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Sex Education: Funding Facts, Not Fear

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Sex Education: Funding Facts, Not Fear

Rachel Rubenstein[†]

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I. Introduction

In Canyon, Texas, teachers encourage students to “stay like a new toothbrush, wrapped up and unused” and compare females that engage in premarital sex to chewed-up gum.¹ In Tunica, Mississippi, teachers describe girls who have sex before marriage as dirty, then demonstrate this concept using a piece of unwrapped chocolate passed around a classroom.² In Nashville, Tennessee, a sex education speaker told students to spit in a cup, asked a girl to drink from that cup, and then compared the cup full of spit to a woman who has had multiple sexual partners.³ She then described in graphic—and inaccurate—detail an abortion.⁴ In New York, sex educators teach students that the vagina is a “sperm deposit,” that it “receives sperm

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1. Katie Gustainis Vela (@katie_gus), TWITTER (Nov. 6, 2013, 9:07 AM), https://twitter.com/katie_gus/status/398089235145584641?ref_src=twsrc%5Etfw.

2. Alana Semuels, *Sex Education Stumbles in Mississippi*, L.A. TIMES (Apr. 2, 2014), <http://www.latimes.com/nation/la-na-ms-teen-pregnancy-20140403-story.html#axzz2xnMH2DV3>.

3. Heidi Hall, *Conservative Group’s Sex Talk at High School*, USA TODAY (May 27, 2013), <http://www.usatoday.com/story/news/nation/2013/05/27/high-school-sex-talk/2364463/>.

4. *Id.*

during reproduction,” and that the penis is a “sperm gun.”⁵ Each of these abstinence-only lessons takes place in a state that receives federal funding to provide such education.

Abstinence-only education focuses on abstinence from sexual activity as the only method for preventing pregnancy and sexually transmitted infections (“STIs”). Such education excludes any instruction about other means of safe sexual activity. Comprehensive sex education includes education about abstinence, but extends instruction to include contraception, sexuality, and other topics related to sexual activity. Most arguments about whether to institute abstinence-only or comprehensive sex education programs in schools are process-oriented; that is, they focus on how to provide sex education.⁶ Much of the scholarly work about this topic presumes that these programs have the same goal, then analyzes which method is more effective in achieving that same goal.⁷ These analyses are flawed because their basic premise is flawed; abstinence-only and comprehensive sex education do not have the same primary goal. While both forms of education do seek to reduce teenage pregnancy, teenage childbearing, and the spread of STIs, abstinence-only education’s primary goal is to reduce premarital sex.⁸ Comprehensive sex education seeks to reduce the negative impact of premarital sexual activity⁹ and

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5. MELISSA GOODMAN ET AL., *BIRDS, BEES AND BIAS: HOW ABSENT SEX ED STANDARDS FAIL NEW YORK’S STUDENTS 23-24* (2012) (describing problems with New York’s sex education curriculum and indicating that this lesson, among others, is anatomically incorrect).
 6. See Sue Alford, *Sex Education Programs: Definitions & Point-by-Point Comparison*, ADVOCATES FOR YOUTH (2001), <http://www.advocatesforyouth.org/publications/publications-a-z/655-sex-education-programs-definitions-and-point-by-point-comparison>.
 7. See Pamela K. Kohler et al., *Abstinence-Only and Comprehensive Sex Education and the Initiation of Sexual Activity and Pregnancy*, 42 J. ADOLESCENT HEALTH 344, 345 (2008); Kathrin F. Stanger-Hall & David W. Hall, *Abstinence-Only Education and Teen Pregnancy: Why We Need Comprehensive Sex Education in the United States*, 6 PLOS ONE 1, 1 (2011).
 8. See, e.g., 42 U.S.C. § 710 (2015); ARK. CODE ANN. § 6-18-703 (1991) (stating that Arkansas’s state policy is to “discourage . . . sexual activity.”); ALA. CODE § 16-40A-2 (1992) (requiring that curricula emphasize that “abstinence from sexual intercourse outside of lawful marriage is the expected social standard for unmarried school-age persons”); FLA. STAT. § 1003.46 (2002) (mandating that schools “teach abstinence from sexual activity as the expected standard for all school-age students while teaching the benefits of monogamous heterosexual marriage” 42 U.S.C. § 710).
 9. See Colo. REV. STAT. § 22-25-102 (stating that one of the legislative purposes behind Colorado’s sex education program is “the modification of high-risk behaviors”); MD. REGS. CODE § 13A.04.18.01 (requiring that “instructional program[s] . . . help students adopt and maintain healthy behaviors and contribute directly to a students [sic] ability to successfully practice behaviors that protect and promote health and avoid or reduce health risks”).

promote knowledge about reproductive health and sexuality.¹⁰ Examining the problem from that point of view, the question then becomes which goal is more valuable, and which educational program the federal government should support.

States promote different approaches to sex education throughout the United States.¹¹ The most important distinction between states in the way they approach sex education is whether their statutory schemes provide for comprehensive sexual education or abstinence-only education. Another vital distinction is whether sex education is mandatory,¹² permitted,¹³ or not addressed specifically or at all.¹⁴ These distinct categories can be divided further; in those states that address sex education, some do not specify how it should be delivered,¹⁵ while others provide specific guidelines regulating the way schools treat abstinence, STIs,¹⁶ and contraception.¹⁷ Some require that programs meet criteria about medical

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10. See, COLO. REV. STAT. § 22-25-102 (stating that one of the legislative purposes behind Colorado's sex education program is "the increase of health knowledge"); MONT. ADMIN. R. 10.54.7012 (providing for a benchmark system that requires students to "explain personal health enhancing strategies that encompass . . . sexual activity [and] injury/disease prevention, including HIV/AIDS prevention").
 11. "Sex education" lacks a widely-accepted definition. For simplicity's sake, this Note uses "sex education" to refer to any educational program that offers instruction regarding human sexuality, family planning, reproductive health, HIV/AIDS, sexually transmitted infections, and/or a combination of the above. See, Alford, *supra* note 6.
 12. See, e.g., CAL. EDUC. CODE § 51930 (Deering 2015) [hereinafter California Healthy Youth Act]; Md. REGS. CODE 13A.04.18.01(2015); 14-851 DEL. ADMIN. CODE § 1.1.4 (2008); FLA. STAT. § 1003.42 (2014); GA. CODE ANN. § 20-2-143; 105 ILL. COMP. STAT. 110/3 (2015); IND. CODE § 20-30-5-12 (2005); IOWA CODE § 279.50 (2007).
 13. See, e.g., LA. REV. STAT. ANN. § 17:281 (1993); ALA. CODE § 16-40A-2 (1992) (authorizing schools in Alabama to provide sex education focused on self-control and ethical behavior); ARIZ. REV. STAT. § 15-716 (1993) (permitting schools to offer HIV/AIDS education).
 14. KAN. STAT. ANN. § 72-1127 (2014) (indicating Kansas's lack of sex education provision in its statutory scheme for education); see, e.g., ALASKA STAT. § 14.30.360 (1998) (showing Alaska's lack of sex education provision, though it does have a health education provision); WYO. STAT. ANN. § 21 (2015) (indicating Wyoming's lack of a sex education statute, though it requires that curricula include health and safety education).
 15. See, e.g., CONN. GEN. STAT. § 10-16c (1980) (delegating guideline development to the State Board of Education); 14-851 DEL. ADMIN. C. § 1.1.4 (mandating comprehensive sexual education and HIV/AIDS education without providing any specific instruction).
 16. Throughout this Note, the phrase "sexually transmitted infection" is used as inclusive of human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS).
 17. See, e.g., FLA. STAT. § 1003.42 (2014); IND. CODE § 20-34-3-17 (2005) (specifying the contents of AIDS education programs).

accuracy,¹⁸ while others do not.¹⁹ States also differ in the way they treat abortion²⁰ and homosexuality.²¹ Additionally, while many states provide procedures for parents who want their children to be excused from sex education classes for religious reasons, these procedures vary from state to state.²²

The federal government provides funding for abstinence-only educational programs.²³ If states accept these funds, sex education programs that use the funds must adhere to the strict guidelines the government provides.²⁴ The Social Security Act contains a funding provision for a “separate program for abstinence education” called the Abstinence Education Grant Program (“AEGP”).²⁵ AEGP’s expressed purpose is “to enable the state to provide abstinence education.”²⁶ If a state accepts funding through this program, it must have “as its exclusive purpose” teaching abstinence,²⁷ which necessarily prohibits education about other methods for maintaining reproductive health.²⁸ Under this statute, funded education programs must adhere to eight guidelines promoting abstinence education and prohibiting non-abstinence-focused information.²⁹ These eight guidelines are adopted verbatim or nearly verbatim in some states’

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18. See, e.g., ARIZ. REV. STAT. § 15-716 (1995); COLO. REV. STAT. § 22-25-104 (2013).
 19. N.H. REV. STAT. ANN. § 189:10 (2008); see, e.g., GA. CODE ANN. § 20-2-143 (2011).
 20. See, e.g., 105 ILL. COMP. STAT. 110/3 (2015) (requiring discussion of alternatives to abortion if family planning is discussed); MO. REV. STAT. § 170.015 (2007) (introducing a broad ban on instruction about abortion and employing instructors that provide “abortion services”).
 21. See, e.g., ALA. CODE § 16-40A-2 (2014) (indicating that Alabama education law requires that sex education programs emphasize that “homosexuality is not a lifestyle acceptable to the general public and that homosexual conduct is a criminal offense under the laws of the state”); see also, ARIZ. REV. STAT. § 15-716 (preventing educators from suggesting “that some methods of sex are safe methods of homosexual sex.”); 105 ILL. COMP. STAT. 5/27-9.1 (LexisNexis 2015) (requiring that all sex education classes “teach honor and respect for monogamous heterosexual marriage”).
 22. See, e.g., ARIZ. REV. STAT. § 15-716 (1995) (allowing parents to request that the school excuse their children from HIV/AIDS education); COLO. REV. STAT. § 22-25-104 (2013) (requiring that schools include students in sex education unless they receive written notice from their parents declining to participate).
 23. See 42 U.S.C. § 710 (2015).
 24. *Id.*
 25. *Id.*
 26. *Id.*
 27. *Id.*
 28. John S. Santelli, *Medical Accuracy in Sexuality Education: Ideology and the Scientific Process*, 98 AM. J. PUB. HEALTH 1786, 1786 (2008).
 29. 42 U.S.C. § 710 (2015).

sex education statutes.³⁰ Despite continuing evidence that abstinence-only education is not effective,³¹ the government recently extended the duration of this program.³²

This Note argues that the federal government should stop funding abstinence-only education because it is ineffective and begin funding sex education programs in states that adopt a statutory scheme consistent with the requirements of the California Healthy Youth Act, California's sex education statute. Specifically, the federal government should endorse state programs that mandate comprehensive sexual education that is directed toward providing medically accurate and complete information and promoting the knowledge and skills necessary for making healthy sexual choices. Such programs should also recognize the needs of minority groups, allow students with religious objections to opt out, and address a variety of potential pregnancy outcomes.³³

Part II provides background on existing federal funding for sex education, including AEGP and President Obama's Teen Pregnancy Prevention Programs ("TPP"), and concludes that these programs are ineffective. It also examines the California Healthy Youth Act as a model for adequate sex education. Part III explains the different forms of sex education and advocates for federally funded sex education that is comprehensive and medically accurate and addresses diverse student needs. Part IV recommends improving sex education in the United States by eliminating AEGP and creating a federal program using a framework based upon the California Healthy Youth Act.

II. Existing Statutes and Funding Sources for Sex Education

A. Federal Funding for Sex Education

Federal statutes regarding sex education incentivize abstinence-only education and promote adoption and parenting as the only options for unplanned pregnancy.³⁴ One such statute funds AEGP, which provides financial support to states that promise to use those funds for abstinence-

30. See, e.g., VA. CODE ANN. § 22.1-207.1 (2011); FLA. STAT. § 1003.42 (2013).

31. See, e.g., Pamela K. Kohler et al., *supra* note 7; Karen Perrin & Sharon Bernecki DeJoy, *Abstinence-Only Education: How We Got Here and Where We're Going*, 24 J. P. HEALTH POL'Y 445, 446 (2003) (stating that the "current level of funding for [abstinence-only education] is unjustified.").

32. Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 214, 129 Stat. 87, 152 (amending 42 U.S.C. § 710 to allocate "an additional \$75,000,000 for each of fiscal years 2016 and 2017").

33. Pregnancy outcomes include adoption, abortion, and/or parenting.

34. See, e.g., 42 U.S.C. § 710 (2010); ADMIN. FOR CHILDREN & FAMILIES, *Competitive Abstinence Education Grant Program*, <http://www.acf.hhs.gov/grants/open/foa/view/HHS-2012-ACF-ACYF-AR-0553> (describing an abstinence-focused grant program funded under 42 U.S.C. § 1310) (last visited Mar. 11, 2016).

only educational programs that meet certain criteria.³⁵ AEGP was enacted under Title V of the Social Security Act in 1996 to provide funding for educational programs that promote abstinence from sexual activity.³⁶ Since its inception, it has been renewed each time it has expired; funding for AEGP was renewed in 2015 and expires in 2017.³⁷ At the time AEGP was renewed, funding increased from fifty million dollars per year³⁸ to seventy-five million dollars per year.³⁹ In 2015, thirty-six states received this funding.⁴⁰ Among states that received AEGP funding in 2015, grants ranged from \$74,258 in North Dakota to \$6.75 million in Texas.⁴¹ Funds are distributed “based on the proportion of low-income children in each State.”⁴² States that receive AEGP funding must furnish at least forty-three percent of the costs associated with their programs through non-federal sources.⁴³

AEGP lists eight requirements to which states must adhere in order to receive funding under the statute. To receive federal funds, a program must comport with the statute’s definition of abstinence education, which means that the program

(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted infections, and other associated health problems;

35. See 42 U.S.C. § 710 (2010).

36. *Id.*

37. Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 214, 129 Stat. 87, 152.

38. 42 U.S.C. § 710 (2010).

39. Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 214, 129 Stat. 87, 152 (amending 42 U.S.C. § 710 to allocate “an additional \$75,000,000 for each of fiscal years 2016 and 2017”).

40. See generally ADMIN. FOR CHILDREN & FAMILIES, *Title V State Abstinence Education Fiscal Year 2015 Awards*, HEALTH & HUMAN SERVS., <http://www.acf.hhs.gov/programs/fysb/resource/titlev-2015-awards> (last visited Mar. 9, 2016) (listing the thirty-six states receiving grants under AEGP).

41. *Id.*

42. ADMIN. FOR CHILDREN & FAMILIES, *State Abstinence Education Grant Program Fact Sheet*, HEALTH & HUMAN SERVS., http://www.acf.hhs.gov/sites/default/files/fysb/sae_facts_20150427.pdf (last visited Mar. 9, 2016).

43. *Id.*

(D) teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;

(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.⁴⁴

Because sex education programs funded under AEGP are confined to teaching within the bounds of these “exclusive purpose[s],”⁴⁵ they cannot provide information about contraception, STIs, or methods for protecting against STIs. In fact, discussion about contraceptives under this federally funded program is prohibited entirely except when describing failure rates.⁴⁶ Programs funded under AEGP are reviewed for compliance with these statutory standards but not for medical accuracy.⁴⁷ As a result, the government is providing states with funds to promulgate medically inaccurate, incomplete, and biased curricula. Students lack access to medically accurate sexual health information under these educational programs, which prevents them from making informed choices about their sexual health.

The language contained in AEGP is unscientific and needlessly alarmist. The statute explicitly states that non-marital sexual activity is psychologically and physically harmful, though there is no scientific support for this contention; no scientific evidence suggests that sexual intercourse during adolescent years has a negative psychological impact.⁴⁸ The statute also propagates the idea that every person's goal is a “mutually faithful monogamous” marriage. Some states adopt this language or even narrower language, specifying that sex is only appropriate in the context of heterosexual marriage.⁴⁹ AEGP ignores those who do not want to marry or

44. 42 U.S.C. § 710 (2010).

45. *Id.*

46. COMM. ON GOV'T REFORM – MINORITY STAFF SPECIAL INVESTIGATION DIV., THE CONTENT OF FEDERALLY FUNDED ABSTINENCE-ONLY EDUCATION PROGRAMS 8 (2004) [hereinafter Waxman Report].

47. Santelli, *supra* note 28, at 1787.

48. John Santelli et al., *Abstinence and Abstinence-Only Education: A Review of U.S. Policies and Programs*, 38 J. ADOLESCENT HEALTH 72, 74 (2006).

49. See, e.g., FLA. STAT. § 1003.46 (2002); IND. CODE § 20-34-3-17 (2005); N.C. GEN. STAT. § 115C-81 (2014); ORE. REV. STAT § 336.455 (2009).

who are not monogamous. Further, AEGP mandates religious standards that lack a scientific basis. It also alienates students who come from single-parent households or whose parents are not married, as well as those students for whom the described marriage is not a goal.

In 2010, President Obama introduced the Teen Pregnancy Prevention Program, providing funding to sex education programs that are medically accurate and age-appropriate.⁵⁰ The program is administered by the Office of Adolescent Health, a subsection of United States Department of Health and Human Services (“HHS”).⁵¹ Applicants can receive funding if they emulate specific evidence-based programs promulgated under TPP.⁵² Grants are also available to groups that seek to develop strategies for preventing teenage pregnancy.⁵³ While a number of the programs funded through TPP are comprehensive, ineffective abstinence-only programs also receive funds.⁵⁴ Though some TPP-funded programs are introduced at school,⁵⁵ they are not a mandatory part of school curricula. Because these programs are not necessarily administered at schools, they are not accessible to all students. Students may be uninterested in attending non-mandatory classes outside of school or unaware of the opportunity to do so. Students also may lack time to participate in non-school activities due to family circumstances or for other reasons. Such education also might not be available to students for access reasons, such as a lack of transportation or lack of a location within a reasonable distance. These issues of access are most prevalent where sex education is most desperately needed, in rural

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50. SEXUALITY INFO. & EDUC. COUNCIL OF THE U.S., *The President’s Teen Pregnancy Prevention Initiative: Providing Young People the Information and Skills They Need*, <http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1190> (last updated May 2012).
 51. OFFICE OF ADOLESCENT HEALTH, *Teen Pregnancy Prevention*, HEALTH & HUMAN SERVS., http://www.hhs.gov/ash/oah/oah-initiatives/tpp_program/about/ (last updated July 20, 2015).
 52. OFFICE OF ADOLESCENT HEALTH, *Evidence-Based TPP Programs*, HEALTH & HUMAN SERVS., http://www.hhs.gov/ash/oah/oah-initiatives/tpp_program/db/ (last updated July 14, 2015); *see also* OFFICE OF ADOLESCENT HEALTH, *Evidence-Based TPP Programs Database*, http://www.hhs.gov/ash/oah/oah-initiatives/tpp_program/db/tpp-searchable.html (last updated July 14, 2015).
 53. OFFICE OF ADOLESCENT HEALTH, *Evidence-Based TPP Programs Database*, Health & Human Servs., http://www.hhs.gov/ash/oah/oah-initiatives/tpp_program/db/tpp-searchable.html (last updated July 14, 2015).
 54. *Id.*
 55. *See, e.g.*, OFFICE OF ADOLESCENT HEALTH, *Aban Aya Youth Project: Program Summary*, HEALTH & HUMAN SERVS., http://www.hhs.gov/ash/oah/oah-initiatives/tpp_program/db/programs/ebp-abanaya.html (last updated Dec. 12, 2015); OFFICE OF ADOLESCENT HEALTH, *Be Proud! Be Responsible!*, HEALTH & HUMAN SERVS., http://www.hhs.gov/ash/oah/oah-initiatives/tpp_program/db/programs/ebp-bpbr.html (last updated Dec. 11, 2015).

and low-income communities.⁵⁶ Providing states with the option to receive funds for mandatory comprehensive sex education in schools would alleviate these problems of access. This Note proposes standards for such a program.

B. The Model: The California Healthy Youth Act

The California Healthy Youth Act, enacted on October 1, 2015 and effective beginning in January 2016, amended the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act.⁵⁷ The amendment introduced provisions to ensure that minority groups receive adequate education and to provide students with the knowledge and skills to make healthy choices.⁵⁸ It also maintained a number of important provisions, including a mandate requiring all information disseminated to students to be medically accurate.⁵⁹ California provides a definition of medically accurate that is consistent with its goal of providing “pupils with knowledge and skills for making and implementing healthy decisions about sexuality.”⁶⁰ The statute defines “medically accurate” as information that is

verified or supported by research conducted in compliance with scientific methods and published in peer-reviewed journals, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the federal Centers for Disease Control and Prevention, the American Public Health Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.⁶¹

The California Healthy Youth Act also includes purposes that were not in the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act. The amendment adds that all sex education programs promulgated in the state should

promote understanding of sexuality as a normal part of human development . . . , ensure pupils receive integrated, comprehensive, accurate, and unbiased sexual health and HIV prevention

56. See Pamela S. Stewart Fahs et al., *Integrative Research Review of Risk Behaviors Among Adolescents in Rural, Suburban, and Urban Areas*, 24 J. ADOLESCENT HEALTH 230, 237-238 (1999).

57. Cal. Assemb. B. 329 (Cal. 2015).

58. Cal. Educ. Code § 51930 (2003).

59. See CAL. EDUC. CODE § 51931-51939 (2003); see generally California Healthy Youth Act § 51933(b).

60. California Healthy Youth Act § 51933(h).

61. *Id.* at § 51931(f).

instruction . . . , [and] provide pupils with the knowledge and skills to have healthy, positive, and safe relationships.”⁶²

To achieve these additional goals, the new statute mandates that schools provide comprehensive sex education, whereas the previous version of the statute merely authorized schools to provide it.⁶³ The new statute also requires all sex education materials to be accessible to students with a variety of needs.⁶⁴ Material cannot be biased⁶⁵ and must be appropriate for students “of all races, genders, sexual orientations, and ethnic and cultural backgrounds,”⁶⁶ as well as those with disabilities and who are learning English.⁶⁷ It requires that schools “affirmatively recognize” and include in their curricula appropriate educational materials for students who are non-heterosexual and students who are gender non-conforming.⁶⁸ The statute was also made more inclusive; it now requires instruction about forming healthy and respectful committed relationships,⁶⁹ where previously it had focused solely on marital relationships.⁷⁰

One of the purposes of the original statute, which is maintained in the new version, is ensuring that students receive “integrated, comprehensive, accurate, and unbiased sexual health and HIV prevention instruction.”⁷¹ The new statute also addresses the need for education about STIs⁷² and mandates that educators provide “medically accurate information on [non-abstinence] methods of preventing HIV and other sexually transmitted infections and pregnancy.”⁷³

The California Healthy Youth Act also requires that students receive “information about the effectiveness and safety of all FDA-approved contraceptive methods in preventing pregnancy.”⁷⁴ Interestingly, the statute specifically includes emergency contraception.⁷⁵ Requiring schools to discuss emergency contraception ensures that students have access to

62. *Id.* at § 51930(b)(3-5).

63. *Compare id.* § 51933; *with* CAL. EDUC. CODE § 51933(a) (2003).

64. California Healthy Youth Act § 51933(d)(2-3).

65. *Id.* at § 51933(d)(4).

66. *Id.* at § 51933(d)(1).

67. *Id.*

68. *Id.* at § 51933(d)(5-6).

69. *Id.* at § 51933(g).

70. CAL. EDUC. CODE § 51933(b)(7) (2003).

71. California Healthy Youth Act § 51930(a)(4).

72. *Id.* at § 51934(a)(1-2).

73. *Id.* at § 51934(a)(3).

74. *Id.* at § 51934(a)(9).

75. *Id.*

information about safe⁷⁶ but controversial⁷⁷ methods of contraception like the morning-after pill, allowing them to make informed, safe choices. Instruction about pregnancy and childbearing must also discuss “all legally available pregnancy outcomes.”⁷⁸ The statute specifically enumerates parenting, adoption, and abortion as choices that must be addressed when discussing pregnancy outcomes.⁷⁹

Parents in California can seek to exempt their children from sex education for religious reasons by following simple notification procedures.⁸⁰ All schools must have a “passive consent (‘opt-out’) process,” under which parents implicitly allow their children to receive sex education.⁸¹ This means that all students receive sex education unless their parents object. Schools are specifically prohibited from creating active consent processes,⁸² which would require that students receive explicit permission to participate in sex education.

III. Moving Towards a Solution

Sex education is typically separated into two categories—abstinence-only education⁸³ and comprehensive sex education⁸⁴—based on the extent of the education students receive. Sex education programs can also be distinguished based on how they treat HIV/AIDS, abortion, homosexuality, and certain forms of contraception.⁸⁵ However, for the purposes of this

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76. AM. ACAD. PEDIATRICS COM. ON ADOLESCENTS, *Policy Statement: Emergency Contraception*, 116 PEDIATRICS 1026, 1030 (2005).
 77. See generally Megan L. Ranney et al., *Nonprescription Availability of Emergency Contraception in the United States: Current Status, Controversies, and Impact on Emergency Medicine Practice*, 47 ANNALS EMERGENCY MED. 416, 465, 467 (2006).
 78. California Healthy Youth Act § 51934(a)(9)(A)(C).
 79. *Id.* at § 51934(a)(9)(A).
 80. *Id.* at § 51937 (stating that “parents and guardians have the ultimate responsibility for imparting values regarding human sexuality to their children.”).
 81. *Id.* at § 51938(a).
 82. *Id.* at § 51938(c).
 83. Abstinence-only education is also sometimes referred to as “abstinence-only-until-marriage” or AOUM education. See *Sex Education Programs: Definitions & Point-by-Point Comparison*, ADVOCATES FOR YOUTH, <http://www.advocatesforyouth.org/publications/publications-a-z/655-sex-education-programs-definitions-and-point-by-point-comparison> (last visited Jan. 16, 2016) (Abstinence-only education is also sometimes referred to as “abstinence-only-until-marriage” or AOUM education).
 84. See Elissa Barr et al., *New Evidence: Data Documenting Parental Support for Earlier Sexuality Education*. 84 J. SCHOOL HEALTH 10, 10 (2014) (providing definitions for abstinence-only education and comprehensive sexual education and discussing the controversy surrounding each method).
 85. See *id.*; see also *Sex Education Programs: Definitions & Point-by-Point Comparison*, ADVOCATES FOR YOUTH,

analysis, distinguishing between abstinence-only and comprehensive sex education and addressing the other issues separately is the clearest way to proceed.

Abstinence-only education programs promote the idea that students should not engage in sexual activity prior to marriage.⁸⁶ These programs do not teach other methods of preventing pregnancy and STIs, depriving students of information that is vital to making healthy and safe choices.⁸⁷ As it stands, most sex education in the United States follows this model, so these programs are the only formal education regarding reproduction to which many students will have access.⁸⁸ These programs teach that pre-marital sexual relationships are psychologically and physically harmful and that abstinence is the only certain way to avoid pregnancy and STIs.⁸⁹ The “exclusive purpose” of federally-funded abstinence-only programs is promoting “the social, psychological, and health gains to be realized by abstaining from sexual activity.”⁹⁰ A number of abstinence-only programs discuss STIs, but do so only in the context of abstinence, omitting any information about non-abstinence protective measures.⁹¹ Some abstinence-only programs do address contraception, but only to describe the rates at which contraception methods fail.⁹² Others do not discuss contraception options at all because they fear that such knowledge will promote sexual activity.⁹³

Comprehensive sex education takes a different approach. Though comprehensive sex education emphasizes that abstinence is the most effective method of preventing pregnancy and STIs,⁹⁴ it also addresses a number of other topics related to sex, including contraception, STI prevention, and sexuality.⁹⁵ Some comprehensive sex education curricula also discuss pregnancy outcomes, including parenting, adoption, and abortion. Comprehensive sex education acknowledges that, despite

<http://www.advocatesforyouth.org/publications/publications-a-z/655-sex-education-programs-definitions-and-point-by-point-comparison> (last visited Jan. 16, 2016).

86. Kohler et al., *supra* note 7.
87. See 42 U.S.C. § 710(b)(2)(A-B) (2015).
88. Waxman Report, *supra* note 46, at 3.
89. 42 U.S.C. § 710(b)(2)(C)(E) (2015).
90. *Id.* at § 710 (b)(2)(B).
91. See, e.g., OHIO REV. CODE § 3313.6011 (2001); R.I. GEN. LAWS § 16-22-18 (2012); MICH. COMP. LAWS § 380.1169 (2004).
92. Barr et al., *supra* note 84, at 10.
93. See Stanger-Hall & Hall, *supra* note 7, at 1.
94. Barr et al., *supra* note 84, at 10.
95. *Id.*; see also Kohler et al., *supra* note 7, at 345.

educators' best efforts, some students will become sexually active prior to marriage and seeks to prepare students for that eventuality.⁹⁶

A. *Choosing Comprehensive Sex Education*

Effective sex education programs have a number of qualities in common. Successful sex education programs “focus on changing specific behaviors.”⁹⁷ To effectively change these behaviors, successful sex education programs provide accurate information to students, engage with them in a way that is tailored to their specific needs, address peer pressure and ways to respond to it, and discuss content in a way that is appropriate for students' age groups and level of sexual experience.⁹⁸ While comprehensive sex education programs encourage abstinence, they also teach about contraceptives and promote safe behaviors, such as communicating with partners and seeking testing for sexually transmitted infections.⁹⁹ Adolescents who receive comprehensive sex education are less likely to become pregnant than both adolescents who receive no instruction and adolescents who receive abstinence-only instruction.¹⁰⁰ Comprehensive sex education programs are effective in “delay[ing] the initiation of sex, reduc[ing] the frequency of sex and the number of partners, and increas[ing] condom or contraception use.”¹⁰¹ Each of these outcomes is desirable, because each is associated with lower rates of sexually transmitted infections and pregnancy.

Health professionals typically consider abstinence to be a behavioral or health issue while policymakers and advocates of abstinence-only education perceive it as moral or religious issue.¹⁰² Abstinence-only education programs and the beliefs underlying their implementation are generally based upon their proponents' moral and religious beliefs.¹⁰³ As such, policymakers tend to couch their curricula in terms of morality and religiosity, using terms like “virginity” and “chastity”¹⁰⁴ rather than in

96. David Carter, *Comprehensive Sex Education is More Effective than Abstinence*. 112 AM. J. NURSING 15, 15 (2012).

97. Perrin & DeJoy, *supra* note 31, at 455.

98. *Id.*

99. Waxman Report, *supra* note 46, at 4.

100. See Kohler et al., *supra* note 7, at 349.

101. DOUGLAS KIRBY ET AL., EMERGING ANSWERS: RESEARCH FINDINGS ON PROGRAMS TO REDUCE TEEN PREGNANCY AND SEXUALLY TRANSMITTED DISEASE 60 (2007); Elissa Barr et al., *New Evidence: Data Documenting Parental Support for Earlier Sexuality Education*, 84 J. SCHOOL HEALTH 10, 11 (2014).

102. See Joseph J. Sabia, *Does Sex Education Affect Adolescent Sexual Behaviors and Health?* 25 J. POL'Y ANALYSIS & MGMT. 783, 799 (2006).

103. See John S. Santelli, *Medical Accuracy in Sexuality Education: Ideology and the Scientific Process*, 98 AM. J. PUB. HEALTH 1786, 1786-87 (2008).

104. See *id.* at 1790.

behavioral terms.¹⁰⁵ This is echoed in federal legislation providing funding for abstinence-only education, which requires educational programs to teach “that a mutually monogamous relationship in the context of marriage is the expected standard of human sexual activity.”¹⁰⁶

Some who oppose comprehensive sex education argue that exposure to non-abstinence information about sex will encourage sexual behavior at a young age.¹⁰⁷ When the television show *16 and Pregnant* and its spin-off, *Teen Mom*, first aired on MTV in 2009, parent groups were outraged, citing the same reason.¹⁰⁸ Some parents feared that both television shows glamorize teen pregnancy and motherhood.¹⁰⁹ However, *16 and Pregnant* actually led to a 4.3 percent reduction in teen pregnancy, mostly as a result of increased contraceptive use.¹¹⁰ In addition, studies show that instruction about contraception and STIs is “not associated with increased risk of adolescent sexual activity or sexually transmitted infection.”¹¹¹ Contrary to the fears of proponents of abstinence-only programs, comprehensive sex education does not encourage sexual behavior at a young age, nor does it encourage abortions.¹¹² Because comprehensive sexual education is effective in meeting its goals and abstinence-only education is empirically ineffective, states should adopt curricular standards consistent with comprehensive sexual education principles.

Abstinence-only education does not cause abstinent behavior in adolescents.¹¹³ A study of abstinence-only programs showed “no scientific evidence that abstinence-only programs demonstrate efficacy in delaying initiation of sexual intercourse.”¹¹⁴ Abstinence-only programs also fail to teach adolescents how to make informed choices when they do choose to

105. See Patricia Goodson et al., *Defining Abstinence: Views of Directors, Instructors, and Participants in Abstinence-Only-Until-Marriage Programs in Texas*, 73 J. SCH. HEALTH 91, 91 (2003).

106. 42 U.S.C. § 710(d).

107. See Kohler et al., *supra* note 7.

108. See *Moms Differ Over What Behavior MTV Shows ‘Teen Mom’ and ‘16 and Pregnant’ Promote*, FOX NEWS (Feb. 19, 2010), <http://www.foxnews.com/entertainment/2010/02/19/mtv-teen-mom-16-and-pregnant/>.

109. See *Id.*

110. Melissa S. Kearny & Phillip B. Levine, *Media Influences on Social Outcomes: The Impact of MTV’s 16 and Pregnant on Teen Childbearing*, 105 AM. ECON. REV. 3597, 3599 (2015).

111. Kohler et al., *supra* note 7, at 344.

112. See *id.* at 344, 347-48; see also Laura Duberstein Lindberg & Isaac Maddow-Zinnet, *Consequences of Sex Education on Teen and Young Adult Sexual Behaviors and Outcomes*, 51 J. ADOLESCENT HEALTH 332 (2012).

113. See Stanger-Hall & Hall, *supra* note 7, at 1-2; see also Waxman Report, *supra* note 46, at 3.

114. Santelli et al., *supra* note 48, at 75.

engage in sexual activities.¹¹⁵ This results in less contraceptive use and higher rates of STIs.¹¹⁶ Abstinence-only programs also “systematically ignore sexually experienced adolescents”¹¹⁷ and instead choose to focus on delaying students’ first sexual experiences.¹¹⁸ Sexually experienced students require different information than sexually inexperienced students but do not receive it because abstinence-only education programs assume that their students are sexually inexperienced.¹¹⁹ Additionally, abstinence-only education fails to reduce teen pregnancy rates;¹²⁰ in fact, it “likely increases teen pregnancy rates.”¹²¹ The more emphasis a state law places on abstinence, the higher the teen pregnancy and teen birth rate.¹²² For example, Alabama’s sex education statute is one of the most restrictive in the country, entirely prohibiting students’ access to non-abstinence information.¹²³ Alabama also has the highest teen birth rate in the country and the fourteenth highest teen pregnancy rate.¹²⁴

Another reason that abstinence-only programs should no longer be considered an appropriate educational method is the inconsistency in terminology. Even in the context of policy, “abstinence” can have a variety of definitions. It may refer to the choice to postpone sexual activities until marriage or the choice to refrain only from engaging in sexual intercourse.¹²⁵ The degree of sexual activity it connotes is often unclear; sexual behavior that is not sexual intercourse may or may not be included in its definition.¹²⁶ This can lead to confusion among students about what activities are risky and among teachers about what they can and cannot teach. Teachers who focus on abstinence from sexual intercourse and fail to clarify abstinence’s definition may inadvertently encourage students to engage in non-intercourse sexual activities; students may think that such activities are not risky.

Abstinence-only education fails to take into account the fact that most Americans begin participating in sexual activities prior to marriage,

115. Waxman Report, *supra* note 46, at i-ii.

116. See Stanger-Hall & Hall, *supra* note 7, at 1.

117. Santelli et al., *supra* note 48, at 77.

118. See *id.* at 75, 79; see also Perrin & DeJoy, *supra* note 31, at 455-56.

119. Santelli et al., *supra* note 48, at 77.

120. See Stanger-Hall & Hall, *supra* note 7, at 1-2.

121. *Id.* at 2.

122. See *id.* at 2, 9.

123. See ALA. CODE § 16-40A-2 (2015).

124. OFFICE OF ADOLESCENT HEALTH, *Alabama Adolescent Reproductive Health Facts*, DEPT’ HEALTH & HUMAN SERVS. 1 (2011), <http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/states/pdfs/al.pdf>.

125. John Santelli et al., *supra* note 48, at 73.

126. See *id.*

regardless of the type of sex education they receive.¹²⁷ It also fails to acknowledge the substantial support among high school parents for comprehensive sexual education, including education about contraception and access to contraception.¹²⁸ Ninety percent of high school-aged students' parents believe that it is very or somewhat important that schools teach sex education.¹²⁹ Only fifteen percent of those parents preferred abstinence-only curricula over comprehensive sex education.¹³⁰ Most parents want their middle- and high-school-aged children to be provided with information about STIs, conception, abstinence, making responsible choices, and contraception.¹³¹

Federally funded abstinence-only education programs provide information that is false or misleading about the effectiveness of contraception and the risks of abortion.¹³² Several programs that receive federal funding incorrectly assert that condoms do not prevent the spread of STIs.¹³³ One program states that "touching another person's genitals 'can result in pregnancy.'"¹³⁴ Another curriculum indicates that one in ten women who have a legal abortion will become sterile, though no such risk is associated with abortion.¹³⁵ Such education appeals to students' emotional and fear responses.¹³⁶ These programs also often present gender stereotypes and religious beliefs as scientific fact.¹³⁷ A curriculum called *Choosing the Best*, whose website asserts that it has provided abstinence-only education to over four million students in forty-seven states,¹³⁸ suggests that women are property to be protected and owned by their fathers or husband;¹³⁹ another program funded under AEGP asserts that women rely upon men for happiness and success and for financial

127. *Id.*

128. *Id.* at 74; see also Stanger-Hall & Hall, *supra* note 7 (stating that "there is strong public support for comprehensive sexual education."); Barr et al., *supra* note 84, at 13.

129. John Santelli et al., *supra* note 48, at 74.

130. *Id.*

131. Cynthia Dailard, *Sex Education: Politicians, Parents, Teachers and Teens*. 4 GUTTMACHER REP. ON PUB. POL'Y 9, 11 (2001).

132. See Waxman Report, *supra* note 46, at 14.

133. See *id.* at i.

134. *Id.* at 12.

135. *Id.* at i.

136. See Stanger-Hall & Hall, *supra* note 7, at 9.

137. See Waxman Report, *supra* note 46, at 17.

138. *About Us*, CHOOSING THE BEST, <http://www.choosingthebest.com/about-us> (last visited Mar. 8, 2016).

139. See Waxman Report, *supra* note 46, at 17.

support.¹⁴⁰ Abstinence-only programs also reinforce heteronormative stereotypes about relationships and gender differences between males and females.¹⁴¹ Perpetuating negative stereotypes about gender roles is harmful and the federal government should not fund programs that do so.

In addition to supplying false and misleading information to students, abstinence-only education also typically relies upon withholding information from students.¹⁴² Some states prohibit programs from addressing homosexuality and from discussing contraceptives except in the context of their failure rates.¹⁴³ Withholding such information, especially about HIV/AIDS and contraceptive methods, can have life-altering effects;¹⁴⁴ students who do not know they are at risk for disease, how to get tested, or how to prevent disease and pregnancy are not capable of making informed decisions about their sexual health.

Some abstinence-only curricula rely on virginity pledges.¹⁴⁵ Though such pledges do delay some participants' first sexual experience, the vast majority of participants did not remain abstinent after their pledge.¹⁴⁶ These pledges were ineffective in reducing the rate of STI transmission and participants were less likely than those who did not participate to use contraceptives and to get tested for STIs.¹⁴⁷ Because abstinence-only education is ineffective, it should not be promoted or paid for by the federal government. Comprehensive sex education, however, is successful, and should be supported by the federal government.

B. *Mandating Sex Education*

In 2000, 48.6 percent of schools required students to receive instruction about preventing sexually transmitted infection.¹⁴⁸ By 2014, that percentage dropped to 38.2 percent.¹⁴⁹ Education about HIV/AIDS prevention had a more precipitous drop, from sixty-four percent of schools

140. *Id.*

141. *See id.*

142. Stanger-Hall & Hall, *supra* note 7, at 9.

143. *See* John Santelli et al., *Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine*, 38 J. ADOLESCENT HEALTH 83, 84, 85 (2006); Santelli et al., *supra* note 48, at 78.

144. *See* Santelli, *supra* note 28, at 1790.

145. Hannah Brückner & Peter Bearman, *After the Promise: The STD Consequences of Adolescent Virginity Pledges*, 36 J. ADOLESCENT HEALTH 271, 271 (2005).

146. *See id.* at 271-72; *see also* Waxman Report, *supra* note 46, at 4.

147. Brückner & Bearman, *supra* note 145, at 272; *see also* Waxman Report, *supra* note 46, at 4.

148. CTRS. DISEASE CONTROL & PREVENTION, DIV. OF ADOLESCENT & SCH. HEALTH, SCHOOL HEALTH POLICIES AND PRACTICES STUDY: TRENDS OVER TIME: 2000-2014 (2014).

149. *Id.*

requiring such education in 2000, to only 41.4 percent in 2014.¹⁵⁰ In 2014, only 27.5 percent of schools provided HIV/AIDS counseling, testing, and referral.¹⁵¹ In order to improve these disappointing statistics, states should mandate sex education and the federal government should incentivize doing so.

In 2010, the federal government spent \$9.4 billion on costs associated with teen pregnancy and childbirth¹⁵² and sixteen billion dollars on medical costs resulting from sexually transmitted infections.¹⁵³ In addition to the financial costs associated with teen pregnancy and STIs, there are significant social costs. Teen pregnancy and childbearing have a significant negative impact on high school success and completion, as well as future job prospects.¹⁵⁴ Adolescents who become mothers are less likely to complete high school¹⁵⁵ and often have economic struggles supporting their offspring.¹⁵⁶ Contracting an STI can also lead to ectopic pregnancy,¹⁵⁷ reproductive cancer,¹⁵⁸ and problems with fertility.¹⁵⁹ School programs providing access to information about preventing STIs and pregnancy are especially important in rural and low-income communities because, often, school is the only place students have access to this information.¹⁶⁰ Communities that lack access to reproductive-health information also tend to be the same communities in which adolescent pregnancy and sexually transmitted infections are most prevalent.¹⁶¹ Sex education is also important for psychological reasons. It is instrumental in maintaining a

150. *Id.*

151. *Id.*

152. CTRS. DISEASE CONTROL & PREVENTION, *About Teen Pregnancy*, CDC <http://www.cdc.gov/teenpregnancy/about/index.htm> (last updated May 19, 2015).

153. CTRS. DISEASE CONTROL & PREVENTION, *INCIDENCE, PREVALENCE, AND COST OF SEXUALLY TRANSMITTED INFECTIONS IN THE UNITED STATES (2013)*.

154. *See id.*

155. Waxman Report, *supra* note 46, at 5.

156. *Id.* at 8.

157. *See* S. D. Hillis et al., *Recurrent Chlamydial Infections Increase the Risks of Hospitalization for Ectopic Pregnancy and Pelvic Inflammatory Disease*, 176 *AM. J. OBSTETRICS & GYNECOLOGY* 103, 104 (1997).

158. *See* Jan M. M. Wallboomers et al., *Human Papillomavirus is a Necessary Cause of Invasive Cervical Cancer Worldwide*, 189 *J. PATHOLOGY* 12, 18 (1999).

159. CTRS. DISEASE CONTROL & PREVENTION, *STDs & Infertility*, <http://www.cdc.gov/std/infertility/> (last updated Nov. 17, 2015)

160. Stewart Fahs et al., *supra* note 56, at 238, 241.

161. *Id.*

healthy self-image, developing confidence in relationships and sexual decision-making, and forming healthy relationships.¹⁶²

States should adopt mandatory curricular standards for several reasons. First, comprehensive sex education programs reduce unintended pregnancy and the transmission of STIs.¹⁶³ Nearly half of high school students report engaging in a number of risky sexual behaviors.¹⁶⁴ Sexually active high school students often fail to use protection, increasing the risk of pregnancy and of acquiring a sexually transmitted infection.¹⁶⁵ Because comprehensive sex education reduces these behaviors and their adverse outcomes, sex education should be required.

Mandatory guidelines also promote consistency within states. In some states, local school districts are given very broad discretion in creating curricula.¹⁶⁶ Though this allows communities the benefit of addressing specific community needs and including the local sense of religion or morality, it is to the students' and communities' detriment. Allowing this sort of discretion means that the curricula's content depend on the whims of local leaders, rather than on any legitimate scientific or educational basis. Often, there is a large disparity between the education that students in urban, suburban, and rural areas receive.¹⁶⁷ Socioeconomic disparities also widen this educational gap.¹⁶⁸ Often, students who are at the lowest risk for teenage pregnancy or STIs—typically students with two present, educated parents and students who are socioeconomically advantaged¹⁶⁹—are the students who receive high-quality sex education. Paradoxically, students who need education the most—those who are at the highest risk for adolescent pregnancy and sexually transmitted infections—receive no education about sex.¹⁷⁰ Mandating sex education in each state and providing guidelines for instruction would improve access to appropriate sex education for the students who need it most.

162. Amy T. Schalet et al., *Invited Commentary: Broadening the Evidence for Adolescent Sexual and Reproductive Health and Education in the United States*, 43 J. YOUTH ADOLESCENCE 1595, 1596 (2014).

163. Kohler et al., *supra* note 7, at 348; Perrin & DeJoy, *supra* note 31.

164. Barr et al., *supra* note 84, at 11.

165. *Id.*

166. *See, e.g.*, CONN. GEN. STAT. § 10-16c (1980) (delegating guideline development to the State Board of Education); 14-851 DEL. ADMIN. CODE § 1.1.4 (2000) (mandating comprehensive sexual education and HIV/AIDS education without providing any specific instruction).

167. Stewart Fahs et al., *supra* note 56, at 331; *see generally* Vincent J. Roscigno et al., *Education and the Inequalities of Place*, 84 SOC. FORCES 2121 (2006) (explaining that the resource disparities among urban, suburban, and rural areas causes educational inequality).

168. Stanger-Hall & Hall, *supra* note 7, at 2-4.

169. *See* Stewart Fahs et al., *supra* note 56, at 237.

170. Kohler et al., *supra* note 7, at 347.

Further, mandating sex education would promote accountability. Instead of states leaving their citizens' health and well-being up to local school boards, mandates would require state legislatures to take responsibility for reducing teen pregnancy rates, teen childbirth rates, and the spread of STIs. Legislators represent—or should represent—their constituents' needs. Elected officials, in consultation with appropriate health and educational authorities, should create curricular standards; they are more appropriate authorities than the committees creating curricula in some states.

In Nevada, for example, a committee composed of five local parents, a medical, nursing, counseling, or religious professional, and a pupil “advise the district concerning the content of and materials to be used in a course of instruction” regarding sex education.¹⁷¹ Nevada's legislature defers legislative decisions to community members who have no qualifications to make such decisions.¹⁷² This practice is not uncommon; several states delegate responsibility for making curricular decisions to unqualified local community members.¹⁷³ Such legislative deference allows for significant differences in curricula from one community to the next. Mandating sexual education according to guidelines promulgated by the legislature or, at the very least, the state's board of education, would solve these problems.

Ensuring that students receive information about gynecologists, testing for STIs, and basic reproductive facts is in the government's best interest. Sex education is important for more than just providing information about negative outcomes of adolescent sexual activity. Proper sex education provides students with knowledge about how to mitigate risks associated with sexual activity, lowering the associated costs to the government.

C. *Requiring Medical Accuracy*

Medical accuracy, while defined clearly by scientific and medical communities,¹⁷⁴ is substantially less clear in sex education legislation. California's definition for medical accuracy¹⁷⁵ should be adopted by other states, and the federal government should incentivize adopting this definition. Implicit in this definition is completeness;¹⁷⁶ omission of important information renders a sex education program medically

171. NEV. REV. STAT. § 389.036 (2015).

172. *Id.*

173. *See, e.g., id.*; IDAHO CODE § 33-1608 (2015); MO. REV. STAT § 170.015 (2015); ARIZ. REV. STAT. § 15-711 (2001).

174. John S. Santelli, *Medical Accuracy in Sexuality Education: Ideology and the Scientific Process*. 98 AM. J. PUB. HEALTH 1786 (2008).

175. *See* text accompanying note 61.

176. Santelli, *supra* note 174, at 1788.

inaccurate. Some states do not require medical accuracy.¹⁷⁷ Others require medical accuracy, but fail to define it.¹⁷⁸ A few states provide a definition for medical accuracy that is complete and appropriate,¹⁷⁹ while others provide a definition that is unclear or inconsistent with scientific fact.¹⁸⁰

Many sex education programs are inconsistent with scientific fact, even those programs that are supposed to be comprehensive.¹⁸¹ Abstinence-only education programs often fail to teach basic facts about reproductive health and contraception.¹⁸² Even worse than their failure to teach basic facts is their reliance on misrepresentation of fact. A study of abstinence-only programs reported that eleven of thirteen reviewed abstinence-only curricula contained “false, misleading, or distorted information about reproductive health.”¹⁸³ Programs include information unsupported by scientific fact; some programs state that condoms are ineffective in preventing the spread of STIs and that they are an ineffective means of preventing HIV.¹⁸⁴ Some programs treat religious belief as scientific fact¹⁸⁵ and use invented statistics to discourage behavior that some religious groups find morally objectionable.¹⁸⁶

Misinformation is a problem because students cannot make informed decisions without an accurate and complete factual basis. A popular film, *Mean Girls*, comments on the state of sex education in the United States. A teacher, Coach Carr—who misspells chlamydia on the chalkboard—provides the following instruction to his students in two separate sex education classes:

Don't have sex, because you will get pregnant and die. Don't have sex in the missionary position. Don't have sex standing up. Just don't do it, okay? Promise?

177. See, e.g., ALA. CODE § 16-40A-2 (2015); ARK. CODE § 6-18-703 (2015); DEL. ADMIN. CODE 14-851 (2015); FLA. STAT. §§ 1003.42, 1003.46 (2015); IDAHO CODE § 33-1608 (2015).

178. See, e.g., ARIZ. REV. STAT. § 15-716 (2015); MICH. COMP. LAWS § 380.1169 (2015).

179. See, e.g., COLO. REV. STAT. § 22-25-103 (2015); CONN. STATE DEP'T EDUC., GUIDELINES FOR THE SEXUAL HEALTH EDUCATION COMPONENT OF COMPREHENSIVE HEALTH EDUCATION 7 (2012); 105 ILL. COMP. STAT. 5/27-9.1 (2015); IOWA CODE § 279.50 (2015).

180. Schalet et al., *supra* note 162, at 1599.

181. See generally, Waxman Report, *supra* note 46, at i-ii; see also Schalet et al., *supra* note 162, at 1605.

182. Waxman Report, *supra* note 46, at 8.

183. Santelli, *supra* note 174, at 1787;

184. Waxman Report, *supra* note 146, at 9-10.

185. *Id.* at 15.

186. *Id.*

At your age, you're going to have a lot of urges. You're going to want to take off your clothes and touch each other. But if you do touch each other, you will get chlamydia and die.¹⁸⁷

While obviously intended to be satirical, this illustrates a common problem in sex education—simplistic descriptions of sexual activity and fear-mongering without any legitimate basis. Chlamydia is not spread by touching other people; it is almost exclusively spread during unprotected vaginal, oral, or anal sex with an infected person.¹⁸⁸ Chlamydia is also not deadly, even if left untreated.¹⁸⁹ Though Coach Carr's repeated assertion that having sex results in death seems like it is exaggerated for comedic effect, it is actually an accurate depiction of what is taught in an abstinence-only classroom. One federally funded abstinence program actually states that, if a student has sex and the condom fails, "you have a death: your own."¹⁹⁰ A sex educator who teaches at thirty-eight high schools throughout Tennessee asserted that "there's a new STD that they're saying is going to be the new AIDS. It's deadly and it's fast. Like, before you even know you have it, it's gone beyond treatable."¹⁹¹ The speaker attributed this information to HHS, but the department was "unaware of the discovery of a new STD as deadly as AIDS."¹⁹² Scare tactics are ineffective because teenagers consistently fail to accurately assess risks.¹⁹³ Additionally, these tactics reduce educators' credibility and spread misinformation.¹⁹⁴

Federally funded abstinence-only programs "rely on the false idea that HIV and other pathogens can 'pass through' condoms,"¹⁹⁵ despite numerous peer-reviewed studies showing that condoms are effective in preventing disease transmission.¹⁹⁶ Some programs indicate that condoms

187. MEAN GIRLS (Paramount Pictures 2004).

188. CTRS. DISEASE CONTROL & PREVENTION, *Chlamydia – CDC Fact Sheet*, CDC, <http://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm> (last updated May 19, 2016).

189. *Id.*

190. Waxman Report, *supra* note 46, at 10.

191. Virginia Pelley, *Dear Teenagers: If You're Not a Virgin, You're Like a Dirty Old Toothbrush—Sincerely, Your School*, DAILY BANTER (Nov. 11, 2013), <http://thedailybanter.com/2013/11/dear-teenagers-if-youre-no-longer-a-virgin-youre-like-a-dirty-old-toothbrush-sincerely-your-school/>; see also Hall, *supra* note 3.

192. Hall, *supra* note 3.

193. See generally Erin Ross, *How Teens' Pentant for Risk-Taking May Help Them Learn Faster*, KQED NEWS (Oct. 7, 2016), <https://ww2.kqed.org/mindshift/2016/10/07/how-teens-penant-for-risk-taking-may-help-them-learn-faster/>.

194. See Hall, *supra* note 3.

195. Waxman Report, *supra* note 46, at 9.

196. See, e.g., Grace A. Alfonsi & Judith C. Shlay, *The Effectiveness of Condoms for the Prevention of Sexually Transmitted Diseases* 1 CURRENT WOMEN'S HEALTH REV. 151

fail more often than they do and suggest that this failure is due to the failure of the condom itself, rather than inconsistent or improper use.¹⁹⁷ Others try to discourage non-intercourse sexual activity through providing misleading information about ways pregnancy can occur;¹⁹⁸ some curricula indicate that merely touching a partner's genitals can result in pregnancy,¹⁹⁹ making it more difficult for students to make informed choices.

Mandating medical accuracy would also prevent programs from expressing religious bias.²⁰⁰ Even if programs were not required to address the needs of a variety of sexual orientations and gender identities, medical-accuracy requirements would prevent the dissemination of incorrect or incomplete information. For example, Arizona requires that sex education programs inform students that the principal way HIV is transmitted is through homosexual sex but also prohibits discussion of condoms except in the context of their failure rates.²⁰¹ This is misleading. Though having anal sex is the "highest-risk sexual behavior,"²⁰² it is only a risk with someone with HIV. It is risky whether the people involved are the same gender or not. Also, there are methods for preventing HIV transmission, even with an infected partner.²⁰³ It also assumes that all homosexuals are biological males having anal sex, which is not the case.

Medical accuracy is not only important in the context of education about disease and pregnancy prevention; it is vital for family-planning information to be accurate and complete. It is in this area that religious bias

(2005); Maria Gallo et al., *Self-Reported Condom Use is Associated with Reduced Risk of Chlamydia, Gonorrhea, and Trichomoniasis*. 34 *SEXUALLY TRANSMITTED DISEASES* 829 (2007).

197. See Waxman Report, *supra* note 46, at 12.

198. *Id.*

199. *Id.*

200. IDAHO CODE § 33-1608 (2016) (stating that the responsibility for sex education "rests upon the home and the church" and referring to the "miracle of life"); NEV. REV. STAT. § 389.036 (2016) (requiring that curriculum development include a religious professional); OKL. STAT. TIT. 70 § 11-103.3(D) (2016) (requiring that HIV/AIDS prevention education teach students that homosexual sex is responsible for most AIDS infections); S.C. CODE. § 59-32-30(A)(5) (2016) (referring to homosexuality as an "alternative lifestyle" and prohibiting discussion of homosexuality outside of its relationship to the transmission of diseases); ALA. CODE § 16-40A-2(c)(8) (2016) (mandating that programs emphasize that "homosexuality is not a lifestyle acceptable to the general public"); ARIZ. REV. STAT. § 15-716(C) (2016) (preventing programs from suggesting "that some methods of sex are safe methods of homosexual sex"); LA. STAT. § 17:281(A)(b)(3) (2016) (prohibiting materials that describe or depict homosexual activity).

201. ARIZ. REV. STAT. § 15-716 (2015).

202. CTRS. DISEASE CONTROL & PREVENTION, *HIV Transmission*, CDC, <http://www.cdc.gov/hiv/basics/transmission.html> (last updated Sept. 6, 2016).

203. CTRS. DISEASE CONTROL & PREVENTION, *HIV Basics*, CDC, <http://www.cdc.gov/hiv/basics/prevention.html> (last updated July 12, 2016).

has the strongest effect; many programs are explicitly prohibited from addressing abortion.²⁰⁴ This prevents students from receiving a complete education regarding their choices, resulting in an inability to make informed decisions. Those programs that do address abortion often provide factually incorrect information about abortion.²⁰⁵ One program reports that abortions cause sterility;²⁰⁶ another states that having an abortion can cause subsequent pregnancies to result in premature birth or miscarriage.²⁰⁷ Abortions do not affect fertility²⁰⁸ or future pregnancies.²⁰⁹ Another program indicates that a fetus has brain wave patterns at forty-three days and that ten weeks after conception, the fetus can hear and see.²¹⁰ This is inaccurate; even the study to which the program cites acknowledges that there is no evidence that fetuses can see and that fetuses only begin to react to sound between the fourth and fifth month of pregnancy.²¹¹ Including language in sex education statutes that mandates medical accuracy would ensure that students receive information that is accurate and complete, thus ensuring that students can make informed decisions about sex.

Medical and scientific communities have processes for ensuring that information provided to the public is accurate.²¹² Professional organizations “promote scientific consensus by offering scientific opinions”²¹³ about important policy issues like sexuality education. Before opinions are disseminated to the public, they are rigorously reviewed for accuracy and clarity.²¹⁴ Without such review, sexual education programs will lack accuracy and clarity. Without any regulation, legislators, boards of education, and local school districts have the discretion to introduce curricula that are not based in fact and that do not effectively teach

204. See, e.g., MICH. COMP. LAWS § 380.1507(8) (2016) (stating that “clinical abortion shall not be considered a method of family planning, nor shall abortion be taught as a method of reproductive health.”); MISS. CODE ANN. § 37-13-171(6) (2016) (prohibiting programs from teaching “that abortion can be used to prevent the birth of a baby”).

205. Waxman Report, *supra* note 46, at 13.

206. *Id.*

207. *Id.*

208. DEP’T OF HEALTH & HOSPITALS, *Abortion & Pregnancy Rates*, LOUISIANA.GOV, <http://dhh.louisiana.gov/index.cfm/page/915/n/275> (last visited Jan. 17, 2016).

209. *Id.*

210. Waxman Report, *supra* note 46, at 16.

211. *Id.*

212. See generally John S. Santelli, *Medical Accuracy in Sexuality Education: Ideology and the Scientific Process*, 98 AM. J. PUB. HEALTH 1786 (2008).

213. *Id.* at 1787.

214. *Id.*

students anything. Eliminating this discretion guarantees that students have information necessary to their health and safety.

D. Passive Consent with an Opt-Out Provision

One of the main arguments against instituting mandatory sex education—even mandatory abstinence-only education—is that sex education is an issue of private values best taught by parents in the home or at a religious institution, rather than by schools.²¹⁵ Every state with a sex education statute mitigates this issue by excusing students from classes they or their parents find objectionable. In some states, this means that students can opt out without specifying a particular reason,²¹⁶ and in others, it means that students can opt out for religious or moral reasons.²¹⁷ A few states have opt-in provisions, under which parents must provide active consent prior to their children’s receiving sex education.²¹⁸

An opt-out policy should be the standard for sex education because it is important for students to have access to sex education unless they have a particular objection to the content. The opt-out policy promulgated should be broad enough to allow parents or guardians with religious objections to curricula to choose to shield their children from material they consider objectionable. However, the opt-out process should be narrow enough that students still receive components of sex education. As it stands, many states have programs allowing parents access to curricula before their children receive any sex education.²¹⁹ Allowing parents to opt

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215. *See, e.g.*, IDAHO CODE § 33-1608 (2016) (describing the legislature’s belief that it is “the primary responsibility for family life and sex education, including moral responsibility, rests upon the home and the church” and that schools are supposed to “complement and supplement those standards which are established in the family”).
216. *See, e.g.*, ARIZ. REV. STAT. §15-716 (2016) (providing that “at the request of a parent, a pupil shall be excused” from HIV/AIDS instruction); FLA. STAT. § 1003.42 (2016) (allowing a “student whose parent makes written request to the school principal” to be “exempted from receiving instruction about reproductive health”); IDAHO CODE § 33-1611 (2016) (providing that “any parent or legal guardian who wishes to have his child excused from any planned instruction in sex education may do so upon filing a written request to the school district board of trustees”).
217. *See, e.g.*, MICH. COMP. LAWS § 380.1170 (2016) (allowing parents to request exemption if “instruction in the characteristics or symptoms of disease is in conflict with his or her sincerely held religious beliefs”).
218. *See, e.g.*, MISS. CODE ANN. § 37-13-173 (2016) (providing for a “right to request inclusion of children in” sex education classes); NEV. REV. STAT. § 389.036(4) (2016) (requiring parental consent forms).
219. *See, e.g.*, IOWA CODE § 279.50(3) (2016) (requiring the school boards to “provide to a parent or guardian of any pupil enrolled in a school district information about the human growth and development curriculum used in the pupil’s grade level”); MASS. GEN. LAWS ch. 79 § 32A (2016) (indicating that, “to the extent practicable, program instruction materials for [sexual education] curricula shall be made reasonably accessible to parents [and] guardians . . . for inspection and review.”); MICH. COMP. LAWS § 380.1507(5)(c) (2016).

out of specific portions of curricula would respect families' religious beliefs while still ensuring that students have access to important materials. To provide students with the most complete sex education possible while still respecting their religious needs, schools should allow an opportunity to review curricula, as provided in some states. Parents could then choose to remove their children from specific portions of curricula without removing them from the class entirely. Giving parents the opportunity to review curricula may also make parents more comfortable with their contents by reducing their fear that their child will receive inappropriate information.

Ideally, making the process more rigorous would have the effect of deterring parents and guardians from opting out unless they truly object and ensuring that students receive the education to which their parents do not object. If the process for opting out is more complicated and opt-out requests are certain to be vetted, parents might be less likely to speciously seek to exempt their children. Additionally, providing a method that would allow parents to opt out of specific components of curricula without removing their children entirely from the program will improve students' access to information. To ensure that all students have adequate access to sex education while accommodating parents' objections, states should adopt a system in which parents passively consent to sex education and can object to lessons that conflict with their religious beliefs.

E. Addressing the Needs of Lesbian, Gay, Bisexual, and Transgender Youth

The federal government should not fund sex education programs that discriminate against lesbian, gay, bisexual, and transgender ("LGBT") students. Most states do not address how to accommodate LGBT students. Those that do address LGBT students often do so in a negative way.²²⁰ At a minimum, states should remove discriminatory language and factually incorrect information about LGBT people. Alabama's sex education statute requires that all sex education programs emphasize that homosexuality is unacceptable.²²¹ Arizona's statute prohibits programs from teaching methods for safe homosexual sex and implies that there are none.²²² In South Carolina, sex education programs "may not include a discussion of alternate sexual lifestyles from heterosexual relationships."²²³ This deprives

220. See, e.g., ALA. CODE § 16-40A-2(c)(8) (2016) (indicating that sex education classes must have "an emphasis . . . that homosexuality is not a lifestyle acceptable to the general public"); ARIZ. REV. STAT. § 15-716(C) (2016) (stating that schools are not allowed to propagate any curriculum that "promotes a homosexual lifestyle, portrays homosexuality as a positive alternate life-style, [or] suggests that some methods of sex are safe methods of homosexual sex."); FLA. STAT. § 1003.46(2)(a) (2016) (requiring that sex education programs "teach abstinence from sexual activity outside of marriage as the expected standard for all school-age students while teaching the benefits of monogamous heterosexual marriage").

221. ALA. CODE § 16-40A-2 (2015).

222. ARIZ. REV. STAT. § 15-716 (2015).

223. S.C. CODE ANN. § 59-32-30 (2015).

non-heterosexual students of information that is instrumental in protecting them from the undesirable outcomes of sex. It also eliminates an opportunity to be supportive; students struggling with their sexualities and gender identities are marginalized or attacked under current statutes.

The federal government should require that programs do more than just refrain from discriminating; they should fund programs that address the needs of LGBT students. The provision adopted in California should be the standard for appropriately addressing the needs of LGBT youth. California mandates that sex education programs

shall affirmatively recognize that people have different sexual orientations and, when discussing or providing examples of relationships, shall be inclusive of same-sex relationships . . . shall teach pupils about gender, gender expression, gender identity, and explore the harm of negative gender stereotypes.²²⁴

Further, sex education cannot “reflect or promote bias.”²²⁵

It is important to affirmatively address the needs of LGBT students. Students who are not heterosexual or who do not identify with the gender they were assigned at birth often feel marginalized in their daily lives.²²⁶ Biased sex education can make such students feel even more isolated because curricula treat heterosexuality as normal and expected and homosexuality as inappropriate, immoral, and unhealthy.²²⁷ These feelings of isolation cause emotional distress, leading to higher rates of depression, self-harm, and suicidal ideation among LGBT students than among heterosexual and non-transgender students.²²⁸

LGBT students also experience different types of risk than non-LGBT students. LGBT youth are more likely to experience dating violence and sexual assault than non-LGBT youth.²²⁹ Young men who have sex with men

224. Cal. Educ. Code § 51934 (West 2015).

225. *Id.*

226. See, e.g., *Lesbian, Gay, Bisexual, and Transgender Persons & Socioeconomic Status*, AM. PSYCHOLOGICAL ASSOCIATION, <http://www.apa.org/pi/ses/resources/publications/factsheet-lgbt.aspx> (last visited Mar. 12, 2016).

227. Josh A. Goodman, *5 Reasons Schools Should Adopt LGBTQ-Inclusive Sex Ed.*, HUFFINGTON POST (Oct. 30, 2013, 5:12 AM), http://www.huffingtonpost.com/josh-a-goodman/lgbtq-inclusive-sex-ed_b_3834914.html.

228. Joanna Almeida et al., *Emotional Distress Among LGBT Youth: The Influence of Perceived Discrimination Based on Sexual Orientation*, 38 J. YOUTH ADOLESCENCE 1001, 1001 (2009).

229. CTRS. DISEASE CONTROL & PREVENTION, *LGBT Youth*, CDC, <http://www.cdc.gov/lgbthealth/youth.htm> (last updated Nov. 12, 2014).

are more likely to contract HIV than any other group,²³⁰ a risk that is significantly reduced by proper condom use.²³¹ LGBT youth are also more likely to engage in unprotected sex.²³² It is important that sex education teach students to use condoms properly, as they are less effective in protecting against disease when they are used incorrectly.²³³ Laws preventing schools from doing so adversely impact their students, especially those who are at higher risk for HIV. Laws that require teachers to tell students that there is no way to make homosexual sex safer also adversely impact their LGBT students. These curricula repeatedly tell LGBT students that there is no way to protect themselves from disease or that attempts to protect themselves will fail. Because LGBT youth are already at a high risk of engaging in unprotected sex, this further endangers students who have no other access to sex education.

IV. Solving the Problem

The federal government should cease funding abstinence-only education curricula through AEGP and other abstinence-only programs. As a first step, AEGP and programs like it should not be renewed when they expire. The last year for which funding is provided for AEGP is 2017.²³⁴ Congress should not amend the statute to extend funding beyond 2017. Next, Congress should enact a federal statute under which states can receive funding for in-school comprehensive sex education programs. To receive funding for these programs, states should be required to promulgate evidence-based, non-discriminatory standards for sex education. California's Healthy Youth Act should serve as a template for the implementation of such standards.

Such a statute is within Congress's spending power. For an exercise of Congress's spending power to be legitimate under the test set out in *South Dakota v. Dole*, it must be "in pursuit of the general welfare" and cannot be otherwise unconstitutional.²³⁵ An exercise of spending power may be considered illegitimate if it is "unrelated to the federal interest in particular

230. CTRS. DISEASE CONTROL & PREVENTION, *Surveillance Overview*, CDC, <http://www.cdc.gov/hiv/statistics/surveillance/incidence.html> (last updated May 26, 2015).

231. Steven D. Pinkerton & Paul R. Abramson, *Effectiveness of Condoms in Preventing HIV Transmission*, 44 SOC. SCI. & MED. 1303, 1310 (1997); see also Steven D. Pinkerton & Paul R. Abramson, *Updated Estimates of Condom Effectiveness*, 9 J. ASS'N NURSES AIDS CARE 88, 88 (1998).

232. JASON CIANCOTTO & SCOTT CAHILL, *LGBT YOUTH IN AMERICA'S SCHOOLS* 53 (2012).

233. B. Stanton et al., *Condom-use Skills Checklist: A Proxy for Assessing Condom-use Knowledge and Skills When Direct Observation is Not Possible*, 27 J HEALTH, POPULATION & NUTRITION 406, 406 (2009).

234. Medicare Access and CHIP Reauthorization Act, *supra* note 32.

235. *South Dakota v. Dole*, 107 S. Ct. 2793, 2796 (1987).

national projects or programs.”²³⁶ If Congress conditions receipt of federal funds, it must do so “unambiguously.”²³⁷

If AEGP meets each element of the *Dole* test, a comprehensive sex education program would do so as well. A comprehensive sex education program is certainly in pursuit of the general welfare and related to the federal interest in current programs associated with adolescent health. *Dole* also prohibits financial inducements from being “so coercive as to pass the point at which pressure turns into compulsion.”²³⁸ In *Dole*, the financial inducement Congress offered was the loss of highway funding if states did not adopt a drinking age regulation. In *National Federation of Independent Business v. Sebelius*, a recent Supreme Court decision that examined coerciveness, the Court decided that the part of the Affordable Care Act conditioning the entirety of a state’s Medicaid funding on its compliance with the Act’s requirements was coercive.²³⁹ The recommended program is not similar to the programs at issue in either *Dole* or *National Federation of Independent Business v. Sebelius* because states would not lose funding they currently receive. Coercion is not an issue.

Sex education should be mandatory in states that accept funding; state governments should require that all public schools provide comprehensive sex education. In most states, this would require statutory amendments. Different states would require different changes, both in content and degree. California, for example, would not need to amend its statutory provisions for sex education to receive the funds, while Alabama’s statute would require significant changes.

The same process currently ensuring compliance with AEGP standards should be applied to all curricula in states that accept funding under the recommended program, with an additional provision for ensuring medical accuracy according to the California Healthy Youth Act’s definition. States that receive funding should also ensure that their curricula include information about how STIs are spread and how to avoid contracting them. Curricula should also contain information about preventing pregnancy through contraception and through abstinence, as well as every option for those who become pregnant, including adoption, parenting, and abortion. Finally, under the recommended program, all curricula should address the needs of LGBT students, and minority students.

V. Conclusion

The federal government should stop funding abstinence-only sex education programs. Instead, it should fund medically accurate and complete sex education according to the definitions provided in the

236. *Id.*

237. *Id.*

238. *Id.* at 2798.

239. *Nat’l Fed’n of Int’l Bus. v. Sebelius*, 132 S. Ct. 2566, 2604 (2012).

California Healthy Youth Act. Material should be factual and unbiased, rather than fear mongering and alarmist. These programs should be comprehensive, including support for abstinence and information about safe practices and pregnancy-outcome choices in the event students choose not to abstain. Programs should also provide parents with the opportunity to review curricula and exempt their children from specific lessons they find objectionable. They should also address the needs of minority groups and avoid discriminatory language and content. A program that meets these criteria will aid in achieving what should be sex education's primary goals: reducing teen pregnancy, reducing the spread of sexually transmitted infections, and helping students make healthy and safe choices.