled the racial distribution within the school. Students who used the health centers most frequently were those with the most serious problems. The frequent users had more high-risk behaviors such as alcohol use, sexual activity, problems with both family and peer relations, and more academic problems in school.

Figure 2 documents the frequency of diagnoses from April 1988 through June 1993. The most common was emotional problems (31%) including parent-child problems, depression, adolescent adjustment reaction, and post-traumatic stress disorder. The second most common was health supervision (12.5%); health maintenance and immunizations comprised 72% of the visits in this category. Respiratory problems accounted for 9.7% of the visits: upper respiratory tract infections and pharyngitis made up 60% and asthma comprised an additional 9%. The fourth most common category was drug and alcohol problems (8.9%) Alcohol comprised 42% of these visits and cannabis abuse, 37%. Together, emotional and substance abuse problems accounted for 40% of total clinic visits.
GOVERNANCE AND FUNDING

School-based health centers have been sponsored by a variety of agencies including public health departments, private and municipal hospitals, community or academic medical centers, school systems, and other community agencies. Most SBHCs are funded through a combination of mechanisms. In a 1993 survey by Advocates for Youth, state and local human and social services accounted for 45% of the operating budgets; maternal and child health block grants accounted for 18%; and foundation grants for 10%; and other sources made up the balance.

---

**Figure 2.** All diagnoses for students seen between April 1988 through June 1993 (total number of diagnoses = 50,765).

Although a number of health centers have started billing Medicaid for services, only 24% of the registered students are eligible for Medicaid. Forty-one percent of the registered students had no insurance. Reimbursement for services has been extremely difficult because most SBHCs carry a significant indigent load (40% to 50% uninsured), and only a small percentage of students have private health insurance. School-based health centers often do not bill private insurers for pregnancy tests, sexually transmitted diseases and some emotional problems because of the potential break in confidentiality. Students with coverage through an HMO must receive services through that plan because outside providers are not reimbursed. Moreover, with the increase in Medicaid managed care plans, access to Medicaid funding may become even more limited.

Determining the cost of providing health services in SBHCs is complicated because of mixed funding streams for targeted elements of the program; in-kind services; unrelated overhead expenses and indirect grant costs; and vari-
able benefit packages. In addition, educational and social services are interspersed with medical services. Because of these factors, national figures on the cost of running a SBHC have been highly variable. For the Denver SBHCs, our analysis of costs for delivering medical, mental health, and substance abuse treatment services for a single school year, including in-kind costs, costs of school outreach and health education, and program administration is $125 per year.

WHAT DO WE KNOW ABOUT THE IMPACT OF SBHCS?

We have learned that:

• the delivery model successfully addresses the barriers that adolescents have accessing services,\(^{30,38,39,40,41}\)
• SBHCs can be successfully integrated into a school culture,\(^ {30}\)
• services are well accepted by students and parents, and teachers and administrators view SBHCs as a valuable asset to the school,\(^ {38,42}\)
• a wide range of basic physical and mental health services can be provided with appropriate service utilization for both male and female adolescents,\(^ {39}\) and
• care can be delivered in a cost-effective manner.

CONCLUSION

It remains to be demonstrated whether SBHCs can have an impact on some of the most serious morbidity among adolescents, such as high school dropout rates, unintended pregnancies, sexually transmitted diseases, HIV, suicide, and homicide.\(^ {43,44}\) Outcome studies to assess health behaviors are extremely difficult to design, and few studies have been published to date.\(^ {45,46,47,48,49}\) It is unrealistic to think that just by introducing clinical services into a school setting, psychosocial problems that are deeply rooted in our society will be easily resolved. For SBHCs to be successful, they must be part of a comprehensive school and community approach that incorporates a continuum of primary, secondary, and tertiary health education, carefully planned interventions, and effective and coordinated physical and mental

Dr. Kaplan is from the Department of Adolescent Medicine, University of Colorado School of Medicine, Denver, Colorado. This work was supported in part by grants from the Robert Wood Johnson Foundation and the Carnegie Corporation. Address reprint requests to David W. Kaplan, MD, University of Colorado School of Medicine, The Children’s Hospital, 1056 E 19th Avenue, Denver, Colorado 80218
REFERENCES


Abortion
SAMPLE TESTIMONY: PARENTAL NOTIFICATION FOR YOUNG WOMEN’S ABORTION*

The following testimony was presented by a Washington state Representative on the floor of the Washington House in opposition to HB 1523.

Good afternoon, I am Representative ____________________ and I represent ____________________. I would like to thank you for giving me the opportunity to testify today against House Bill 1523.

House Bill 1523 endangers the health and lives of young women in the state of Washington. Proponents of the bill misleadingly claim that its purpose is to promote family unity, reduce teen pregnancy and reduce unnecessary abortions. The bill will have none of these effects and, indeed, in many cases may endanger the young women of this state.

There is no question that responsible parents should be involved when their young daughters face crisis pregnancies. It is the hope of every parent that a child confronting a crisis will seek the advice and counsel of those who care for her most and know her best. And, in fact, most young women do turn to their parents when they are considering an abortion. Indeed, in states that enforce no mandatory parental consent or notice requirements, more than 75 percent of minors under 16 involve one or both parents.¹

But government cannot mandate healthy family communications where it does not already exist. Laws mandating parental notice or consent actually harm the young women they purport to protect by increasing illegal and self-induced abortion, family violence, suicide, later abortions and unwanted childbirth.

The American Medical Association takes the position that: “Physicians should not feel or be compelled to require minors to obtain consent of their parents before deciding whether to undergo an abortion ... [M]inors should ultimately be allowed to decide whether parental involvement is appropriate.”²

Young women who do not involve a parent in their abortion decision have good reasons.

Although most young women find love, support and safety in the home, many justifiably fear that they would be physically or emotionally abused if forced to disclose their pregnancy. Often young women who do not involve their parents come from homes where physical violence or emotional abuse are prevalent. In these situations, government-mandated disclosure could have devastating effects. Consider these facts:

• Approximately 2.9 million cases of child abuse were reported in this country in 1992. Young women considering abortion are particularly vulnerable because family violence is often at its worst during a family member’s pregnancy.³
• Among minors who did not tell a parent of their abortion, 30% had experienced violence in their family or feared violence or being forced to leave home.⁴

ADVOCATES FOR YOUTH
In Idaho, a 13-year-old sixth grade student named Spring Adams was shot to death by her father after he learned she was to abort a pregnancy caused by his acts of incest. Proponents of house Bill 1523 claim that the “judicial bypass” provision will protect those young women who are victims of family violence. This simply ignores the practical reality that many young women will find it overwhelming, if not impossible, to appear before a judge to request permission to obtain an abortion. Some women will not be able to maneuver the legal procedures required, or be able to attend hearings scheduled during school hours. Others will not go or will delay going because they fear that the proceedings are not confidential or that they will be recognized by people at the courthouse. To avoid embarrassment resulting from recognition in their local court, young women may endure additional costs by seeking a bypass in a different county. Many young women experience fear and distress and do not want to reveal intimate details of their personal lives to strangers. The time required to schedule the court proceeding may result in a delay of a week or more, thereby increasing the health risks of the abortion. Some young women who manage to arrange a hearing face judges who are vehemently anti-choice and who routinely deny petitions, despite rulings by the U.S. Supreme Court that a minor must be granted a bypass if she is mature or if an abortion is in her best interests. Let me give you some examples:

- In denying the petition of one young women, a Missouri judge stated: “Depending upon what ruling I make I hold in my hands the power to kill an unborn child. In out society it’s a lot easier to kill an unborn child than the most vicious murderer ... I don’t believe that this particular ‘juvenile has sufficient intellectual capacity to make a determination that she is willing to kill her own child.”

- A Toledo, Ohio, judge denied permission to a 17½-year-old women, an “A” student who planned to attend college and who testified she was not financially or emotionally prepared for college and motherhood at the same time. He stated that the girl had “not had enough hard knocks in her life.”

- The Ohio Supreme Court upheld the denial a petition of a 17-year-old girl who testified that her father beat her. At the time, she was a senior in high school with a 3.0 average, active in team sports, worked 20-25 hours a week and paid for her automobile expenses and medical care.

- In Indiana, minors travel to Kentucky or Illinois rather than attempt a bypass proceeding before judges who are known to be anti-choice.

Because the judicial bypass procedure is ineffective for many young women, HB 1523 will endanger the lives of many young women in Washington by forcing them to turn to illegal or self-induced abortion—forcing them to delay the procedure until it is both more difficult to obtain and more dangerous to their health—forcing them to bear a child against their will. Indeed, the American Medical Association (AMA) has acknowledged these risks. I quote: “[b]ecause the need for privacy may be compelling, minors may be driven to desperate measures to maintain the confidentiality of their pregnancies. They may run away from home, obtain a ‘back alley’ abortion, or resort to self induced abortion. The desire to maintain secrecy has been one of the leading reasons for illegal abortion deaths since... 1973.” The AMA has also concluded...
that parental consent and notice laws “increase the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure.”13 Although a first or second trimester abortion is far safer than childbirth, the risk of death or major complications significantly increases for each week that elapses after eight weeks.”14

In their zeal to promote this dangerous legislation, proponents of HB 1523 have callously implied that young women’s lives are not endangered by parental notice laws. They have even questioned the truth of the well-known and tragic story of Rebecca Bell, a young Indiana woman who, despite her close relationship with her parents, sought and died from an illegal abortion rather than comply with the Indiana parental consent law.15 The unavoidable tragedy of Rebecca Bell’s death is well documented. Since her death, her parents have become activists fighting parental notice and consent laws around the country because, according to her father, “had there not been [the Indiana parental consent law], she’d be here today.” In fact, just last week, Rebecca Bell’s mother visited Texas to oppose a parental notification and consent bill, calling such laws “a killer.”16

Finally, House Bill 1523 completely ignores the devastating effects of teenage childbearing. Forced childbearing that results from parental consent and notice laws can have devastating effects on the life opportunities of young women and their children.

• Teenage girls are more than 24 times more likely to die from childbirth than from first trimester legal abortions.17
• Women who give birth before age 18 are only half as likely to graduate from high school as those who postpone childbirth until after age 20.18 Eight out often women who become mothers before age 18 drop out of high school, and only one in fifty finishes college.19 Forty percent of women who have a child by age 15 never finish the eighth grade.20
• Teen mothers earn about half the income of those who first give birth in their 20’s, and continue to earn less money for the rest of their lives.21 Sixty-seven percent of families headed by teen mothers live below the poverty level.22 In 1985, 53% of the $15.69 billion spent on Aid to Families with Dependent Children (AFDC) went to families that began when the mother was a teenager.23
• The children of teenage mothers are twice as likely to die in infancy as those born to women in their twenties.24 The children of teenage parents are more likely to become teenage parents themselves, thus perpetuating the cycle of poverty.25

House Bill 1523 will not promote family unity; it will endanger the lives of the young women of Washington. I urge you to reject this dangerous legislation and instead to recognize that all women in this state, including minors, must have access to a full range of reproductive health choices. By casting your vote against House Bill 1523, you will be telling the people of Washington that the health and lives of teenage women are of paramount importance, and should both be endangered by legislation that claims to promote family unity when it, in fact, endangers the health and lives of young women. Thank you.

* This testimony was drafted by Nicole McLaughlin of the National Abortion Rights Action League’s Legal Department.
RESOURCES


4. Henshaw and Kost, “Parental Involvement,”


7. *Hodgson v. Minnesota*


11. Tamar Levin, “Parental Consent.”

12. AMA, “Mandatory Parental Consent.”


Pregnancy Prevention
PREVENTING TEEN PREGNANCY IN AMERICA:
COORDINATING COMMUNITY EFFORTS

Testimony of
Barbara Kemp Huberman, RN, BSN, MED

Barbara Huberman, is Director of Training and Sexuality Education for Advocates for Youth, a national organization dedicated to teen pregnancy prevention. Advocates provides information, education and training to youth-serving professionals, policy makers and the media. She is the Founder and, until the Fall of 1995, was the President of the Adolescent Pregnancy Prevention Coalition of North Carolina. In that capacity, she was instrumental in helping establish local community coalitions in 68 of the state’s 100 counties. She has also served as President of the National Organization on Adolescent Pregnancy, Parenting and Prevention and a Board Member of the newly created National Campaign to Prevent Teen Pregnancy.

If we are sincere about solving this important public health and societal problem, we must begin to rely on facts, science and research to guide us.

While we discuss the “problem of teen pregnancy,” 2,700 teens will get pregnant each day.

While we argue about which subjects to include in sex education, 8,000 teens become sexually active each day.

While we debate on WHOSE values are right or wrong, teenagers hear us preach one thing and then do another when it comes to sex. Adults devalue fidelity, have children out of wedlock and no longer honor “til death do us part.”

While we plan programs that have NO relationship to the world of VCR’s, cyberspace and AIDS, we will spend over 35 BILLION dollars each year on the band-aids — AFDC, Medicaid and food stamps—for teens who give birth and have no resources to survive without our help. In North Carolina, of every dollar spent on teen pregnancy, only ONE cent went to primary prevention. This is despite the fact that North Carolina has one of the most aggressive statewide programs in the country dedicated to prevention of pregnancy.

While we blame the “victim,” the children born to some of these teen mothers will have no future and repeat the cycle. Another 1,400 each day will give birth so they have “someone to love them,” so they can get out of an abusive situation, or so that they can have some control and power in their lives.

While we debate whether we should focus on “abstinence only” messages in our schools, many teenagers will be getting sex education taught by
incompetent, non-educators who know that sex sells, that is, the media. Many of our teens will spend 27,000 hours watching television, 12,000 hours in school, and will receive only an average of 10 hours of comprehensive, honest and accurate sexuality education.

While you and I learn about what we know can make a difference and help change values and behavior, a teen will have a baby every 67 seconds.

There are no magic bullets, no quick fixes, no politically non-controversial strategies for prevention. But there is a body of research now that should drive any policy and funding decisions. It is time to pay attention to this data and stop allowing federal, state and local dollars to support programs based on a narrow ideology that allows only one simple solution—abstinence until marriage education—and refuses to accept that 85% of our teens make a different choice. We must have multiple, long-term interventions that first deal with the immediate, an adolescent’s decision to be sexually active. Then, we must address the root causes of teen childbearing: poverty, lack of opportunity and education, and sexual abuse. Simple answers cannot address the deficits many young people face every day. To opponents of comprehensive sexuality education and family planning services for youth who say “I don’t care if it works or not, it’s morally wrong,” I say it is morally wrong for us to allow young people to be sent into the adult world without the knowledge, skills and values to negotiate sexual decision making responsibly.

Let me share with you the culminating incident that led me to hold these very strong, reality-based convictions about the need for prevention. Twenty years ago, while working as a nurse/counselor at a maternity home for pregnant teens, I walked out of a labor room after spending the entire night holding the hand of a 10-year old as she gave birth. After that I said “Enough! Someone has to be the advocate for PREVENTION.”

There are no ideal solutions for a young woman after an unplanned pregnancy has happened. We must focus on primary prevention so that no young woman has to deal with the pain of adoption or abortion, the consequences of a premature marriage or has to become a child raising a child.

In poll after poll, in interviews, conversations and surveys, the American public—parents, voters and citizens—support realistic, relevant and responsible prevention programs. Attached to my testimony are two polls from North Carolina that have been repeated in other states and nationally. The numbers are virtually the same. You can see that support for realistic, relevant-to-today’s-world prevention programs that include comprehensive sexuality education and access to contraceptives crosses party lines, religious beliefs, gender, race and all other boundaries. The second study surveyed PTA presidents and offers compelling evidence that parents, without a doubt, want sexuality education and access to contraceptives, even at school sites.

In most other developed countries, teens are just as or even more sexually active than American kids. The media in those counties is more explicit in sexual programming. Mothers do have careers and divorce does happen. They blend cultures and races, and there is poverty.
But their teen pregnancy rates and their abortion rates are significantly lower than ours. Why are we so unwilling to learn from their example? Is it because we always feel we have the answers and they don’t see the truth? Is it fear? Are we looking for the easy political solution? Is it ignorance? I can tell you what some of the differences are, and then maybe we can begin today to reframe the American teen pregnancy prevention philosophy.

1. Countries such as Sweden, France, the Netherlands and Canada have age-appropriate, comprehensive sexuality education in preschool through college, taught by trained, competent educators. It is national policy, and parents feel the school supports them in their role as sexuality educators of their children. They are not suspicious or fearful of what their children are learning—that sexuality is an integral and healthy part of life. Strong relationships and marriage, if and when they do come, are enhanced by this knowledge and ongoing discussions of roles and responsibilities.

Where we have taken a similar approach in the United States, we have seen encouraging results. Prevention curricula such as Reducing the Risk, Get Real about Aids, and the Teen Outreach Program all share one goal: to produce sexually healthy, responsible, and respectful adults. Reducing the Risk has achieved behavioral changes in the teens who took part in the research study. A forty percent reduction in unprotected intercourse was found in youth who had not yet initiated intercourse. The Teen Outreach Program showed a 33 percent lower teen pregnancy rate for the students who participated in the program.

2. Unlike the United States, other industrialized countries provide access to contraceptives and general health care for adolescents. There is no debate about whether teens should or should not be able to get them. It is a given that teens will use protection. The stigma is on the failure to act responsible, not the decision to be sexually active. Family planning services are free, easily available in neighborhoods, and non-judgmental health care professionals support young people in their decision to access family planning services. Pelvic exams—which scare many young women away from seeking services—are not required. Services are completely confidential.

You may think family planning is available in this country, but I challenge you to walk in the corner drugstore, take condoms off the shelf, stand in line, put them on the counter, and pay for them while six people are watching you. The importance of contraceptives in teen pregnancy prevention cannot be denied. A community-based, community-wide comprehensive prevention program in rural South Carolina achieved dramatic reductions in teen pregnancy over a three-year period. Among other things, this program had a significant contraception component. When the press reported the program’s success, many policy makers were impressed with the results and sought to have the legislature authorize funds to replicate the program in other counties in the state. Unfortunately, some legislators instead chose to outlaw the dispensing of contraceptives on school grounds, thereby undermining a key source of the program’s effectiveness. Within three years the teen pregnancy rate returned to the same level it had been at prior to the program.

3. The last difference between the United States and other developed countries with much lower rates of teen pregnancy is broader and speaks direct-
ly to the role of policy makers. In other countries, local and national poli-
cies and leaders recognize and acknowledge the normalcy of being a sexual
person. The allocation of resources reflects the national philosophy of
respect for healthy and responsible sexual behavior.

Abstinence from sexual intercourse is a choice that each of us may make
at some time in our lives, but it is not the only choice. Abstinence is an
important message in our educational programs and policies, but it CAN-
NOT BE THE ONLY HEALTHY MESSAGE. Over 90 percent of first-time
marriages in this country are not virginal marriages. Postponing sexual
intercourse until marriage is NOT a widely held societal value anymore since
the average age of marriage in this country is now over 25.

The contrast between the United States and its industrialized counterparts
in this regard is clear. Historically, the political will to take a realistic
approach to teen pregnancy prevention has not been present at the national
level. Currently, there are only three federal programs that specifically target
the reduction of teen pregnancy.

**Title X**, which provides family planning services in local communities.
Thirty percent of these funds are for adolescent clients, the rest for adult women;

**Centers for Disease Control and Prevention Grants**, which were
initiated in 1995, fund 13 communities to design prevention partnerships. Keep
in mind, however, that there are 83,000 cities and towns in the United States;

**Adolescent Family Life Act**: (AFLA), which is over 15 years old,
funds abstinence programs, promotes adoption, and gives the majority of its
grants to programs that take care of pregnant and parenting teens. In 1995,
nine of the 15 grants went to after-the-fact programs, not prevention pro-
grams. This is typical of AFLA’s funding history. Hence, it is no surprise that
this initiative has not done much to identify successful prevention models.
So much more could be accomplished if federal funds and policies supported
genuine and effective prevention strategies.

In sharp contrast to the what has happened at the national level, there are
states and local communities across the United States that have decided to
take on teenage pregnancy prevention and take off the blinders. North
Carolina has led the way in public-private-volunteer partnerships which
focus on prevention.

We understood that the solutions to teenage pregnancy did not just lie
with the schools or with health providers. It was a community problem, and
therefore the solution had to involve the entire community. Each local coun-
cil in North Carolina included representatives from the media, religious insti-
tutions, business, neighborhood representatives, government, and parent
organizations, as well as the schools, medical community and social service
agencies. Many were partners with their local United Way, which provided
them with funding and provided annual allocations to support the state
coalition. The local councils became the catalysts for community efforts and
developed long-range plans for the reduction of teen pregnancy based on
their community’s resources and values.

The local councils drew upon existing community agencies and served as
clearinghouses of information about community resources. Councils trained school teachers in youth development and sexuality education, designed sexuality education training programs for clergy, coordinated parent-child communication campaigns, and promoted access to family planning for sexually active youth by helping clinics expand their service hours. Some councils had peer education programs, and media campaigns. Other councils developed innovative fundraising campaigns with local businesses to raise money for prevention efforts.

The councils also understood that supportive policies were just as important as good programs. Grassroots support from the local councils was instrumental in convincing the North Carolina State Legislature to fund three major prevention programs, at a investment of over four million dollars each year.

The bottom line is that after ten years of state and community coordinated efforts, the teen pregnancy rate in North Carolina has dropped steadily for the past four years. So it can be done.

Despite the lack of investment in prevention at the federal level, we do have a good idea of what works. The teen pregnancy rate among sexually active teens (those who are most at risk for pregnancy and sexually transmitted diseases or STD’s) has come down by over 20 percent. Why? Even though the rate of sexual intercourse is rising, more teens are using contraception and using it more effectively. It is also possible teens are having fewer sexual partners because of their fear of AIDS and therefore have reduced their risk possibility.

We now have more effective technology to prevent pregnancy. This includes Norplant, Depo-provera and latex condoms.

We know that young women who are actively involved in sports, extracurricular activities and have educational and career opportunities have fewer pregnancies.

You can stick your head in the sand and believe that “just say no” messages with work for all teens. You can ignore the facts and the research and fund programs that don’t work and/or have no reliable data to support their claims of effectiveness. You can bow to those who say don’t get involved, it’s too controversial. You can put young men in jail when what they need is a better education and a job. You can choose to listen to a vocal and misinformed minority.

But there will be a price to pay. Kids will get pregnant. Kids will die. And you and I will lose. Society will be faced with more poverty, crime, illiteracy, and burdens for tax dollars.

It would be so much more healthy and cost effective to provide the knowledge and education and the access to family planning services young people need to prevent pregnancy.

What our youth need from all of us is the will to invest in realistic, relevant and responsible prevention programs. “Just Say No” must become “Just Say Know.”

Thank you.
COMPONENTS OF PROMISING TEEN PREVENTION PROGRAMS

Teen pregnancy and early childbearing are complex issues which have attracted a great deal of attention from service providers, educators and policymakers in recent years. Experience and research clearly indicate that adolescent pregnancy is associated with a variety of factors—it is not simply a problem of teens having unprotected sexual intercourse at an early age. For many young people, the issues related to early pregnancy and childbearing include much broader social, economic, cultural and psychological factors, including poverty, school failure and sexual abuse. A further complicating factor is that adult men are frequently the fathers of children born to teenage women.

These complexities pose particular challenges to pregnancy prevention program planners. It must be recognized that there is no “magic solution” to teen pregnancy, nor will a single intervention work for all teens. Communities should look for immediately lower pregnancy or birth rates over a short period of time; the process is time-consuming, and requires affirmation of young people and a serious commitment of financial resources. To reach a broad teen audience, programmers need to implement a combination of strategies and involve all key members of the community.

While there is still much to learn about the causes and consequences of early pregnancy, program planners can benefit greatly from the existing body of research and the “lessons learned” from numerous programs in place across the country. This document summarizes key ingredients of teen pregnancy prevention programs and may be used as a guide for developing new strategies and strengthening existing interventions.

GENERAL PRINCIPLES

The following principles are important to consider for program implementation:

• **Set clearly defined and realistic program goals and objectives.** These may relate to the delayed initiation of sexual intercourse, increased and more effective contraceptive use, reduced rates of pregnancy and childbearing among participants, and/or increased rates of school completion.

• **Encourage community collaboration.** Parents, neighborhood organizations, schools, health providers, and youth agencies can provide critical support during all phases of program design and implementation. The media, business sector, religious organizations, and policy makers also play an important role in the prevention partnership.

• **Involve youth in needs assessment, program design, implementation and evaluation.** Teens can be involved in a variety of activities including agency advisory boards, community outreach efforts, and program planning and review.
• Create activities that are both age appropriate and developmentally appropriate. Interventions should be tailored for younger, middle, and older adolescents and should account for varying levels of cognitive development.

• Provide culturally appropriate program activities. Activities should be relevant to young people and should reflect an understanding of and sensitivity to the racial and ethnic backgrounds of participants.

• Coordinate messages to target both young women and men. It is important to emphasize joint responsibility, sexual communication, assertiveness, and refusal skills. Either gender-specific or coed programs can reach both young women and men.

• Offer long-term and consistent support. Programs should be tailored to individual participants. While some young people need little support to prevent a pregnancy, others will require more comprehensive interventions over a sustained period of time.

• Provide information on both abstinence and contraception and ensure access to contraceptive services. Messages on abstinence and postponement of sexual activity are important for those who have not yet initiated sexual intercourse and should be presented as viable options for those who are already sexually active. Sexually active teens also require accessible and affordable contraceptive and reproductive health services. Still other adolescents may need additional interventions to strengthen their motivation to prevent or delay too-early childbearing.

**PROGRAM STRATEGIES**

Pregnancy prevention programs must account for the varying levels of risk among teens. When developing specific interventions, the following issues are important to consider:

**SEXUALITY EDUCATION**

All young people need comprehensive sexuality education to prepare them for healthy adult relationships. Sexuality education programs should increase adolescents’ knowledge and help them to explore attitudes, feelings and values about human development, relationships, dating, gender roles, sexual orientation, sexual behavior and healthy sexual decision-making. Educational programs are most effective when they:

• provide accurate information on both abstinence and contraception

• are developmentally appropriate

• encourage skill development, including decision-making, assertiveness and negotiation skills as well as life skills training and goal setting

**CONTRACEPTIVE SERVICES**

A sensitive, well-trained and non-judgmental staff person plays an important role in helping teens learn about and decide to use contraception effectively and consistently. The first contact with a family planning service
provider is critical in setting the stage for future visits. Family planning staff should utilize a guided counseling process to help a teen decide which method of contraception is most appropriate. This type of counseling is particularly useful for teens who receive a negative pregnancy test during a “pregnancy scare”. In addition, the role of males should be addressed in family planning settings. Although men are influential in contraceptive use and acceptance among young women, they are seldom specifically engaged in prevention efforts.

Comprehensive sexual and reproductive health services for adolescents should include gynecological exams; contraceptive methods; pregnancy testing; and screening, treatment, and/or referral for sexually transmitted diseases including HIV/AIDS. Teen-friendly services are most effective when they:

- guarantee confidentiality
- offer accessible hours, including walk-in appointments and flexible and extended hours during evenings and weekends
- offer a convenient setting where teens naturally congregate
- provide free-of-charge or affordable services (on a sliding fee scale)
- offer directive contraceptive education and counseling
- offer to delay the pelvic exam at the initial visit

**MOTIVATIONAL OPPORTUNITIES AND RELATED SERVICES**

For those teens at highest risk of pregnancy, effective prevention strategies include improving educational and economic opportunities and/or intervening in the numerous social and psychological factors associated with sexual risk-taking. Strategies should be designed for the individual young person and need to include access to:

- psychosocial counseling, including treatment for sexual abuse, drug and alcohol use, and/or family distress
- monitoring programs for youth to develop a close relationship with an adult
- educational opportunities, including tutoring and access to higher education
- recreational activities such as sports, drama and social clubs
- vocational and job skills, including job placement
- community service opportunities

**CALL TO ACTION**

Based upon these program strategies and principles, communities may want to assess adolescent needs, review service availability, identify gaps and resources, and develop a comprehensive plan of action for adolescent pregnancy prevention. This plan should address ways to develop new programs, strengthen existing efforts, or better coordinate activities and referral net-
works so that all teens have access to a wide array of prevention services. To be most effective, community-wide program efforts must be supported by expanded financial resources, increased public awareness, and the implementation of favorable policies at the national, state and local levels.

Please contact Advocates for Youth’s National Teen Pregnancy Prevention Clearinghouse at (202) 347-5700 to receive additional information, technical assistance, or training on pregnancy prevention programs or related issues.

ENDORSEMENTS

The Components of Promising Teen Pregnancy Prevention Programs were developed by Advocates for Youth’s National Teen Pregnancy Prevention Initiative’s Advisory Committee. The following members of the committee have endorsed The Components:

Claire Brindis, Dr.P.H.  Lorraine Williams Greene, Ph.D
Center for Reproductive Health  “I Have a Future”
Policy Research  Meharry Medical College
UCSF Institute for Health Policy  Nashville, Tennessee
Studies
San Francisco, California

Patricia Canessa, M.A.  Bernice Humphrey
The Arts of Living Institute  Healthy Girls Initiative
Chicago, Illinois

Robert H. Duckett  Girls Incorporated
First Things First  Indianapolis, Indiana
Planned Parenthood Federation of
America
Washington, D.C.

Margaret Pruitt Clark, Ph.D.  Wendy Lesko
Advocates for Youth  Activism 2000 Project
Washington, D.C.

Kensington, Maryland

Marta Flores
Plain Talk Initiative
San Diego, California
REFERENCES


Compiled by Laura Davis
FACT SHEET

ADOLESCENTS AND ABORTION

In 1990, more than 800,000 teenagers (aged 15 to 19) became pregnant; 95 percent of these pregnancies were estimated to be unintended.1 Teen pregnancy rates have increased from 1980 to 1990.7 Despite the health risks of childbearing to both teens and infants, and the safety of legal abortion, a number of states have enacted laws restricting access to abortion. These laws, particularly mandatory parental consent or notification, place adolescents at risk by creating barriers that thwart or delay teen’s access to reproductive health services. Results include mental anguish, psychological or physical abuse from parents, postponed acquisition of abortion services and/or the birth of unwanted children.

Many Pregnant Teens Choose Abortion

- In 1990, 835,000 teenage pregnancies were reported in the U.S. The pregnancy rate among all adolescents increased 24 percent from 1986 to 1991, but decreased 2 percent in 1992.1

- The pregnancy rate for sexually active adolescents, however, has decreased 19 percent in the past two decades. Among this group, about 9 percent of 14-year-olds, 18 percent of 15- to 17-year-olds and 22 percent of 18- to 19-year-olds become pregnant each year.2 One factor influencing this decline may be increased access to contraceptives.

- In 1992, the last year for which complete data are available, 1,359,145 abortions were performed in the U.S.; 185,867 were to teens. Twenty percent were to women under 20 years of age (0.8 percent for teens under age 15 and 19.1 percent for teens age 15 to 19.3

- The abortion ratio (abortions per 1000 live births) for adolescents is declining. 1992 was the fifth year in a row the abortion ratio decreased for adolescents. The 1992 abortion ratio for women aged 15 to 19 was the lowest since 1974.3

- A 1996 report of teens choosing abortion showed 4 percent of these young women were under 15 years of age, 7 percent were age 15, 12 percent were age 16, almost 18 percent were age 17, and 69 percent were age 18 to 19.3

- Forty-seven percent of women who postponed childbirth until after 25 obtained a college degree. Only 5 percent of women who gave birth under the age of 20 gained a college education.2
Abortion Rates Vary by Race and Socio-Economic Status

- Almost 60 percent of white teens with unintended pregnancies choose abortion, while less than 50 percent of Hispanic and African-American teens choose abortion.2

- An adolescent’s academic aspirations and her family’s financial status affects her abortion decision: teens from financially secure backgrounds are more likely than teens from low-income homes to choose abortion. Fewer than half of the unintended teen pregnancies in low-income families end in abortion, while almost three-quarters of higher income adolescents abort their unintended pregnancies.2

Adolescents Risk More From Childbirth Than Abortion

- For teens, a legal abortion is safer than childbirth or even a shot of penicillin. One study showed the risk of death from childbirth was 6.6 deaths per 100,000 live births, compared with .6 deaths from abortion (legal and illegal) per 100,000 procedures. The risk of death from a shot of penicillin was 1.1.5 Teens aged 15 to 19 are 12 times more likely to die from childbirth than from a first trimester legal abortion.12

- Abortion is actually “the safest operation which is available in the United States.” Adolescents less likely than adults to experience medical complications after abortion.6

- Adolescents are four times more likely to experience adverse psychological effects after childbearing than after abortion.6

- Babies born to adolescents, particularly to adolescents under 15, have a higher risk of being born premature, having low birth weight, or dying.7

- Teens risk more than their health in childbearing. Teen mothers are less likely to complete their education, and more likely to have limited career and economic advantages. They are also more likely to be poor, have failed marriages, and have additional unintended pregnancies.7

- One study showed that, after two years, teens who had abortions were more likely to have remained in or graduated from high school, and were less likely to have experienced a repeat pregnancy than their peers who gave birth or whose pregnancy test was negative.8

State Laws Restrict Adolescents’ Access to Abortion

- As of May 1996, 18 states had laws requiring the consent of one parent or guardian for an adolescent seeking an abortion (13 are enforced); 3 states have laws requiring the consent of both parents (all are enforced); 14 states have laws mandating notification of one parent (10 are enforced); and 2 states have laws requiring notice to both parents (both are enforced). Eighteen of the parental consent statutes have “judicial bypass” procedures, where a minor can obtain an abortion without parental consent by applying to a court instead. Twelve of the parental notice statutes have judicial bypass provisions.9
Parental notification laws have no effect on an adolescent’s decision to tell her parent or guardian prior to acquiring an abortion. The chief factor determining whether an adolescent will consult a parent is not legislation, but the quality of the parent-child relationship.10

In states with parental consent or notification laws, adolescents say they do not consult their parents because they fear emotional and physical abuse, including eviction from their homes. Teens also fear their parent(s) will not keep the information confidential, or that the news will upset a fragile parent.6

The Supreme Court mandates states with parental consent or notification laws allow teens to obtain an abortion by appealing to another adult, such as judge, doctor, or minister for permission. Evidence suggests, however, that forcing a young woman who is facing an unintended pregnancy to apply to a court, physician, or other authority figure has significant adverse physical and emotional effects on the adolescent.6

Adolescents are more likely than other age groups to have abortions later in the term of their pregnancy, particularly after 16 weeks of gestation.3

The risk of complications in an abortion increases 50 percent per week for each week after the 10th week of pregnancy.6 Parental consent laws and/or judicial bypass procedures often postpone an adolescent’s ability to acquire an abortion by two or more weeks. In Massachusetts, minors using the bypass procedure experience delays of at least a week, usually two, from the time they initiate the procedure to obtain a bypass until the abortion.6

**Most Minors Are Mature Enough to Make Abortion Decisions**

A 1992 study of women seeking pregnancy tests found those aged 14 to 17 to be as competent as adults to make informed and independent decisions about abortion and to understand the risks and benefits of the procedure.11

The vast majority of adolescents are capable of giving informed consent. No doctor would perform an abortion on an adolescent or any other patient without informed consent.6

During the 10 years that the Massachusetts parental involvement law has been in effect, courts have ruled on approximately 9,000 bypass petitions — all but 13 were granted, and 97 to 98 percent were granted on the grounds of maturity. All of the denials were appealed and only one was affirmed.6

Compiled by John R. Loxterman
References


11. Most minors are mature enough to make their own abortion decision. Fam Plann Perspect 1992; 24:187-188.

Adolescents worldwide are at risk of HIV infection as they lack accurate information and services dealing with sexuality and sexually transmitted diseases (STDs). Adolescence is defined by social norms and conditions and varies across cultures. In much of the developed world, it typically refers to the period between childhood and adulthood, characterized by school, dating and extracurricular activities. In much of the developing world, this period is often characterized by early marriage and/or immediate entry into the work force. Cultural taboos often inhibit any discussion of sexual matters with young people. To compound the issue, youth are often victims of sexual violence and abuse. According to the World Health Organization (WHO) young adults ages 15 to 24 will account for over 50 percent of HIV infection in the next decade, the majority of which will occur in the developing world.1

Adolescent HIV infection has major social, cultural, economic and health implications. The virus primarily attacks the young and most productive generations. The cost of treating HIV/AIDS is an enormous drain on overburdened and unprepared health care and social systems. In response, many developing countries are adopting programs that emphasize the prevention of HIV infection. One popular approach uses peer educators to teach other young people about sexuality and STDs — including the differences between HIV, the infection, and AIDS, the state of illness as well as to provide youth with skills that will help them negotiate safer sex behavior. Many programs also use an “enter-educate” technique in which popular forms of entertainment — TV, films, and radio — are used to spread messages of safer sex and responsible behavior.

Adolescents Are Sexually Active: Condom Use Is Low

- Sexual activity among adolescents is on the rise in many parts of the world as evidenced in part by the increased numbers of sexually transmitted diseases (STDs).2
- Average age at first sexual encounter varies across cultures and regions. Studies in parts of Africa show that at least 50 percent of young women ages 15 to 19 are sexually experienced.3 In Latin America, one in six women has had at least one child by age 18.4 Less research is available about the sexual practices in Asia; however, in some countries 70 percent of adolescents have had intercourse by age 17.5
- Most adolescents do not practice safer sex. Of young people surveyed in South Africa, only 11 percent of sexually active students had ever used a condom.6 In Mexico City, a study revealed that 60 percent of respondents thought a condom could be reused.7 Of young women in rural Malawi, only 19 percent knew that they needed to use a condom every time they had sex to prevent HIV infection.8
Adolescents Lack Accurate Knowledge About HIV/AIDS

- Studies in Mauritius, Brazil and India show high awareness of the existence of AIDS, but youth are misinformed about risks and modes of HIV transmission. Beliefs about transmission via casual contact, including kissing, sharing utensils, toilet seats and/or wearing an infected person’s clothes, are persistent.9,10,11

- Many adolescents perceive others to be at risk, regardless of their own risky behavior. Many studies reveal that adolescents believe that transmission of HIV occurs only among drug users, homosexuals, prostitutes and/or promiscuous partners, thus condoms are seen as appropriate only for illicit sex.12

- Adolescents tend to be monogamous for a while, but may have a series of partners over a short time period. Because condoms are seen to signify a lack of love or trust, many adolescents do not use them with regular partners.12

- Many adolescents are misinformed about sexual health. Studies in Colombia and Nigeria noted that traditional herbal medicines or soda and lime concoctions are thought to cure STDs and prevent pregnancy.13,14

- One study in South Africa revealed that 26 percent of students surveyed believed that AIDS was curable, while an additional 43 percent were not sure.6 In Indonesia, a similar study found that only 32 percent had even heard of AIDS.15

Social and Economic Factors Increase Adolescents’ Risk of Infection

- Experts estimate that up to 170 million children under the age of 18 live or work on the streets of urban areas throughout the world.16 Many, both male and female, are forced to use sex as a survival mechanism, in exchange for money, food or a place to sleep. For others, sex becomes equated with love as it provides the only form of physical affection available.13

- Sexual exploitation through forced prostitution is common in parts of the world. Some organizations in Thailand estimate that up to 800,000 girls below the age of 16 are involved in commercial sex work. Studies reveal that many of these young women were sold into prostitution by their families.17

- Adolescent commercial sex workers have little access or lack the ability to use condoms with clients. In Rio de Janeiro, 69 percent of young male commercial sex workers and in Thailand 72 percent of female commercial sex workers in brothels were HIV infected.18,17

- Adolescents are disproportionately exposed to sexual abuse and violence. Hospitals in Peru and Costa Rica estimated that 90 to 95 percent of pregnant girls under age 15 had been victims of rape, including incest.19 In Malawi, 55 percent of adolescent girls interviewed stated that they are often forced to have sex.8 Forced sex is often rough which puts young girls at higher risk of HIV infection; ripping and tearing of the vaginal wall facilitates HIV transmission.20

- Drug use among street youth is common. Drugs affect an individual’s decision-making capabilities rendering them more likely to engage in unprotected sex.
In Bogota, 95 percent of street youth reported using drugs, mostly glue, alcohol and marijuana.13

**Young Women Have Higher Biological and Cultural Vulnerability to HIV Infection**

- According to WHO, 70 percent of all new HIV infections worldwide are among women between 15 and 25; women become infected 5 to 10 years earlier than men.21,22 The immature genital tract of young women is a less efficient barrier to HIV than that of older women. This may be exacerbated by female genital mutilation or untreated STD infections.22

- In the developing world, the female to male HIV infection ratio is, on average, two to one. In Malawi and Zimbabwe, studies have shown that women between the ages of 15 to 19 are infected at a ratio of five to one.21

- Women have much less bargaining power and lack negotiation skills in sexual encounters.23 Fifty-seven percent of adolescent girls in a study in Malawi stated that it was easier to risk pregnancy and disease than to ask a boy to use a condom. Seventy-five percent said they would like help in learning how to convince a boy to use one.8

- In many parts of the world it is often believed that sex with a virgin can cure a man’s STDs. Older men, sometimes referred to as “sugar daddies,” seek out sex with young women in exchange for meals, rides to school or even school fees, based on the belief that young girls are less likely to have an STD.12

- In many cultures it is common for men to prepare for manhood by visiting a commercial sex worker. Marriage does not always imply monogamy, and it is often acceptable for a married man to visit a commercial sex worker or have extramarital sexual relations, which puts their wives and partners at risk.24,25

- For many young women, marriage presents the greatest risk of infection, as their ability to use protection is negated by their responsibility and hopes for childbearing.20

Compiled by Terrell Sellix
January 1996
References


Educational attainment and poverty are intricately linked to early childbearing among adolescents. It is important to note that pregnancy occurs among all young women, regardless of socioeconomic status, geographic location, race or ethnicity. Statistics show, however, that teen childbearing occurs disproportionately among low-income women. The decision to carry a pregnancy to term and become a parent may be influenced by age, race, ethnicity, culture and religion as well as access to services.

Public perception holds that too-early childbearing leads to increased welfare costs, hopeless futures and a continuing cycle of poverty for adolescent mothers and their children. Many teen mothers come from already disadvantaged backgrounds and too often, early childbearing perpetuates or increases that disadvantage. Many young teen mothers can, however, achieve academic success, have rewarding careers and lead productive and fulfilling lives. To reduce the incidence of unintended pregnancy among teens and address the negative consequences associated with early childbearing, it is imperative to provide teens with viable educational and economic opportunities combined with solid family and social support systems.

Teen Birth Patterns

- In 1992, the birth rate for girls 15- to 19-years old was 60.7 births per 1000 girls. This reflects a slight decline from 1991, but a significant increase from the 1987 rate of 50.6.¹

- The bulk of adolescent childbearing occurs to teens age 17 to 19. The birth rate among teens younger than 15 is relatively low.²

- Teen birth rates vary according to race and ethnicity. For example, although the birth rate is quite low, young, African-American teens between the ages of 10 and 14 are seven times more likely to give birth than their white peers.³ Older Hispanic teens, 18- to 19-year-olds, have a birth rate of 147.7 per 1000, compared to 65.9 for their white, non-Hispanic counterparts.⁴

Teen Mothers Often Come from Disadvantaged Backgrounds

- Teens from poorer families are more likely to initiate sexual intercourse at a younger age and less likely to use contraception.⁵ One study indicates that teens who report depression are more likely to become parents than their peers.⁴
Despite the popular perception that school dropout rates are due to pregnancy, over 20 percent of teen mothers drop out of school before they become pregnant.\(^1\)

In one study of teen mothers, poverty was a significant predictor of subsequent high school dropout. Hispanic girls were twice as likely to drop out if their family received public assistance. African-Americans and Caucasians showed the same pattern, being respectively 1.5 and 1.2 times less likely to finish school if their families had received public assistance.\(^6\)

There is evidence of an intergenerational pattern of teen childbearing such that children of teen mothers are more likely to become teen parents themselves.\(^7\) The relationship is particularly strong within the African-American community.\(^8\)

The intergenerational linkage of teen births points to the strong effects of the socioeconomic environment and family instability, both emotional and financial, in determining early childbearing.\(^8\)

In a study of children of teen mothers, 17 percent had become teen parents: 25 percent of the females and 11 percent of the males. Also, 50 percent were sexually active before age 14, and 41 percent were having sexual intercourse without contraception on a regular basis.\(^4\)

**Teen Childbearing May Reduce Educational and Economic Attainment**

Studies show a significant relationship between teen childbearing and decreased educational attainment.\(^10,11\) According to one study, early childbearing reduced schooling by one to three years.\(^3\)

Teen mothers have approximately a 60 percent chance of graduating from high school by age 25, compared to 90 percent of those who postpone childbearing.\(^12\)

For Hispanic female teens, avoiding pregnancy is the single most important factor in determining high school graduation.\(^15\)

White, non-Hispanic female teens who have a child before age 18 complete an average of 11 years of schooling; postponing childbirth until age 18 or 19 increases the average to 11.5 years. Those who postpone childbearing until age 20 are more likely to complete some college education.\(^13\)

African-American and Hispanic adolescents follow a similar pattern with African-Americans completing slightly more schooling than white, non-Hispanics, while Hispanics complete slightly less.\(^13\)

Among dropouts, teen women who have children are much less likely to return to school.\(^14\)

Non-parenting, white, non-Hispanic teens are five to eight times more likely to attend college than their parenting peers.\(^13\)

African-American and Hispanic teens who delay childbearing until age 20 are three to five times more likely to attend college as are their counterparts who do not delay childbirth.\(^13\)
In one study, 54 percent of teen mothers were high school graduates. Researchers found that if all births had been delayed until age 20, high school completion rates would have risen to 86.4 percent.15

In addition to lower educational status, early childbearing has an impact on the economic status of teens by affecting employment opportunities, marital options and family structure.16

A study of teen mothers revealed that those who have more children receive less financial aid from their families.9

One quarter of teen mothers live below the poverty level.17

Across all ethnic groups, delaying birth by one year leads to a significant improvement in subsequent economic viability.16

For an African American family in which the mother began childbearing before age 16, the average income is only 96 percent of the poverty level. This rises to 236 percent if she is 26 to 27 years of age when her first child is born and to 275 percent if she postpones childbearing past age 27.18

### Early Childbearing May Be Delayed with Education and a Supportive Environment

Young women who are encouraged to question traditional gender roles and those who have high educational aspirations are more likely to avoid teen pregnancy.14

Teens who have healthy parent-child communication, high self-esteem and high educational aspirations are more likely to postpone childbearing.19

For every additional year of school, African-American women delayed first birth by more than a year while white, non-Hispanic women and Hispanic women delayed childbearing for nearly a year.8

A more positive attitude toward school has been significantly related to fewer non-marital births.14

One study found that 50 percent of teens who decide to carry the pregnancy had repeated a grade, as opposed to only 34 percent who chose an abortion.13

A follow-up study of teen mothers found that 20 years later 82 percent were self-supporting.20

Compiled by Shelby Pasarell
October 1995
References


19. Leland NL and Barth RP. Characteristics of adolescents who have attempted to avoid HIV and who have communicated with parents about sex. *J Adol Research* 1993;8:58-76.


ADVOCATES FOR YOUTH
1025 Vermont Avenue, NW
Suite 200
Washington, DC 20005
(202) 347-5700
© Advocates for Youth, July 1996
Permission is hereby granted to quote with credit. For reprints, please call.
Adolescent Sexuality Education

FACT SHEET

SEXUALITY EDUCATION CURRICULA AND PROGRAMS

Young people today experience complex personal and social situations at early ages, placing them at risk for HIV/AIDS, other STDs and unplanned pregnancy. In the U.S., almost one-third of 15-year-olds and 71 percent of 18-year-olds have had sexual intercourse. A survey of teenagers who have had sexual intercourse found that only 29 percent reported consistent condom use. These facts, coupled with the 16,972 reported AIDS cases among 13-24 year-olds as of July 1994, underscore the need for sexuality education.

There is intense debate over the content and efficacy of both “comprehensive” and “abstinence-only” sexuality education curricula. “Comprehensive” programs promote abstinence as the best choice for prevention of pregnancy and disease, but also provide accurate information about contraceptive use and disease prevention. “Abstinence-only” programs teach that abstinence is the only acceptable means for adolescents to prevent pregnancy and disease and do not provide contraceptive information. Some “abstinence-only” curricula are fear-based, focusing on negative consequences rather than responsible behavior.

Abstinence-only supporters argue that comprehensive sexuality education encourages teens to engage in sexual intercourse. A World Health Organization review of 19 international studies evaluating the sexual behavior of students exposed to comprehensive sexuality education revealed that program participants did not engage in earlier or increased sexual activity. In fact, six indicated “either a delay in the onset of sexual activity or a decrease in overall sexual activity.” Ten studies showed increased safer sex practices by youth engaging in sexual intercourse.

Public Supports Sexuality Education

- Eighty-nine percent of adults support sexuality education in schools and 73 percent support teens’ access to birth control information and contraceptives in school clinics.

States May Require Sexuality Education But Few Require Teacher Training

- Although 47 states have laws or policies recommending or requiring sexuality education, only 17 have mandates. Thirty-five states have guidelines to select and implement programs; 17 have developed curricula.

- More than 90 percent of states allow parents to exclude children from all or part of a sexuality education program. Within HIV/AIDS education programs, a nationwide survey showed that less than 5 percent did so.
Forty-one states do not have teacher training requirements for sexuality education, which is most often taught by home economics teachers (36), classroom teachers (32) and physical education teachers (32). A survey of over 4,000 sexuality education teachers found that at least 50 percent had taught the topic for 8 or more years.

**Abstinence Recognized as Ideal, But Not Always Realistic**

- In 1992, a comprehensive content review of state curricula and guidelines found that abstinence is included in 27 of the 28 studied.
- The most common topics covered by state guidelines and curricula are anatomy, puberty, decision-making, families, abstinence, STDs and HIV/AIDS. Masturbation and sexual behavior are least common. Only 18 of 29 states suggest that sexuality is a natural and healthy part of life, 13 cover information on sexual identity and orientation and 11 discuss abortion.
- Seventy-five percent of sexuality education teachers surveyed believe abstinence should be encouraged, but nearly all feel that pregnancy and disease prevention information should also be included. In practice, 86 percent teach that abstinence is the best way to prevent pregnancy and STDs, while only 1 percent teach that abstinence is the only alternative.
- In the same survey, most teachers felt that 10 essential, yet controversial, topics included within sexuality education — especially safer sex, sexual orientation and sources of contraception — are taught later and with less information than they should be.
- Over 70 percent of sexuality education teachers believe that information about STDs and sexual decision-making should be taught before 8th grade; over 50 percent feel that information about birth control and homosexuality should be taught before 8th grade.

**Comprehensive Programs Increase Abstinence and Safer Sex**

- A study of nearly 2,000 males aged 15-19 found that comprehensive sexuality education emphasizing refusal skills strongly correlate with a reduction in both sexual partners and frequency of intercourse. Contraception education increases knowledge and concern about HIV/AIDS and motivation to reduce risk behavior.
- An evaluation of nearly 800 high school students who used Reducing the Risk, a comprehensive curriculum, revealed that 24 percent fewer students initiated first sexual intercourse in the follow-up period than those who were not in the program. Frequency of sexual intercourse did not change for sexually active students who had had sexual intercourse before the program.
- Students in this program showed a 9-15 percent increase in parent-child communication on issues such as abstinence, pregnancy, birth control and STDs; 50 percent felt the program made it easier to talk to parents about sexuality.
In a study of over 500 8th graders receiving the Postponing Sexual Involvement curriculum from trained teen leaders, participants were 5 times less likely than those not in the program to have begun having sexual intercourse by the end of 8th grade (4 percent vs. 20 percent).  

The program also appeared to have a lasting effect. By the end of ninth grade, just 24 percent of the students who had participated in the program had begun having sexual intercourse, compared with 39 percent of non-participants.  

Of those who had sexual intercourse and used contraception after the program, 73 percent said they used contraceptives because of what they learned in school.  

Abstinence-Only Programs Fall Short in Outcome  

Most assessments of abstinence-only programs are related to beliefs or attitudes about sexual intercourse, rather than sexual behavior.  

A school district review of the abstinence-only Teen-Aid curriculum found the program met only one of the 16 criteria for unbiased and accurate information. Biases included inaccurate information about HIV/AIDS and glossary definitions. An analysis of 11 fear-based curricula revealed similarities in content and strategy, medical inaccuracies, an exclusive focus on abstinence, and sexist, homophobic and anti-choice statements.  

A study of over 300 6th and 7th graders in the abstinence-only program Success Express showed increased sexual interaction in seven categories, even among students who had not been sexually active prior to the program, compared to students not in the program. Males showed a 10 percent increase in behaviors such as touching female breasts or genitals and genital to genital contact.  

Sex Respect, a fear-based curriculum, ignores topics such as growth and development, anatomy, physiology, masturbation, childbirth, sexual response, sexual orientation, contraception, abortion, and sexual abuse.  

Compiled by Sarah Lewis and Arati Vasan  
November 1994
References


ADVOCATES FOR YOUTH
1025 Vermont Avenue, NW
Suite 200
Washington, DC 20005
(202) 347-5700
© Advocates for Youth, July 1996
Permission is hereby granted to quote with credit. For reprints, please call.
FACT SHEET

ADOLESCENT PREGNANCY AND CHILDBEARING

The United States continues to have the highest adolescent pregnancy, abortion, and birth rates in the industrialized world. Over 80 percent of teens report their pregnancies were unintended.¹ Most teen mothers come from socially and economically disadvantaged backgrounds. Early childbearing compounds these disadvantages and puts teen mothers at greater risk of experiencing physical, mental, educational, and economic difficulties.²

Recent research reveals positive trends about teen pregnancy. Both pregnancy and birth rates among sexually active adolescents have declined over the last several years, and teens are using contraception more frequently and more effectively than in recent decades. Continued public and political support for effective pregnancy prevention programs can make an important difference.

Teen Pregnancy Rates Are Decreasing Among Sexually Active Teens

- The majority of pregnancies — among both teens and adults — are unintended. It is estimated that 85 percent of pregnancies among teen women and 55 percent of pregnancies among adult women are unintended.²

- Approximately ten percent of teens aged 15 to 19 (835,000 teenagers) became pregnant in 1990, the most recent year for which data are available.

- Depending on the method of calculation, pregnancy rates have either increased or decreased over the last two decades. When the pregnancy rate is calculated for all teenage women aged 15 to 19, there was an increase of nearly 23 percent between 1972 and 1990. This increase reflects the fact that more teens are having sexual intercourse than in previous decades and are therefore at risk of pregnancy.² When the pregnancy rate is calculated only among sexually experienced teens rather than among all teens aged 15 to 19, the pregnancy rate declined 19 percent between 1972 and 1990. This significant decline in pregnancies indicates that although more teens are sexually active, they are using contraception more effectively than teens in earlier decades.²

- Pregnancy rates are higher among older teens than younger teens. Among teens who are sexually experienced, approximately 9 percent of 14-year-olds, 18 percent of 15- to 17-year-olds, and 22 percent of 18- to 19-year-olds experience a pregnancy each year.² Almost two-thirds of all adolescent pregnancies occur to women aged 18 to 19.²

- The rate of pregnancy also varies by race and ethnicity; African American teenagers are more likely than Hispanic or white teens to become pregnant.

¹ Advantages For Youth
² Advantages For Youth
Each year, approximately 19 percent of African American teens, 13 percent of Hispanic teens, and 8 percent of white teens aged 15 to 19 become pregnant.²

**The Teen Birth Rate Has Decreased Slightly Since 1991**

- Of all adolescent pregnancies occurring each year, it is estimated that approximately 50 percent end in birth, 35 percent end in abortion, and 14 percent end in miscarriage.²

- The birth rate among teens aged 15 to 19 (births per 1,000 females) increased 25 percent between 1986 and 1991. The increase in the birth rate during this period relates to increased sexual activity and decreased abortions. It is not due to any increase in pregnancy rates. In 1992 and 1993, the most recent years for which data are available, there were small declines in the adolescent birth rate. The rate dropped from 62.1 births in 1991 to 59.6 births in 1993.³

- The number of children born to teens has also slightly declined. Among women under age 20, there were 531,591 births in 1991 compared to 513,647 births in 1993.³

- In 1993, the teen birth rate dropped among both African American and non-Hispanic whites. Among African American teens, the birth rate dropped from 118 in 1991 to 111 in 1993. Among whites, the rate dropped from 43 in 1991 to 40 in 1993. The birth rate among Hispanic teens, 107 births per 1,000 females aged 15 to 19, remained the same from 1991 to 1993.³

- Poverty, school failure, and family distress often preceeds early childbearing. In 1988, 83 percent of teen women aged 15 to 19 who gave birth were from poor or low income families.²

**More Teen Births Occur Outside of Marriage**

- Overall, the teen birth rate (births per 1,000 teens aged 15-19) is significantly lower 1990s than in the 1950s and 1960s. The rates of non-marital teen births have risen dramatically, however. In 1960, for example, only 15 percent of all teen births occurred outside of marriage. In 1993, 72 percent of teen births occurred to women who were not married.³

- The largest increase in non-marital teen births occurred among white teenagers. In 1970, 18 percent of all births to white teens occurred outside of marriage compared to 61 percent in 1992.³

**Adult Men Frequently Father the Children Born to Teenagers**

- New research indicates that that males involved in teen childbearing are frequently not teenagers themselves. A national study shows that adult men father over 50 percent of babies born to teen women aged 15 to 17.³ A study on California births indicates that seven in 10 births among teenagers are fathered by men older than age 20.³
These fathers are, on average, 3.7 years older than young mothers who are aged 15 to 19. The age gap is largest for younger teens. The fathers are 4.6 years older than teen mothers aged 13 to 14, and 9.8 years older than teen mothers aged 11 to 12.

Teen Abortion Rate is Decreasing; Few Teens Choose Adoption

- Adolescents account for approximately 25 percent of all abortions performed in the United States each year.²

- Since 1980, the number of abortions and the abortion rate (number per 1,000 females aged 15 to 19) among teens have decreased. In 1980, 444,780 abortions occurred among teens aged 15 to 19 compared to 314,000 in 1991. The abortion rate in 1980 was 42.8 compared to 37.6 in 1991.⁵

- When the rate of abortion is calculated only for sexually experienced teens, rather than for all teens, a significant decline is revealed. Between 1980 and 1990, the abortion rate decreased by 24 percent among sexually experienced women aged 15 to 19. This decline may be related to the fact that fewer teens are becoming pregnant. It is also likely, however, that more restrictive laws, the limited availability and accessibility of abortion providers, and decreases in public funding for abortion, have limited abortion services to teens.⁴

- The decision to have an abortion varies by socioeconomic background, race, and ethnicity. Among teens who have an unintended pregnancy, nearly 75 percent of those from higher income families choose abortion, compared to less than 50 percent of teenagers from poor or low-income families.² Approximately 60 percent of white teens who experience an unintended pregnancy choose abortion. Among African American and Hispanic adolescents, fewer than 50 percent of those who have an unintended pregnancy choose abortion.²

- Few large-scale studies have been conducted on adoption among teens and there are no government statistics on adoption. It is therefore difficult to determine the rate of adoption among teen mothers.⁴ According to national survey data in 1982 and 1988, it is estimated that among children born to never-married women aged 15 to 44, two percent were relinquished for adoption.⁷

Compiled by Laura Davis
March 1996
References


Adolescent STD/AIDS Prevention

FACT SHEET

ADOLESCENTS, HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES (STDs)

One-quarter of all new HIV infections in the United States are estimated to occur in young people under the age of 22. Each day between 27 and 54 young people in the United States under the age of 20 are infected with HIV. The World Health Organization (WHO) estimates, worldwide, between six and seven million people between the ages of 15 and 24 have been infected with HIV. Clearly, prevention messages needed to reduce risk behaviors are not reaching enough adolescents. Knowledge alone does not affect behavior. Effective programs must develop risk perceptions in addition to building risk reduction skills. Peer education has proven an effective strategy in helping adolescents build those skills. In addition, the peer educators themselves build self-esteem, which transfers into other parts of their lives.

HIV/STD Rates for Adolescents Are High

- By December 1995, 2,354 cases of AIDS among 13-to 19-year-olds in the U.S. were reported to the Centers for Disease Control and Prevention (CDC); among 20- to 24-year-olds, 18,955 AIDS cases were reported. Because of the long incubation period between infection with HIV and AIDS diagnosis, most 20- to 24-year-olds were infected during their teens.

- Younger age is associated with a slower progression of HIV infection to AIDS. Research on HIV-infected hemophiliacs found that 43.7 percent of subjects infected after 34 years of age had developed AIDS within eight years compared to only 13.3 percent of those infected before the age of 18.

- The percentage of female adolescent AIDS cases in the U.S. has more than tripled from 14 percent in 1987 to 43 percent in 1994 of all adolescent cases.

- HIV continues to be the leading cause of death among men and the third leading cause of death among women ages 25 to 44. In 1994, more than three-fourths of diagnosed AIDS cases among women occurred among African-Americans and Hispanics.

- Approximately three million teenagers contract an STD each year and teens account for one quarter of the 12 million STD cases estimated annually. Roughly 25 percent of sexually active adolescents become infected with an STD every year.

- Nationwide, gonorrhea rates have decreased among adolescents over the past few years. Nevertheless, in 1993, women aged 15 to 19 had the highest infection rate among all women; men aged 15 to 19 had the second highest gonorrhea rate among all men.
In a recent study of ethnically diverse urban adolescent women, 15.6 percent were infected with human papilloma virus (HPV), 11 percent were infected with chlamydia, 7 percent with gonorrhea, and 5.4 percent with trichomoni aniasis. The study confirmed that cervical HPV is acquired predominately by sexual contact, and often soon after the onset of sexual activity.11

Perception of Risk Is Low

In a recent study of sexually active female adolescents attending a hospital-based clinic, 81 percent responded that they had “never done anything that could give them a chance of getting AIDS.” Most estimated their chances of infection to be “very low” (36 percent) or “nonexistent” (37 percent), and to be “below” (22 percent) or “very much below” (41 percent) that of their peers. The main reasons given for their perceived low personal risk included current monogamy, belief in their partner’s safety and fidelity, ability to choose partners carefully, use of condoms, and lack of injection drug use.12

Knowledge is low regarding STDs, however teens report greater knowledge than adults. In a recent Gallup poll, only 12 percent of American teens and 4 percent of adults were aware that an STD infects one in five people in the US. Twenty six percent of adults and 42 percent of teens could not name an STD other than HIV/AIDS.13

High Risk Behaviors Continue

Nationwide, more than half of all high school students (53 percent) reported sexual intercourse. Of this group, 52.8 percent reported that they or their partner had used a condom during last sexual intercourse.14

Using data from the National Youth Risk Behavior Survey (YRBS), researchers at the CDC found approximately 25 percent of adolescents reported use of alcohol during last intercourse, and five percent indicated use of both alcohol and other drugs. Roughly 22 percent said that “no contraception was used” or they were “not sure if anything was used.”15

A small proportion of high school students place themselves at risk for HIV infection through injection drug use. The 1995 YRBS suggested 2 percent of the approximately 12.5 million high students in the U.S. have injected cocaine or other illicit drugs.24

The influence of cultural and community norms are very important in HIV prevention interventions. In a survey of community-based organizations working with adolescents on condom negotiation, the single most frequently discussed problem was gender norms which prevent females from being proactive, usually because of a real or perceived lack of power in relation to males. In the same study, researchers noted that young people sometimes value risk behavior as a “badge of maturity.”16

Intense homophobia and a fear of peer reaction prevent many adolescents from identifying as lesbian, gay, or bisexual. Because of this, researchers who work with sexual minority youth agree that it is necessary to ask about “same sex behaviors” rather than sexual orientation.16
Risk Behavior Among Young Men Who Have Sex With Men Is High

- In a recent study of young men who have sex with men (MSMs) conducted by the San Francisco Department of Health, 28.7 percent of 17- to 19-year-olds and 34.3 percent of 20 to 22 year olds reported unprotected anal intercourse during the last six months. Similarly, a recent study of 516 young MSMs in Los Angeles found 55.3 percent reporting unprotected anal intercourse in the last six months.

- In a New York City-based study of racially diverse young gay men under the age of 22, knowing someone with HIV was actually associated with unsafe sex, suggesting that people who practice unsafe sex were more likely to know others with HIV. Knowing someone with AIDS, however, had fairly consistent associations with safer sex.

- A study of young male commercial sex workers with a mean age of 20 found that 77 percent reported engaging in anal intercourse. Of these, 23 percent stated neither they nor their customer(s) ever used condoms, and 39.5 percent said that condoms were only used some of the time.

Effective Strategies: Communication and Peer Education

- Research has shown that adolescents who feel able to communicate with a sexual partner about AIDS-related issues are 10 to 17 times more likely to report using condoms than are those who feel hesitant about such communications.

- A study in a hospital-based adolescent clinic found that adolescents understood preventing HIV significantly more after an intervention combining a brief lecture with a video presentation. Peer education changed teens in their perception of the risk for HIV infection, as well as personal attitudes that help prevent transmission. The study also found that more questions were asked of the peer educators than of a group of adult educators.

- A recent intervention working with young gay males showed a 60 percent reduction in unprotected anal intercourse after sustained sexuality-related peer education. The men reported consistent condom use during anal intercourse with 78 percent of new partners, compared to 52 percent before the intervention.

Compiled by Kent Klinder
October 1996
References


13 American Social Health Association. Gallup study: Teenagers know more than adults about STDs, but knowledge among both groups is low. Unpublished paper, ASHA 1995.


ADVOCATES FOR YOUTH
1025 Vermont Avenue, NW
Suite 200
Washington, DC 20005
(202) 347-5700
© Advocates for Youth, July 1996
Permission is hereby granted to quote with credit. For reprints, please call.
MANDATORY PARENTAL CONSENT AND NOTICE LAWS AND THE FREEDOM TO CHOOSE

Responsible parents should be involved when their young daughters face crisis pregnancies. It is the hope of every parent that a child confronting a crisis will seek the advice and counsel of those who care for her most and know her best. Most young women do turn to their parents when they are considering an abortion. Unfortunately, some young women cannot because they come from homes where physical violence or emotional abuse are prevalent or because their pregnancy is the result of incest. The government cannot mandate healthy family communication where it does not already exist. In certain circumstances, many teens facing a crisis pregnancy are forced to travel to another state where there is a less stringent or no parental involvement law to avoid telling their parents. Laws mandating parental notice or consent actually harm the young women they purport to protect by increasing illegal and self-induced abortion, family violence, suicide, later abortions, and unwanted childbirth.

In states that enforce no mandatory parental consent or notice requirements, more than 75% of minors under 16 involve one or both parents.1

The American Medical Association takes the position that: “Physicians should not feel or be compelled to require minors to obtain consent of their parents before deciding whether to undergo an abortion.... [M]inors should ultimately be allowed to decide whether parental involvement is appropriate.”2

The American Academy of Pediatrics takes the position that: “Legislation mandating parental involvement does not achieve the intended benefit of promoting family communication, but it does increase the risk of harm to the adolescent by delaying access to appropriate medical care.... [M]inors should not be compelled or required to involve their parents in their decisions to obtain abortions, although they should be encouraged to discuss their pregnancies with their parents and other responsible adults.”3

Young women in Massachusetts and Mississippi avoid their states’ parental involvement laws by crossing state lines to obtain abortions. Meanwhile, these parental involvement laws appear to have had little effect on reducing abortion rates among teens.4

Young Women Who Do Not Involve A Parent Have Good Reasons

Most young women find love, support and safety in the home. Many, however, justifiably fear that they would be physically or emotionally abused if forced to disclose their pregnancy. Often young women who do not involve a parent come from families where government-mandated disclosure would have devastating effects.
There were approximately 2.9 million cases of child abuse reported in 1992. Young women considering abortion are particularly vulnerable because family violence is often at its worst during a family member’s pregnancy.5

Among minors who did not tell a parent of their abortion, 30% had experienced violence in their family or feared violence or being forced to leave home.6

In Idaho, a 13-year-old sixth grade student named Spring Adams was shot to death by her father after he learned she was to terminate a pregnancy caused by his acts of incest.7

Mandatory Parental Consent & Notice Laws Endanger Health

Parental consent and notice laws endanger young women’s health by forcing some to turn to illegal or self-induced abortion, to delay the procedure, or to bear a child against their will.

In Indiana, Rebecca Bell, a young woman who had a very close relationship with her parents, died from an illegal abortion because she did not want her parents to know about her pregnancy but Indiana law required parental notice before she could have a legal abortion.8

The American Medical Association noted that “because the need for privacy may be compelling, minors may be driven to desperate measures to maintain the confidentiality of their pregnancies. They may run away from home, obtain a ‘back alley’ abortion, or resort to self-induced abortion. The desire to maintain secrecy has been one of the leading reasons for illegal abortion deaths since ... 1973.”9

Recognizing that maintaining confidentiality is essential to minors’ willingness to obtain necessary health care related to sexual activity, all states have laws permitting minors to receive medical treatment for sexually transmissible diseases without parental consent or notification.10

Judicial Bypass Provisions Fail to Protect Young Women

Many states that require parental consent or notice provide a judicial bypass through which a young woman can seek a court order allowing an abortion without parental involvement. For adults, going to court for a judicial order is difficult. For young women, it is overwhelming and at times impossible. Some young women cannot maneuver the legal procedures required, or cannot attend hearings scheduled during school hours. Others do not go or delay going because they fear that the proceedings are not confidential or that they will be recognized by people at the courthouse. Many experience fear and distress and do not want to reveal intimate details of their personal lives to strangers.11 The time required to schedule the court proceeding may result in a delay of a week or more, thereby increasing the health risks of the abortion.12 Some young women who manage to arrange a hearing face judges who are vehemently anti-choice and who routinely deny petitions, despite rulings by the U.S. Supreme Court that a minor must be granted a bypass if she is mature or if an abortion is in her best interests.

In denying the petition of one young woman, a Missouri judge stated: “Depending upon what ruling I make I hold in my hands the power to kill an unborn child. In our society it’s a lot easier to kill an unborn child than the most vicious murderer... I don’t believe that this particular juvenile...
has sufficient intellectual capacity to make a determination that she is willing to kill her own child.”

A Toledo, Ohio judge denied permission to a 17½-year-old woman, an “A” student who planned to attend college and who testified she was not financially or emotionally prepared for college and motherhood at the same time, stating that the girl had “not had enough hard knocks in her life.”

The Ohio Supreme Court upheld the denial of a petition of a 17-year-old girl who testified that her father beat her. At the time, she was a senior in high school with a 3.0 average, active in team sports, worked 20-25 hours a week, and paid for her automobile expenses and medical care.

In Indiana, minors travel to Kentucky or Illinois rather than attempt a bypass proceeding before judges who are known to be anti-choice. But young women in Indiana may be losing even this option. A judge in Kentucky recently denied the petition of an Indiana 14-year-old, ruling that out-of-state minors are not eligible for a bypass. The judge then breached the confidentiality of the proceedings by sending copies of his decision to state and county officials.

Effects of Teenage Childbearing Can Be Devastating

The forced childbearing among teenagers that can result from parental consent and notice laws can have devastating effects on the life opportunities of young women and their children.

Teenage girls are more than 24 times more likely to die from childbirth than from first trimester legal abortions.

Less than 60% of teen mothers graduate from high school by age 25—compared to 90% of those who postpone childbearing. Additionally, those who postpone childbearing until age 20 are more likely to complete some college education.

Teen mothers are four times as likely as women who have their first child after adolescence to be poor in their 20s and early 30s and they earn less money than their counterparts throughout their lives. More than half of AFDC payments go to families formed by a teenage mother.

Of teen mothers receiving AFDC, fifty-three percent have incomes below fifty percent of the poverty line.

Infants of teen mothers are more likely to suffer from low birthweight than those born to older mothers. In addition, the children of teenage parents are more likely to become teenage parents themselves, thus perpetuating the cycle of poverty.

Making Abortion Less Necessary Among Teenagers Requires A Comprehensive Effort to Reduce Teen Pregnancy

Abortion among teenagers should be made less necessary, not more difficult and dangerous. A comprehensive approach to promoting adolescent reproductive health and reducing teen pregnancy will require an array of components, including: age-appropriate health and sexuality education; access to confidential health services, including family planning and abortion; life options programs that offer teens practical life skills and the motivation to delay sexual activity; and programs for pregnant and parenting teens that teach parenting skills and help ensure that teens finish school. Although radical right forces vehemently claim that comprehensive programs to combat teen pregnancy are ineffective, the fact is that such an approach has never been implemented on a significant scale in the United States.
References


17. *In re Jane Doe 1*, 57 Ohio St. 3d 135 (1991).


School-Based and School-Linked Health Centers

School-based and school-linked health centers are comprehensive health care centers providing medical and mental health screening and treatment for young people on or near school grounds. These centers are designed to overcome barriers that discourage adolescents from utilizing health centers, including lack of confidentiality, transportation, inconvenient appointment times, prohibitive costs and general apprehension about discussing personal health problems. The comprehensive nature of the services offered by these centers distinguishes them from other types of school health programs, including health screening, school nursing and health education classes. Over the past twenty years, three types of health centers have evolved: school-based health centers (SBHCs) are centers located in schools or on school grounds serving only that school; school-linked health centers (SLHCs) are centers located off school grounds that have a formal relationship with at least one school; campus-linked health centers (CLHCs) are centers located on school grounds serving youth from that school as well as students from at least one neighboring school.

SBHCs/SLHCs Are Well-Established Health Care Providers

- The first SBHC was established in Dallas, TX in 1970. In 1984, 31 centers were in operation. As of November 1994, the number had risen to 607 sites in 41 states and the District of Columbia.\(^1\)
- Sixty-four percent of health centers are school-based, 29 percent are campus-linked, and seven percent are school-linked. Fifty-nine percent of SBHCs/SLHCs are located in urban school districts, 29 percent in rural areas, and 12 percent are in suburban areas.
- Forty-six percent of SBHCs/SLHCs serve high school students, nine percent serve middle/junior high school students, and six percent serve elementary school students. Thirty-nine percent of centers serve other grade level combinations.
- Over 50 percent of students attending a school with a SBHC/SLHC were enrolled at the center in 1992-93; 76 percent of these young people used the services. On average, students used the center nearly 4 times per year.
- The Office of the Inspector General, the American Medical Association, the National Association of State Boards of Education, and the congressional Office of Technology Assessment have all released reports and statements affirming the unique potential of SBHC/SLHCs to address the unmet health needs of adolescents.\(^2\)
- Students and parents support SBHCs/SLHCs. One survey showed that 88 percent of students attending schools with SBHCs support the concept.\(^3\) Another study showed that parents signed consent forms for 71 percent of students in SBHCs and more than 90 percent requested that their children have unlimited access to care.\(^4\)
SBHCs/SLHCs Offer A Wide Range Of Health Services

- Treatment of minor injuries is offered by 93 percent of centers. Primary care, routine physical exams, sports physicals, immunizations, and prescriptions for some medications are offered at 80 percent of centers. More than 70 percent of centers provide laboratory tests, manage chronic illness, and dispense medication on-site.
- Eighty-five percent of SBHCs/SLHCs offer mental health counseling for substance abuse, sexual abuse, family dysfunction, suicidal feelings and depression.
- Over 96 percent of SBHCs/SLHCs offer health education at the health center site, and 86 percent bring health education into the classroom.
- Many SBHCs/SLHCs offer social services, including clothing banks (25 percent), job training (23 percent), tutoring (24 percent), and child care (19 percent).
- Three-quarters of SBHCs/SLHCs have a nurse practitioner or physician assistant on staff and 61 percent have at least one physician. Forty percent have a social services counselor or social worker, and 14 percent have a substance abuse counselor.

SBHCs/SLHCs Offer Some Reproductive and Sexual Health Services and Can Reduce the Risk of Unintended Pregnancy

- Over 85 percent of SBHCs/SLHCs offer family planning counseling. Forty-two percent of centers serving secondary school students make oral contraceptives available while 55 percent offer referrals. Thirty-two percent of centers make latex condoms available; 64 percent of those that do not refer students to alternative sources. Over 70 percent of centers perform gynecological exams as well as diagnose and treat sexually transmitted diseases. Students can obtain an HIV test at 39 percent of centers.
- SLHCs are more likely than SBHCs or CLHCs to provide all types of reproductive health care except abortion counseling.
- Sexually active girls who have more contact with SBHCs/SLHCs use contraceptives more consistently than girls who make fewer clinic visits.
- One school and community-based teen pregnancy prevention program saw a decrease in the annual average pregnancy rate from 77 per 1,000 women aged 14-17 prior to the program to 37 per 1,000 after the intervention. The rates rose again when the state prohibited the dispensing of contraceptives on school grounds.
- Girls enrolled in a Baltimore school-linked pregnancy prevention program postponed sexual involvement seven months longer than girls not enrolled. Pregnancy rates among participants declined 30 percent over two years, while rates among other girls in a comparison group increased by 58 percent.
- A study of six SBHCs found neither greater levels of sexual activity nor increased frequency of intercourse in schools with SBHCs that made contraceptives available, compared to students at schools without health centers.
SBHCs/SLHCs Can Improve Students’ Health and Access to Care

- A study of students in a North Carolina alternative school found that health center users were significantly more likely to stay in school, to graduate or to be promoted than were students not registered at the health center.9
- Students who frequently use SBHCs demonstrate greater health care needs than less regular users. Frequent users were at greater risk for alcohol and substance use, sexual activity, and poor family and peer relationships.10
- Because of low Medicaid reimbursement rates, many adolescents cannot access mental health services. In one study, more students with Medicaid used SBHCs/SLHCs for mental health services than did non-Medicaid recipients.11
- Once California SBHCs had been in operation for two years, students who attended the clinics decreased their use of hospital emergency rooms for routine health care services, making the SBHCs a cost effective alternative.12
- Nearly 40 percent of all SBHC/SLHCs users are completely uninsured. At a California SBHC, 93 percent of clinic enrollees report no other source of medical care.13

SBHCs/SLHCs Depend on a Patchwork of Local, Private, State and Federal Funding

- In 1994, 25 states increased allocations to SBHCs of federal/state Maternal and Child Health Block Grant monies (Title V) to a total of $11.9 million. Three states earmarked funds from the U.S. Department of Education’s Drug Free Schools and Communities program for their SBHCs. Another allocated a portion of its federal Social Services Block Grant (Title XX) to SBHCs.1
- State funding has also spurred the growth of SBHCs/SLHCs. In 1994, 25 states appropriated a total of $22.3 million for SBHCs, a 140 percent increase over the $9.2 million in 1992. Three states have raised funds for SBHCs/SLHCs with revenue generated by tobacco excise tax increases. Another has placed a sales tax on physical fitness membership fees, yielding millions of dollars for the state’s supplemental school health program.1
- Nearly half of all SBHCs/SLHCs receive federal Medicaid support and 28 percent of students who use SBHCs/SLHCs have Medicaid coverage. Twenty-nine states have established systems to reimburse centers for services provided to teen Medicaid recipients.1
- While SBHCs/SLHCs annual budgets vary widely — from less than $5,000 to more than $875,000 — the median cash operating budget is $125,000 a year. The median value of in-kind contributions (primarily rent, utilities and maintenance) is $30,500 per year.

### Sponsors of SBHC/SLHC

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Public Health Depts</td>
<td>.26%</td>
</tr>
<tr>
<td>Community Health Centers</td>
<td>.19%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>.13%</td>
</tr>
<tr>
<td>School Systems</td>
<td>.11%</td>
</tr>
<tr>
<td>State Public Health Depts</td>
<td>.8%</td>
</tr>
<tr>
<td>School/Health Agencies</td>
<td>.5%</td>
</tr>
<tr>
<td>Hospital Health Centers</td>
<td>.6%</td>
</tr>
<tr>
<td>Mental Health Agencies</td>
<td>.3%</td>
</tr>
<tr>
<td>Other</td>
<td>.9%</td>
</tr>
</tbody>
</table>
The average cash cost to SBHCs/SLHCs per enrolled student is $163. Each student visit costs health centers an average of $64.

References


Compiled by Caroline Russell

ADVOCATES FOR YOUTH
1025 Vermont Avenue, NW
Suite 200
Washington, DC 20005
(202) 347-5700
© Advocates for Youth, July 1996
Permission is hereby granted to quote with credit. For reprints, please call.