REVERSING COURSE: The Impact of "Faith-Based" Sexual Health and Family Planning Policies at Home and Abroad

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Recent trends in U.S. sexual education and reproductive health policies threaten to jeopardize the significant progress made during the 1980s and 1990s in improving teen sexual health domestically and HIV/STD infection rates, unwanted pregnancies, and reproductive health care worldwide.

The issue of sex education and reproductive health policy has historically been more divisive in the United States than in other advanced industrial nations. Proponents of scientific teaching of sexual health issues have crossed horns since the early 1900s with those who want to focus solely on issues of morality. While some argued that government should fund family-planning centers both at home and abroad, others demanded that the state avoid any policies that might be interpreted as endorsing non-marital or non-reproductive sexuality.

But from the late 1960s through the mid 1990s, an emerging consensus on the importance of comprehensive sex and birth-control education led toward more systematic sexual education and family-planning policies. As early as 1969, President Richard M. Nixon stated that "no American woman should be denied access to family planning assistance because of her economic condition." He endorsed "as a national goal the provision of family planning services...to all who want but cannot afford them." To that end, President Nixon signed into law Title X of the Public Health Service Act, the aim of which was to provide nationwide access to family-planning services. Successive administrations and legislatures supported this goal during the 1970s and 1980s. By 1980, the family planning budget was worth more than twice in real dollars what it is today. (Nixon quote from statement released by the White House, July 18, 1969)

Debates about sex education continued, but the virulent AIDS epidemic in the mid-1980's increased the threat to public health so significantly that not educating the public about sex, reproduction, and disease prevention was no longer an option. By 1986, President Reagan's U.S. Surgeon General, C. Everett Koop, who was as socially conservative as the president he served, issued a report calling for public schools to begin comprehensive AIDS and sexuality education in the third grade. Koop's report said: "There is now no doubt that we need sex education in schools and that it [should] include information on heterosexual and homosexual relationships. The need is critical and the price of neglect is high" (Koop quote from 1986 report on HIV/AIDS).

There were some countervailing trends during the 1980s. At the 1984 United Nations International Conference on Population in Mexico City, President Ronald Reagan announced that the U.S. would no longer provide any funds to any nongovernmental agency, for any reason, unless it agreed to "neither perform abortions nor actively promote abortion as a method of family planning in other nations." This Mexico City Policy (which some of its opponents called the Global Gag Order) remained in place until rescinded in 1993 by Present William Clinton. While this order was in place, it resulted in denial of funds to many family service providers around the world, even those who did not perform abortions but did let clients know it was an option.

But on the whole, access to sex education and family planning continued to expand during the 1980s. Research in the United States showed that sex education in public schools delayed the onset of sexual intercourse among young people an average of three years and reduced the number of partners and sexual encounters. By 1999, more than two thirds of US school districts had policies that mandated sex education programs. Sixty-five percent of these districts used programs that combined discussion of abstinence and how to say no to sex with education about safe sex practices for those who would not or could not commit to abstinence until marriage. Sex education led to greater use of contraception, with the result that unwanted teen pregnancies during the late 1980s and 1990s declined significantly, and rates of infection from sexually transmitted diseases and the HIV virus went down or stabilized.

By the mid 1990s, however, a strong counter-offensive against sex education and women's reproductive freedoms had been mounted. This counter-offensive has achieved startling victories since the 2000 election and its victories now threaten the gains in sexual and reproductive health that were made between the 1960s and the end of the 1990s.

The Push to Repeal Comprehensive Sex Education and Family Planning Programs

An important turning point in the attempt to roll back comprehensive sex education and family planning came when Dr. William J. Bennett, who had been Secretary of Education under Reagan and "Drug Czar" under the first President Bush, became a "Distinguished Fellow" at the conservative Heritage Foundation. Bennett began pushing a new strategy for sexual education that emphasized moral condemnation of all premarital sex. He and his allies down-played the use of science-based education about safe sex methods, fearing that knowledge of such options would undercut their insistence that abstinence until marriage was the only safe and moral course of action.

Bennett, who had been an architect of the "Just Say No" campaign against drug use, applied the same approach to teen sexuality. He advocated eliminating federal curriculum guidelines from schools so they could replace existing science-based sex education programs with religious-based abstinence-only programs. He was especially keen on programs that encouraged students to make a public pledge to remain virgins until marriage.

The campaign to elevate abstinence-only programs over comprehensive sex education bore its first fruits in 1996, when the federal government adopted Title V of the Social Security Act. This act mandated that in order to receive federal funds for sex education, presentations for school-age children must present abstinence as the only effective or acceptable method against pregnancy or disease. Since the 2000 election, however, there has been an especially dramatic turning point in federally sponsored sexual-education and family-planning programs. At home, the Bush administration has decisively shifted federal policy away from education about safe sex, disease protection, and pregnancy avoidance toward abstinence-only programs designed, administered, and often taught by religious groups. This shift in emphasis within the United States has been extended to countries around the world that depend on U.S. aid funds to control the spread of AIDS and prevent unwanted pregnancy.

On the domestic front, funding to teach abstinence has risen from $96 million in 2000 to $206 million in Fiscal Year 2006. As a result of this shift in federal funding, more than one-third of all students in the United States receive abstinence-only programs as their only sexual education. In 1988 that had been the case for only 2 percent of American students. Although more than ninety percent of parents, educators, and public health officials believe that kids should get sexual education that includes accurate science-based information about conception, contraception, and prevention of sexually transmitted disease, along with abstinence information, there is now no federal funding for such programs.

International policy has also been dramatically transformed. Although the Bush administration pledged to spend three billion dollars per year from 2003 to 2008 to combat HIV/AIDS globally, it added the stipulation that one-third of that funding had to utilize the "ABC" strategy. ABC programs promote Abstinence for unmarried people, Be faithful for married couples, and Condom use only for high-risk populations such as prostitutes and intravenous drug users. Much of the ABC funding is funneled through religious groups that refuse on religious and moral grounds to provide any information at all about or access to condoms, sometimes even for married couples.

The result has been a demonstrable drop in condom use in many impoverished countries that rely on U.S. aid to fund sex education, family planning services, and STD/HIV testing. This trend poses a particular problem in Africa and India, both centers of AIDS infection, where widespread poverty forces hundreds of thousands of women into prostitution, and married men of all classes and educational levels regularly resort to prostitutes, frequently paying more for unprotected sex.

When ABC programs replace comprehensive reproductive services, condom use drops and the risk of AIDS, STD infections, and unwanted pregnancies rise. President George W. Bush's first official act as head of state, on January 22, 2001, was reinstating the "Mexico City Policy." In consequence, funding for groups that provide comprehensive family planning services, including information about abortion, has been rescinded, even though all have complied by not using any US funding to actually provide abortions. As a result, health authorities in many impoverished countries are unable to provide practical, proven methods to protect global health.

Both at home and abroad, these shifts in policy have been driven by a "faith-based" approach to sexual and reproductive decision-making that rules many types of scientific investigation and evaluation out of order. To be sure, faith-based community organizations often provide much-needed services in areas such as feeding the poor, disaster relief, and health and childcare. But the assumption that everyone, whatever their personal faith, can be persuaded to refrain from sexual activity until marriage and to be universally monogamous once married is unrealistic. Therefore, publicly-funded programs aimed at promoting and safe-guarding public health should be carefully and rigorously monitored to determine their success or failure in reducing unwanted pregnancy and STD/HIV infection. Such is no longer occurring, either in domestic programs aimed at protecting America's teenagers or in international ones. The result is that programs whose primary aim should be to curb the spread of AIDS, protect women's reproductive health, and reduce venereal disease have been redirected to impose a version of Christian sexual morality that even the majority of Christians do not fully endorse.

Abstinence-Only Sexual Education Programs in the United States: The Dismissal of Scientific Evidence

The commitment to encouraging faith-based organizations to take over sexual education programs has led to a situation where the federal government no longer reviews abstinence programs for content or accuracy before or after they are funded. Groups receive SPRANS-CBAE (Special Projects of Regional and National Significance - Community Based Abstinence Education) funding on the basis of a synopsis of their program, which is reviewed solely on whether the program presents abstinence as the only acceptable behavior for unmarried teens and the only sure way to avoid pregnancy, STD's, and other health problems. At the same time, outspoken anti-condom proponents who dismiss scientific data in favor of absolutist religious principles have been appointed to key positions in the Presidential Advisory Council on HIV/AIDS.

Many proponents of abstinence programs view containing the HIV epidemic, STD infections, and unwanted pregnancies as secondary to establishing the moral principle that sex must not occur outside of marriage. They hope to scare teenagers into remaining virgins by suppressing any material that does not claim dire consequences for not remaining abstinent. Programs developed around these principles are filled with graphic descriptions of STDs, with the aim of frightening teens out of potential promiscuity.

The results are predictable: Inaccurate information, often based on scare tactics rather than actual research, is presented as fact. For example, some programs claim that "sweat and tears are risk factors for HIVtransmission," while others declare that "condoms fail to prevent HIV 31 percent of the time." Contraception is discussed only in the context of failure rates. No one mentions that in fact, according to the most recent studies, condoms are 98 percent effective in preventing most STD's and have a pregnancy rate of just 93 to 98 percent, when used correctly and consistently.

According to a 2004 report issued by Rep. Henry Waxman (D-CA), 80 percent of the abstinence programs his staff examined present "false, misleading, or inaccurate information" about condoms, or contain unsupported blanket claims such as the assertion that "sex outside of marriage increases (the) risk of mental illness, depression, and suicide."

The emphasis on scaring teens away from becoming sexually active instead of helping them manage their sexual choices in a responsible way sometimes even leads to rejection of improved programs and technologies that reduce the risks associated with sexual activity. According to the April 2005 New Scientist, the announcement that a vaccine against the Human Papilloma Virus (a sexually transmitted virus that is the leading cause of cervical cancer) would soon be available led conservative lobbyists in the United States to oppose the vaccine's release because alleviating negative consequences of sexual behavior might encourage promiscuity! And the New York Times reported in November of 2005 that the FDA, ignoring the recommendations of more than 70 medical organizations and acting before its own scientific panels had prepared their reports, voted to put off approval of emergency contraception for over the counter sales.

Federal guidelines are now so out of touch with the actual research on what does and does not work in preventing pregnancy, HIV infection, and STDs that three states (California, Maine, and Pennsylvania) have stopped accepting federal funds for abstinence-based programs because federal guidelines do not allow the teaching of safe-sex practices. "This money is more harmful than it is good," said Dr. Dora Anne Mills, the state's public-health director, because "you can't talk about comprehensive reproductive information." (The Washington Times, Sept. 22, 2005)

Doing More Harm Than Good: How Sexual Abstinence Programs Backfire

Any sexual-education program -- be it abstinence-only or comprehensive -- must start from the fact that the onset of puberty in the United States has dropped to somewhere around 13 years of age while the average age of marriage has now risen to 26. Comprehensive sex-education programs have been shown to delay the onset of sexual intercourse by up to three years. Evaluations of abstinence programs are only beginning to come in. But the first results do not show any longer-term impact on delaying the onset of sexual behavior. For example, a recent study by Texas A&M University found that sexual behavior increased in students exposed to abstinence programs at the same rate as students who were not.

No program, however well conceived, is likely to keep most of the population abstinent for a decade or more past puberty. And when young people do initiate sex, they are less likely to do so in a safe, responsible manner if they have been told that there is no middle ground between abstinence and unprotected sex than if they have been given a wider range of alternatives.

A case in point is the teen virginity pledges now promoted by some religious groups, where the abstinence curriculum culminates in elaborate ceremonies with special effects and music designed to appeal emotionally to teenagers, in which students take a public pledge

of virginity and are presented with a ring symbolizing their commitment to refrain from sex until marriage.

A long-term study at Yale and Columbia University, comparing teens who took such pledges with those who did not, found that teens who take virginity pledges do delay the onset of vaginal intercourse longer than other teens, and after beginning it, have fewer sexual partners. But the problem is that most teens who take public abstinence pledges do not refrain from all sexual contact. Although pledge takers tend to begin genital sex later than their peers, they are in the meantime more likely to engage in oral sex, mutual masturbation, and anal intercourse, all of which are seen as ways to technically preserve virginity. These practices do lessen the risk of pregnancy but carry a significant risk of STD infection.

Furthermore, although abstinence programs seem to delay the start of vaginal sex somewhat among those who participate, most participants eventually do engage in premarital intercourse. The Yale and Columbia study, using data from the National Longitudinal Study of Adolescent Health on U.S. students pre and post high school graduation, indicated that 88 percent of abstinence-pledging teens have genital sex prior to marriage. When these young people do start having sex, they are less likely to use contraception, having been taught it "doesn't work anyway." They are also less likely to recognize and therefore seek treatment for symptoms of STDs, making them more likely to infect their sexual partners. Thus, the Journal of Adolescent Health reports that "young adults who as teenagers took pledges not to have sex until marriage were just as likely to contract a venereal disease as people who didn't make the promise."

Abstinence-until-marriage programs carry a particular risk for gays, who in most states can never marry. Because religious-based sex education programs often present homosexuality as sinful and an absolute moral wrong, such programs do not provide gay teens with information they need to protect themselves from disease.

The notion that moralistic approaches to sex education can backfire is supported by comparisons with Europe and Canada. Although Canada and almost all Western European countries are more accepting of teen sex than the United States, and all offer comprehensive sexual education and easy access to contraception, these countries experience far fewer problems associated with teen sex. On average, teens in the U.S. start having sex earlier, and have more partners, pregnancies, and sexually transmitted diseases than their counterparts in other developed countries. American teen-aged girls are four times more likely to get pregnant than teens in France, and five times more likely than girls in Germany, and nine times more likely than their counterparts in the Netherlands. Gonorrhea infections among U.S. teens are far higher than among French, Dutch, or German teens, and HIV infection rates for U.S. teens are 50 percent higher than among their European counterparts.

These countries have had more success in controlling the adverse effects of teen sex because they are legally permitted to focus on scientifically accurate information, and they let social agencies work with schools to give students access to confidential information,

contraception, and testing for STD/HIV. When free or low cost contraception is easily available, sexually active young people use protection more consistently. Even though abortions are more readily available in Western Europe than in the U.S., Western Europeans have fewer abortions because they begin with fewer unwanted pregnancies.

The Double Burden of Race and Class

The public family-planning budget is now half what it was in 1991, when absolute dollar amounts are adjusted for inflation in health costs and increases in population and health costs. This means that privately-funded clinics must struggle to provide effective contraceptive education, along with pregnancy and STD testing. And even as the Bush administration cuts funding for family planning services, some religious groups have launched a campaign to encourage individual pharmacists to refuse to dispense modern contraceptives.

The declining access to sexual education and low-cost contraception and healthcare is a special threat to the health of poor and minority women. According to the Sexuality Information and Education Council of the United States (SIECUS), Hispanic teens have the highest rates of teen pregnancy of any ethnic group, and African-American girls are four times more likely than their white counterparts to get pregnant. Infection rates for sexually-transmitted diseases and HIV/AIDS in African-Americans are far higher than among whites, and Hispanic STD rates, although lower than among Blacks, are still more than twice as high as among whites. The rate of HIV infection is 18 times higher in Black women than in white. A study by the Centers for Disease Control found that poverty plays a huge role in the rate of sexually-transmitted HIV/AIDS in women. And it is precisely poverty-stricken individuals who most need federally funded sex-education and family planning programs.

Teenagers, African Americans, and Hispanics are twice as likely -- and poor women in general are three times as likely -- to be served by public clinics than by private clinics or HMO's. Two-thirds of women served by family-planning services funded through Title X live below the poverty level. Such clinics offer the only affordable access to reproductive health care and contraception for these women --half of whom are white and three-quarters of whom are twenty or older. According to the Journal of Urban Health, the percentage of unintended pregnancies occurring in low income women living in New York is extremely high, suggesting that national rates of unintended pregnancy may dramatically underestimate the problems faced by low-income populations in getting access to family planning services.

A 2005 study by the Centers for Disease Control strongly suggests that recent cutbacks to family planning services are increasing the rate of unintended births. The CDC study found a 50% increase between 1995 and 2002 in unwanted births, from 9% to 14%. Most heavily impacted are minority women, young women, and less educated women.

When women have unplanned and unwanted pregnancies because they lack access to contraception, it costs the health-care system between $9,000 and $14,000 more per

woman than the cost of five years of contraceptive use (not counting savings in Temporary Assistance for Needy Families payments and other social welfare costs). Planned Parenthood estimates that every year among unmarried women, public family-planning funds prevent more than 1,331,100 unintended pregnancies and more than 632,300 abortions. Therefore, every public dollar spent on family planning saves an estimated three dollars that would otherwise be spent on pregnancy-related costs to Medicaid.

Family-planning clinics perform another vital function: providing accessible, affordable, and confidential testing for sexually transmitted disease. If rates of heterosexual transmission of HIV/AIDS continue to rise at their present pace, heterosexual transmission will soon become the most common form of spreading the disease. At this time, HIV rates are about the same in men and women, but infection rates for women are expected to soon surpass the rate for men. Unprotected women also run a higher risk of contracting genital herpes, gonorrhea, and Chlamydia infections.

Global Abstinence Promotion

Despite evidence that abstinence programs alone are ineffective in the United States, especially among more impoverished sectors of society, U.S. policy makers are promoting similar programs in areas of the world that are financially devastated and already highly infected with AIDS. Many world leaders worry that the Bush administration's push for abstinence programs will erode the limited progress that global sexual education and family-planning services have made so far.

Since the first AIDS diagnosis in 1981, more than 20 million AIDS-related deaths have occurred around the world, and more than 39 million people are now infected with HIV or AIDS, of whom 25 million are in Sub-Saharan Africa. The region with the second highest rate of HIV/AIDS is the Caribbean, with Haiti, where AIDS is the leading cause of death for young people, worst affected.

Yet since 2000, the US has cut funding to the largest provider of contraceptives: The United Family Planning Association. In July 2002, the US withheld 34 million dollars it had promised UNFPA, resulting in a shortfall in funding that some experts estimate will translate into 2 million unintended pregnancies, 5 million abortions (most of them illegal), 374,000 infant deaths and 27,000 maternal deaths.

The U.S. government has earmarked $900 million to be spent between 2003 and 2008 on abstinence-based programs. This is fully one-third of its total commitment to the global fight against AIDS, STD infections, and unwanted pregnancies. Religious organizations abroad, such as the Glory of Virginity Movement and the Family Life Network, along with faith-based American organizations such as True Love Waits, are vying to receive this abstinence funding. Although U.S. law forbids these groups from engaging in religious proselytizing, Human Rights Watch reports that "saving souls" through delivery of an evangelical Christian message is the clear aim of many faith-based programs, while AIDS prevention (through abstinence only) comes in a distant second.

Every region on earth has experienced increases in HIV/AIDS since 2000, with the most dramatic increases in East Asia (especially China), Eastern Europe, and Central Asia. In China, more than 1 million people are infected, and the number could rise to 10 million by 2010 unless massive prevention efforts are launched. India has at least 5 million people who are infected with AIDS. By the year 2010, according to some predictions, as many as 20 million African children will have lost one or both parents to AIDS.

In Africa in particular, the lack of access to and education about condoms threatens disastrous results. Nearly two-thirds of the world's AIDS population is found in sub-Saharan Africa and more than half are female. Even when contraception is available, it is rarely used during sex between spouses or primary partners, although the infection of married women by their husbands is a primary source of transmission of the HIV virus and STDs.

New research and more effective treatments give hope that people in highly infected regions will be able to live prolonged and healthier lives, which would reduce the social and economic impact of the HIV/AIDS epidemic. But the new treatments are not a cure and at this time are unavailable to most of those infected in impoverished regions. At present only 7 percent of infected Africans receive treatment. Until there is a vaccine to prevent AIDS or a cure for it, efforts must concentrate on reducing the risk of infection. Critical to slowing the epidemic is access to condoms, education about methods to prevent its spread, and encouragement of responsible sexual behavior, especially by people not willing to commit to monogamy, or unable to pressure their partners to do so.

Ironically, the hostility toward use of condoms actually increases the risk of unplanned pregnancies, many of which occur among women who cannot afford to have a child and who will therefore seek an abortion. In this context, whatever one's personal attitude toward abortion, the reinstatement of the Mexico City Policy by President Bush collides with the reality of life in countries where life-threatening poverty and female sexual exploitation are widespread.

It is simply unrealistic to believe that making abortion illegal in such countries will stop desperate women from trying to end unwanted pregnancies. But it will increase the threats to women's lives. Death rates from illegally performed procedures can be hundreds of times higher than in developed countries. And many health clinics now refuse to treat women suffering complications of illegal abortions for fear they might lose their U.S. funding. U.S. policy first makes unwanted pregnancies more likely, and then penalizes women who seek what they see as a birth control of last resort.

Consider the way that policy has worked in just two concrete instances. The Family Planning Association of Nepal was recently denied U.S. funding because of its stance in a case where it advocated the release from prison of a thirteen year old girl who had been raped and impregnated by one family member, taken for an abortion by another family member, turned in to the authorities by yet another family member, and was then sentenced to twenty years in jail. The plight of this girl and recognition of the need to reduce the high rate of maternal deaths in Nepal led the association to work with

government officials there to legalize abortion. As a result of this stance, the agency was disqualified from receiving U.S. aid, and half a million people lost access to family planning services, which is likely to increase unwanted pregnancies, abortions, HIV/AIDS, and related death rates.

In Ethiopia, where only twenty percent of the population lives within a two-hour walk of any health provider, one half million dollars in U.S. aid was withdrawn in 2001 because the Family Guidance Association there sought to educate Ethiopian authorities about the relationship between illegal abortion and staggering maternal death rates.

Conclusion: The Problem with Wishful Thinking

It is wishful thinking to expect that all young people will remain abstinent until marriage, that all married people in the world will remain monogamous, and that women who are desperately poor will never turn to prostitution. Therefore, reality-based sexual education and family planning programs that have been proven effective must be supported by governmental funding if our objective is to protect rather than merely to proselytize the public.

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