New York City
Sexuality Education
Report

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INTRODUCTION

On August 9th, 2011, the City of New York issued a mandate requiring all public schools to offer mandatory sexual education. The following is a detailed analysis of the four curricula recommended by the NYC Department of Education (DOE) for use in all public schools: HealthTeacher, HealthSmart, Reducing the Risk and the DOE’s own HIV/AIDS curriculum supplement. HealthTeacher is for Grades K-5, HealthSmart for Grades 6-12, and Reducing the Risk is the recommended HIV/AIDS curriculum for Grades 9-12 with the DOE’s curriculum acting as a supplement for Grades K-12.¹ The three curricula not by the DOE are published by Education, Training, Research Associates (ETR), which was developed in 1981 as the education department of Planned Parenthood in Santa Cruz, CA but now operates as a private, non-profit organization.²

The intent of this report is to assess whether the content of the current programs is comprehensive, evidence-based, age-appropriate and medically accurate. Our analysis reveals a number of significant flaws in each of these areas.

In looking at the New York City sexual education programs and curricula, a variety of factors were examined. These factors are addressed one by one in this report. They include looking at the definition of sexuality and sexual activity, the approach taken to the discussion and promotion of abstinence, and essential concepts relating to risk reduction vs risk avoidance strategies.

In addition to examining the curricular materials, supplemental resources for teachers and students were assessed.

Finally, an analysis is provided of curriculum treatment of controversial topics, which included noting inappropriate and inadequate treatment of subjects such as abortion.

The report concludes by highlighting a number of the flaws in the curriculum, and identifying ways in which it does not achieve its stated goals. Given the importance of the development of healthy behaviors and attitudes among our city’s young people, rectifying these problems in the current materials and program should be an urgent priority.
PART ONE: Definitions

A. “Sexuality”

The Merriam-Webster dictionary defines “sexuality” as: the quality or state of being sexual: a: the condition of having sex b: sexual activity

“Sexual” is defined as 1: of, relating to, or associated with sex or the sexes <sexual differentiation> <sexual conflict> 2: having or involving sex <sexual reproduction>³

But when the term is defined for students, an altogether different understanding is encouraged.

[Sexuality]… is integral to people’s identities as males or females; as family members; as participants in relationships; as members of society. Sexuality can be affirmed, even as abstinence from sexual intercourse is emphasized…⁴

Sexuality encompasses more than “the birds and the bees,” students are informed, and it is not limited to a specific relationship or time of life.

…sexuality is also a wonderful and natural part of the teen years…Healthy sexuality has the power to be a positive element in young people’s lives.⁵

Here are some ways sexuality can have a positive influence on young people, even when they’re not sexually active:

- **It’s a natural part of growing older.** Sexuality is one aspect of the exciting process of growing up.

- **It’s part of becoming a healthy adult.** Sexuality draws young people toward intimacy as they learn to relate to romantic partners. They learn key skills for adulthood.

- **It’s a source of healthy energy.** Elements of sexuality can help teens improve their social skills, explore their creativity and show enthusiasm.

- **It feels good…** A boy notices a spark of excitement when he sees someone he’s attracted to. A girl cries at the ending of a romantic movie. A class feels pride about speaking up against antigay violence…⁶

National surveys indicate that a strong and widespread majority of parents are opposed to pre-marital sex both in general and for their own adolescent.⁷ Parents want their teenagers to be taught to abstain from sexual activity.⁸ The wishes of these parents are undermined when children are taught that sexuality is a natural part of adolescence; the very idea is counterproductive to the Department of Education’s goal to
promote abstinence. The claim, “sexual expression can have a positive influence on young people” endorses early sexual debut, notwithstanding the disclaimer, “even when they are not sexually active.” Instructing teens that sexuality helps them explore their creativity and teaches skills for adulthood certainly does not further the interests of parents who want their children to wait until marriage, or at least adulthood.

Moreover, once students are taught that sexuality is “integral” to their identity, “a wonderful” and “positive” element of their lives - their current lives — the idea that it is an appetite in need of restraint sounds inconsistent; waiting years for the right time and person doesn’t make sense. Instead, the takeaway lesson for them is that sex, whether in middle, high school, or adulthood, in or outside of a committed and monogamous relationship, is “positive” and “healthy.”

In fact, this may be precisely what the authors of these programs believe. A chart in the NYC Department of Education’s HIV/AIDS curriculum indicates that “increased sexual activity and experimentation” is a feature of the normal psychosocial development of middle adolescence. But this is faulty thinking. Normal adolescence is characterized by increased sexual interest and appetite; teens then have a choice, as they do with all appetites, how to respond to their urges. While sexual activity is currently common among teens, that finding in and of itself does not speak to whether the behavior is normal or healthy.

Furthermore, the organizations to which teachers are referred include Planned Parenthood and SIECUS (Sexuality Information and Education Council of the United States) - these groups tell children that sexuality extends from cradle to grave; they instruct adults to explain intercourse to five-year-olds and let them know they have “body parts that feel good when touched.”

But this approach to teaching children about sexuality is not shared by experts in child development. The American Association of Child and Adolescent Psychiatry explains in “Talking To Your Kids About Sex” that children have different levels of curiosity and understanding depending upon their age and level of maturity. Because of this, parents should follow the child’s lead and “respond to the needs and curiosity level of their individual child, offering no more or less information than their child is asking for and is able to understand.”

So from a child development perspective, the advice given parents by Planned Parenthood and SIECUS is too much, too soon. And providing too much information to a child, information that cannot be easily absorbed, can be harmful.

If educators believe that sexual behavior, as opposed to sexual appetite - is part of normal adolescent development, how can they encourage teens to embrace abstinence? The answer lies in their definition of that term.
B. “Sexual Activity”

We know from national surveys and studies that young people are confused about what is meant by “sex”, “safe sex”, and “abstinence.” For example, in one survey, 63% said they had “never had sex,” but of those, 13% had had oral sex. In another, 46% indicated using birth control pills was “safe sex.”

Surely, prior to any discussion about prevention of pregnancy and STDs, key terms must be defined. Indeed, an emphasis is placed throughout all the programs reviewed for this report on the importance of clarity and effective communication in teaching about reproductive health.

But consider the inconsistent manner in which the key term “sexual activity” is used in two books belonging to the HealthSmart series. In one handbook students learn that

sexual activity refers to any action that might lead to pregnancy or an STD.

But a different handbook lists the following as “sexual activities:”

- Touching, hugging, massage, rubbing bodies together with clothes on
- Masturbation, alone or with a partner
- Talking about sex, sharing verbal fantasies
- Kissing or licking the body (clean skin; no oral contact with genitals or open sores)
- Whatever else people can come up with that doesn’t involve blood, semen, or vaginal fluids.

This is not coherent. According to the first handbook, the above behaviors are not sexual activities. According to the second, they are. There is no clarity, even with the meaning of this fundamental concept.

C. “Risky Behavior”

Throughout the material reviewed, the term “risky behavior” is used often. To what does it refer? Health Smart, for example, claims to target risky behaviors such as… teen sex, and tobacco and alcohol use… suggesting it includes all teen sexual activity.

But a review of the HealthSmart publications focused on reproductive health and sexuality indicates that the term is used in an inconsistent and confounding manner. Consider the list of activities provided above; these behaviors are described as “low risk”. But for what reason? They present no possibility whatsoever of pregnancy or STD. Another list, one that includes vaginal or anal intercourse with a condom, is described to students as having “some risk.” It would appear that talking about sex and having sex are both risky, but to a different degree. This is puzzling.
In most instances, as demonstrated in the following examples, “risky behavior” refers to sex without a condom. Intercourse with a condom is not considered “risky”- to the contrary, it can be a responsible and healthy choice for teens - as responsible and healthy as abstaining. More often than not, students are taught that abstinence and “safer sex” both help “avoid” or “prevent” STDs, HIV, and pregnancy. In other words, there are two good choices: refraining from sexual activity, and intercourse with a condom. The consistent failure to highlight and reinforce the differences between abstinence and sex with condoms is one of the major flaws of the curricula.

Examples:

1. Teachers are instructed to advise students on how to avoid high risk situations, defined as “situations that can lead to unwanted or unprotected sex.” Teachers are to

   Remind students that there are two ways to avoid pregnancy and HIV: say no to sex, or use protection.

In ETR’s Reducing the Risk, students are instructed to watch for signs that “an unprotected sex crisis” could happen.\(^{21}\) Depending on their urgency, students are told, these signs could constitute either a yellow or red alert.

   Red alert signs show that there’s going to be an unprotected “sex crisis” at any moment and you have to act fast to avoid it. Red alert signs usually occur about 20 minutes to an hour before the crisis when:

   - You’re alone with the other person
   - You may have done a lot of touching and are feeling close.

Students are advised,

   You can still stop and decide not to have sex or you can still use protection. But if you go past a red alert signal without stopping and/or preparing first, your life may be forever changed.

This is misleading, because a student’s life could be forever changed – by a pregnancy, an incurable infection, or by an emotional reaction she or he is not equipped to handle – even if a condom is used: Every health provider has seen patients facing a pregnancy or an STD who insist, “but we used a condom, every time!”\(^{22}\) The point is all sexual activity, with or without a condom, is risky and this is particularly so in adolescence. It is inaccurate to equate sex with a condom with abstaining from sex (“there are two ways to avoid pregnancy and HIV: say no to sex, or use protection”; “if you go past a red alert signal without stopping and/or preparing first, your life may be forever changed”) because the former carries considerable risk, as will be detailed below, while the latter is completely risk-free.
By means of comparison, we would not instruct students that cigarettes with a filter provide the same degree of protection against the harmful consequences of nicotine as not smoking.

Students who are abstinent can be 100% certain they’ll avoid pregnancy and genital infections. It’s critical that students understand this reality.

2. In a role play activity called “Not without a condom,” a student negotiates with his or her partner, insisting he use a condom. This activity, teachers are informed, guides students in developing negotiation skills to avoid engaging in risky sexual activity.28

3. Teachers are directed to ask their class,

> What are some benefits of graduating from high school without getting pregnant or being infected with an STD, including HIV?29

Need it be said that, for a program whose stated goal is to encourage abstinence, the question for students should be: what are the benefits of graduating from high school without having been sexually active? Again, the focus is on condom use, not delaying sexual activity.

4. Students are assigned to visit two stores where contraceptives are sold. They complete a “Shopping Information Form” for each location, describing what “protective products” are sold. Students list 3 kinds of condoms - indicating brand name, price, whether lubricated or not, whether reservoir or plain - and 1 kind of foam. They rank how comfortable they would be buying protection at these stores, and whether they would recommend either location to a friend. Finally, the student provides each store’s hours of business.30 The message is clear: if condoms are used, sexual intercourse during adolescence is a responsible choice.

D. “Abstinence”

The definitions of abstinence are more precise and consistent. However, parents may not agree with them.

> …abstinence means choosing not to do any sexual activity that carries a risk for pregnancy or STD. By this definition, vaginal, anal, and oral sex are all forms of sexual activity. So is sexual touching (directly touching a partner’s genitals), because it can pose a risk for certain STDs.

Elsewhere, regarding HIV avoidance for middle school:

> Abstinence …means no vaginal, anal, or oral sex. It doesn’t mean you can’t be close, but it does mean keeping somebody else’s blood, semen or vaginal fluids out of your body.36
When parents say they want their children to delay sexual behavior, it is doubtful they are referring solely to “the exchange of body fluids.” When abstinence means avoiding only “those activities that carry a risk of pregnancy or infection,” an endless variety of highly arousing scenarios are still available.

As things stand, students in sixth grade and up are led to believe they can do very sexual things, and still be considered “abstinent.” Having been introduced in school issued material to the idea of “kissing or licking the body,” they may decide to do precisely that, believing their choice represents “abstinence” - the healthiest, most responsible choice, the one their parents support. How is this justified? In light of the curriculum’s claim to respect students’ “cultural and family values,” it’s a question that must be clarified.

**PART TWO: Is abstinence right for you?**

Given the very limited parameters of “sexual activity,” are students at least given a firm, no-nonsense message to refrain from it? Are they instructed, unequivocally and authoritatively, to **JUST SAY NO** – as they are for tobacco, drugs, and alcohol?

Hardly. The message is ambivalent at best. Abstinence is ideal, students learn, but, well, it may not be ideal for them.

**A. Red Light, Green Light**

The opening chapter of ETR’s *Health Facts: Abstinence* states abstinence “is the most common and healthiest choice teens can make.” The benefits are many: staying healthy, not getting pregnant, following beliefs and morals, earning the respect of family and friends, doing what’s right for you, focusing time and energy on other goals, not being a target of gossip, and having more free time to enjoy.

After all that, the question is posed,

*Does abstinence make sense for you? Knowing how you feel about sex can help you decide whether abstinence is the right choice in your life.*

Red light, green light. Abstinence is best, but students must decide if it’s right for them. It begs the question: if it’s indeed “best,” why would anything else be “right?” Nonetheless, with one exception - the HIV/AIDS curriculum, the “it’s up to you” message begins in middle school.

There are countless examples:

1. In an activity sheet called “Birth Control Choices,” the list includes abstinence, foam, condoms, pill, patch, ring, Depo-Provera, Implanon. Students indicate:

   *Which method would be best for you today? Why?*
Which method do you think would be best for you in 5 years? Why?

The teacher should summarize,

*Remember that there is no method that works equally well for everyone. It’s important to make an informed choice about the method that is right for you so that you can protect yourself when you are ready to have sex.*

2. A worksheet for students reads:

*Picture a time in your life when you would be ready to have sex. It may be now, next year, or when you’re married…*

3. Middle school teachers are instructed to say:

*One responsibility that comes with getting older is making the decision to remain abstinent or to become sexually active.*

After telling students, “the best decision for you right now is not to have sex,” teachers are to continue,

*When you’re older, you may decide to become sexually active…what are some things you could do to prevent pregnancy, HIV and other STDs?*

The teacher should list the student responses on the board and summarize:

*When you decide that you’re ready for sex, the best way to protect yourself from pregnancy, HIV and other STDs is to use a condom.*

4. During a condom demonstration, teachers should

*remind students that this information about condoms can be used if and when they decide they’re ready to have sex, which may not be for a long time.*

5. “What’s your advice?” is an activity for middle school. One scenario reads:

*I am an 8*th* grader. My boyfriend is a few years older than I am. I’ve told him I want to be abstinent until I’m older, but he’s been pressuring me to have sex with him ... Do you have any ideas about what I should do?*

One of the points to emphasize, the teacher is directed, is

*If she is confused at all, she should wait until she feels ready.*

Once again, even in the case of an eighth grade girl, it’s all about “feeling ready,”
6. From websites described to teens as reliable and authoritative:

...If you find yourself feeling confused about decisions related to sex, you may be able to talk to an adult… Keep in mind, though, that everyone’s opinion about sex is different. Even though another person may have useful advice to share, in the end, the decision is up to you.34

At every point in your life, you can choose if and how to express your sexuality… Most sexual behaviors involve some level of risk. It is up to you to determine how much risk you are willing to take.35

It would appear that students are taking this message to heart. A great many are deciding that, yes, I am older, I am mature, I am picturing the time of life when I am ready to have sex, and that time is now. That may help explain why 41% of the city’s 9th graders say they’ve had sex; four years later the number goes up to 58%. And one in five of those students have had sex with four or more people.36

In one student handbook, factors that increase the chance that a teen will take sexual risks are listed. Among the factors:

…Parents… might believe it’s OK for teens to have sex… Friends think it’s OK for teens to have sex…37

But when students are instructed, “only you can decide when you’re ready,” the curricula itself endorses teen sex. Is this method of reproductive health education part of the problem, or the solution? It seems a fair question to ask.

B. Double Standard

From ETR’s Health Facts: Reproductive Health:

Q: How old should you be to start having sex?

A: Each person has to answer this question for himself or herself. Young people need to think about the things that might be affected by this decision — time spent with friends, studying for classes, working on a career, or preparing for college. They also need to look at their values and what they believe is right.

It continues:

People who decide to have sex must be mature, responsible, and able to communicate with their partner. Neither person should feel pressured; both must accept the possible consequences of sexual activity, and take steps to prevent pregnancy and STD.
Finally, 

Most health care providers and educators agree that young people are more likely to reach their goals and avoid health risks if they wait until they’ve finished high school before becoming sexually active.  

This is ineffectual. Compare it to a question about cigarettes:

Q: How much can you smoke before it hurts your health?

A: When people first try smoking, they often feel dizzy and sick to the stomach. They may get a headache. Their throat and eyes burn. That’s because their bodies are reacting to a poison.

From the very first cigarette, smoking hurts a person’s health. It increases blood pressure and heart rate, constricts the blood vessels that supply the heart, and increases carbon monoxide levels in the blood. And every cigarette the person smokes from then on does damage.

Within a few months…smokers have trouble breathing…They start to have trouble waking up without a cigarette, staying alert without a cigarette, or calming down without a cigarette. They can’t keep up the way they used to in sports or active games. They panic if they run out of cigarettes.

Within a few years, the problems get worse. Trouble breathing and coughing are worse. They keep getting sick. A few years after that, smokers have a greater chance of getting cancer or heart disease that could kill them.

Granted, smoking tobacco is unhealthy for many people. It’s wise to never start. But there’s a double standard at work: while students are warned that tobacco is dangerous from their first puff, teen sex may or may not be a good idea.

If the same blunt approach was used to discourage sexual activity, the answer to “how old should you be to start having sex?” might read like this:

It’s possible to get an STD from one of the first times you have sex. You could discover warts on your penis or near your vagina or anus. Genital warts are ugly and embarrassing. To get rid of them, you may need to go to a doctor, who can use acid to burn them off. Even after treatment, the warts often return.

It’s also possible to get blisters on these same areas. Blisters on your private parts hurt a lot. Sometimes the pain is so severe that people have trouble walking, and they can’t go to school or work. It’s not an easy thing to explain. The blisters eventually disappear, but they tend to come back, especially when you’re under stress. An outbreak can ruin a vacation, prom, or wedding.
Another thing that could happen, even the first time, and even with a condom, is you or your partner could get pregnant. That’s a real life-changer, whether you give birth or have an abortion. There are entire books written about women and men who deeply regret ending their pregnancies.

Finally, you could get HIV. Sooner or later, HIV becomes AIDS, and AIDS will kill you.

How old should one be to start having sex? This is not a complex question requiring lengthy elaboration. Sex is for adults - both in years and maturity. When sex educators believe there’s no right or wrong answer to this question, when they say, “you must decide what’s right for you,” they are negligent. The evidence is overwhelming that students benefit from delaying sexual behavior, and the benefits go beyond the avoidance of pregnancy and sexually transmitted infections.

The negative consequences of intercourse constitute a crisis of significant magnitude in the United States, and the casualties are often born by youth. Nearly half of the estimated 19 million new sexually transmitted infections each year are in young people between the ages of 15 and 24.40

Adolescents who refrain from sexual activity do not get pregnant and remain free of genital infections. They also are free of worrying about these things, a significant advantage over their sexually-active peers. They gain in other ways, too. Significant, far-ranging benefits are associated with delaying sex until at least age 18. One study found that abstinent teens, when compared to sexually active teens, were:

- 60 percent less likely to be expelled from school;
- 50 percent less likely to drop out of high school;
- Almost twice as likely to graduate from college.41

This was the case even when controlling for social background factors such as race, parental education, family income, and family structure.

Abstinence by boys is associated with higher academic achievement,42 and by girls, with decreased rates of out-of-wedlock pregnancy and births, decreased single parenthood, increased marital stability, decreased maternal and child poverty, decreased abortion, decreased depression, and decreased rates of cervical cancer.43

When the question, “when is it OK to begin having sex?” is asked, the instructor should explain that the sex drive is wonderful and natural, but sex itself is serious business, and adolescents are not ready for it in any way. One cigarette won’t cause permanent damage, a teacher can point out, but a single sexual encounter can alter an entire life.
PART THREE: “Risk”

Risk assessment is a complex process. To effectively promote healthy decision-making, students must be taught to assess the risk of sexual activity. They must have a solid grasp of the limited efficacy of condoms, the dangers of early sexual debut and multiple partners, and of other factors that impact the risk of pregnancy, infection, and negative consequences of sexual behavior during adolescence.

This portion of the report demonstrates how the curricula fail to provide these skills. The risk of pregnancy and STDs are discussed below; risks related to HIV are considered later in the report. In each case, students are given a false sense of security: they are misinformed about the risks of sexual activity, and as a result, left vulnerable to its hazards.

A. “Protection” from Pregnancy, STDs

Central to the curricula is the reliance on condoms to prevent teen pregnancy and infection. How did this public health strategy originate and evolve, and what have we learned in the interim?

The use of condoms as a prevention strategy developed in the 1980s as a response to the HIV/AIDS epidemic. Because the virus is larger than the diameter of latex pores, condoms were, and still are, considered a barrier to HIV transmission, at least under laboratory conditions. In the ‘80s, groups at high risk for acquisition of the deadly infection through sexual behavior were strongly advised to use condoms. Sexual intercourse with a condom came to be known as “safe sex.” Since the device also acted as a contraceptive, people could, in theory, avoid both HIV and pregnancy with their use.

The notion of “safe sex” was institutionalized in the years that followed. The original idea - promoting condoms to prevent HIV among homosexuals, intravenous drug users, and their sexual partners - grew to include prevention of all sexually transmitted infections, as well as pregnancy, among all sexually active people, including adolescents.

The following decade brought epidemics of both herpes and HPV, and it became clear that practicing “safe sex” was sometimes not so safe. Health practitioners began using the term “safer sex” instead. But whether “safe” or just “safer,” the ‘80s paradigm – reliance on condoms to avoid pregnancy, STDs and HIV - was entrenched in medical practice, public health, and sex education.

Now, almost thirty years after the introduction of the “safe sex” strategy, we know much more about the efficacy of condoms in preventing pregnancy and sexually transmitted infections. We know that the efficacy is less, in some cases dramatically so, than was assumed. The curricula do a poor job of conveying this information to students.

While in some instances students are provided accurate statistics,
...the effectiveness rate [of condoms in preventing pregnancy] ranges from 85% to 98%\(^7\)

In many other places students are led to believe that condoms provide complete protection from pregnancy:

*Condom: a latex sheath used...to prevent pregnancy...*\(^8\)

While it could be argued that the 98% figure is very close to 100%, and that therefore use of the word “prevent” is justified, it should be noted that this high rate of prevention is achievable, according to studies, by adult couples with “perfect use” of condoms – correct use, every time. Much more common is “typical use” – the device is not worn for every act, and when it’s worn it’s occasionally used incorrectly. With “typical use” by adults, studies show pregnancy prevention falls to 85%.\(^9\) Taking into account their immaturity, use of alcohol before sex, and other factors, teens’ typical use of condoms could be expected to prevent pregnancy at a much lower rate.

These rates of condom efficacy are the same as those quoted by the manufacturers of Durex condoms, as found in the instruction pamphlet in the condom package.\(^50\)

Of interest is a study of over 10,000 women who received abortions; 54% reported having used contraception.\(^51\) The male condom was the most commonly reported method. 42% of condom users cited condom breakage or slippage as a reason for pregnancy. Other research on contraceptives demonstrated a probability of condom failure that was only one percentage point lower than probability of failure for withdrawal.\(^52\)

Among sexually active youth in New York City, 16% say they have been pregnant or gotten someone pregnant.\(^53\) In New York City in 2009, there were 21,902 pregnancies in teens nineteen and under.\(^54\) Of these, 573 were in girls under fifteen years old.\(^55\) How many of them put their trust in condoms? To teach students

*every time a couple has sex without protection, they risk getting pregnant*\(^56\)

as if the possibility of conceiving is eliminated with condoms, is irresponsible.

In a similar way, quantitative assessment of transmission of herpes, HPV, syphilis, Chlamydia and gonorrhea are withheld from students. These organisms, especially herpes and HPV, are highly prevalent;\(^57\) they can cause serious physical and emotional harm. However the curriculum, again, does not reflect the current state of medical knowledge. Fundamental terms are used in an inaccurate and inconsistent manner.

*While condoms do not offer complete protection from STDs…, they greatly reduce the risk…*\(^58\)

*Condoms are a good way to prevent STDs…*\(^59\)
Condoms help protect against other common STDs—gonorrhea, syphilis, chlamydia, and herpes.\(^{60}\)

While there is no doubt that proper use of condoms prevents some infections to some degree, research demonstrates levels of protection that many people would consider unacceptable. While it is not a simple matter to quantify the amount of protection that condoms confer from transmission of infection, the following data have been reported in authoritative, peer-reviewed journals:

Herpes: 30% lower risk\(^ {61}\)

HPV: 50-70%\(^ {62}\) lower risk; but some studies have shown no protective effect associated with condom use for women\(^ {63}\)

Chlamydia and gonorrhea: 50% lower risk\(^ {64}\)

Syphilis: 50% reduction\(^ {65}\)

Students should be told that these are conservative estimates, and many questions remain unanswered. In one study of sexually active African American teen girls, despite 100% condom use, one in five became infected with chlamydia, gonorrhea, or trichomonas within twenty-eight months.\(^ {66}\) One in five is a lot, but the actual rate of acquiring an STD was probably even higher, because the study did not look at HPV and herpes—the two most common ones.

This story from “STD Scenarios,” for middle school, demonstrates how students are given a false sense of security. They are led to believe that with condom use they will completely avoid STDs:

> Greg and Cecilia have been dating for 7 months and recently became sexually active. Now Greg has developed a burning sensation when he urinates...Could Greg and Cecilia have avoided this situation? YES. How? Greg and Cecilia could have avoided this situation by abstaining from sex or using condoms. They can abstain or use condoms in the future — with each other and with any other partners they may have.\(^ {67}\)

With nearly 22,000 teen pregnancies, and more than half of high school students engaged in behaviors that put them at risk for HIV and other infections, New York City faces a crisis of some magnitude; leading students to believe that only “unprotected” sex is risky will only add to the problem. There are individuals who have AIDS due to a single “protected” encounter,\(^ {68}\) while many others have “unprotected” sex with one person their entire lives, without exposing themselves to any risk of disease at all. Educators are providing NYC’s adolescents with a false sense of security. No doubt, a high price is being paid for their faulty approach.

One other issue related to condoms and risk deserves to be noted. The authors of the programs reviewed devote an extensive amount of material to instruction of the twelve teaching steps for proper condom
use. It is taken for granted that careful, detailed, and deliberate reviewing of these steps will increase the chance of a positive outcome.

A report from Kim Dernovsek, MD, an international authority on prevention of STDs, suggests otherwise. She describes how, at an AIDS and STD Symposium at the 2002 American Academy of Dermatology meeting, a speaker was explaining this teaching method. He asked for dermatologists in the audience to form two competing groups, and he gave each physician a card upon which was described one of the twelve steps involved in condom use. The task was to put the twelve cards in proper order.

Remarkably, these medical professionals appeared to have a great deal of difficulty ordering the steps. Ultimately each group came up with a different order. As Dr. Dernovsek describes the scene, it was an embarrassing comedy, one that demonstrates the complexities of correct condom use and challenges the assumption that teenagers can master the procedure.

B. Vulnerability of sexual and racial minority students is ignored

Regarding the risk of genital infections and HIV, students are told it’s not who you are, but what you do that determines your risk.

> It is behaviors, not membership in any particular group that puts people at risk for HIV. Anyone who has sex…can become infected.

> PID [advanced Chlamydia or gonorrhea infection] is a risk for any sexually active woman.

> STDs, including HIV, are a risk for all sexually active people…

First, the claim “anyone who has sex can be infected” is false: two people who delay sexual activity and remain monogamous have essentially no risk of getting HIV or any other STD. But even for those who fall outside that category, the risks differ dramatically—by at least several orders of magnitude. That’s because the degree of risk depends not only on what you do, as students are taught, but on who you do it with.

It’s this last point that is omitted, and it represents a great disservice to all students because they remain ignorant of factors that increase their risk of infection, including infection with HIV. Also, as a result of the distortion, students at high risk will not be not sufficiently alarmed; students at very low risk will worry, and get tested, needlessly.

It goes without saying that “who you are” - your sexual, racial, or ethnic identity – is technically unrelated to risk of infection. We all have the same anatomy and physiology; viruses and bacteria do not discriminate. But basic epidemiology demonstrates that “who you are” predisposes you to associate with others who are members of the same group. Some groups have a higher prevalence of HIV and STDs. The
reasons for this are complex and include issues related to sexual behaviors, number of partners, access to health care, discrimination, financial resources, etc.

Compared to whites, the STD rates in African American communities are disproportionately high. A meeting was held at the CDC in 2007 to specifically address this issue. It was reported that the disproportionate rates include those for gonorrhea (18:1), Chlamydia (8:1), and syphilis (5:1). Of note, it has also been demonstrated that in African-American female adolescents, being diagnosed with a sexually transmitted infection is associated with the development of depressive symptoms within the following six months.76

Students must know that men who have sex with men (MSM) and women and men who have sex with women and men (MSM/W and WSM/W) - commonly called bisexuals - are also vulnerable minorities. MSM is a population with a high prevalence of sexually transmitted infections, including HIV.77 This is related to the risk behaviors that characterize this group: early age of sexual debut, high numbers of sexual partners, concurrent partnerships, infrequent condom use.78

The rate of new HIV diagnoses among men who have sex with men is more than 44 times that of other men and more than 40 times that of women; the rate of primary and secondary syphilis among men who have sex with men is more than 46 times that of other men and more than 71 times that of women.79

MSM/W also report more high risk behaviors: higher numbers of sex partners, more casual sex partners, higher likelihood of using the internet to recruit sex partners, and less condom use.80 This increases their risk of infections.

Students should be taught that MSM/W bridges two populations: MSM, a group with a high prevalence of STDs, and heterosexual females, a group with a lower prevalence of STDs.81 Therefore when a female has sex with a MSM/W, she is at increased risk of acquiring a STD, compared to a sexual encounter with a man who is virginal or has sex only with women (MSW). Similarly, when a man has sex with a WSM/W, he is at higher risk of acquiring an infection (albeit to a lower degree than the prior example) compared to an encounter with a woman who only has sex with only MSW.

Critical to students’ welfare and ability to make informed choices about their sexual behavior is the fact that people often lie about past behaviors82 and HIV status. This occurs with greater frequency than people, especially young people, may imagine, and it occurs with higher frequency among MSM and MSM/W. For example, between 33% and 75% of MSM/W do not disclose to female partners that they have sex with men.83 These women therefore cannot make an accurate assessment of the risks posed by a sexual encounter.

More alarming is when people do not disclose when they are HIV positive. A 2003 survey of HIV positive individuals found that 42% of those who were MSM or MSM/W reported having sex without disclosure of
their status. The rate of non-disclosure is lower among those who identify as heterosexuals, but it is still high. Sex education curricula encourage young people to communicate with their partners, but they must also emphasize to students that people lie about their sexual histories.

Being African American or identifying as MSM or MSM/W does not in and of itself impact one’s risk of infection. But participating in sexual behavior with another person who is a member of one of those minorities (and who has been sexually active with others in those groups) certainly does. The importance of this information cannot be overstated. These facts must be available to all students—the knowledge could impact their choices not only in their teen years, but in adulthood. In fact a note to teachers indicates that students suspect these truths, and seek verification.

In an activity called “Risk Continuum,” students are given cards on which different behaviors ("french kissing," “vaginal sex without a condom,” “anal sex without a condom,” “donating blood,” “sharing needles for piercing”) are written. Students are to indicate the level of risk of HIV transmission associated with the behavior—red, yellow, or green.

Teachers are advised:

Heated discussion may emerge about the proper placement of a behavior along the risk continuum. Stress that any behavior not placed under the green light puts us at risk of HIV. End any discussion that becomes nonproductive.

To the contrary, a classroom discussion about what activity is where on the risk continuum is valuable and should be encouraged. That teachers and students are misled about this life and death issue is shocking. Yet that is precisely what is happening. It is a matter of great urgency, and it must be rectified immediately.

**PART FOUR: Inaccurate and misleading information about HIV transmission**

HIV/AIDS continues to be an enormous problem for New York City, the epicenter of the HIV/AIDS epidemic...more than half of our high school students engage in behaviors that put them at risk for acquiring this devastating disease.

For effective teaching of concepts related to prevention of HIV, accurate and consistent use of terms is essential. The language must reflect the current state of scientific research, including quantitative estimates. When research is inconclusive, or a particular question remains unanswered, this too must be conveyed.

The reviewed materials fail to accomplish this. Fundamental terms are used in a careless manner, and students are likely to complete the program confused and misinformed.
A. Misuse of terms “Protect”, “Prevent”, “Avoid”

Consider the words “protect,” “prevent,” and “avoid,” used innumerable times, most often in the context of describing the efficacy of condoms. Following are the Merriam-Webster dictionary definitions of these words:

Protect - “to cover or shield from exposure, injury, damage, or destruction”

Prevent - “to keep from happening or existing”

Avoid - “to prevent the occurrence or effectiveness of”

Now consider how these terms are used in the material in discussing HIV transmission:

Condoms...provide effective protection against HIV…

Condoms...provide good protection from HIV...

…A latex condom...is very effective in preventing HIV

Condoms are a good way to prevent... HIV

“How is STD/HIV prevented?” is a handout for students to assess how well they are protecting themselves. Methods of protection are listed (“withdrawal, douching, hoping, rhythm…” and their effectiveness indicated. The effectiveness of a latex condom in preventing HIV is indicated as the same effectiveness as abstinence.

In other places, condom “protection” is described as somewhat less than perfect:

Condoms are helpful in reducing the risk of HIV transmission; however, they are not 100% effective.

Latex or polyurethane condoms can reduce the risk of HIV transmission.

People who do not have unprotected sex...have a very low risk of getting [HIV]

With so many contradictory messages, students should be asking, so which is it? Do condoms prevent and protect - do they keep infection from happening? - or not? And if not, then what sort of “protection” are we talking about? Clarity is needed.

B. Students misled about the limits of “protection” from HIV

Earlier in this report, the efficacy of condoms in preventing pregnancy and transmission of STDs was discussed. What follows is a discussion of the efficacy of condoms in preventing transmission of HIV.
As noted, the latex from which condoms are made is impermeable to HIV. Transmission of the virus through the intact membrane is impossible — condoms confer 100% protection in the laboratory. In real life, however, conditions are different.

Putting aside the question of how feasible it is to rely on an adolescent’s perfect condom use — the HIV/AIDS curriculum reminds teachers of “the high rate of condom failure among adolescents due to incorrect and inconsistent use,” and instructs them to provide step-by-step, individualized condom demonstrations in a private setting — even with such use, condoms can be defective, they slip and break, and semen can escape around the edges.

Terms like “very effective” and “good protection” mean different things to different people. If the risk reduction is not quite 100%, is it at least 98 or 99%? This is a legitimate question that many students probably have.

Quantitative estimates of condom efficacy in preventing HIV transmission have been available for over a decade. Studies were done of couples in which one person was HIV positive and the other was HIV negative. Compared to the couples who never used a condom, there was an 80% reduction in HIV transmission between couples who always used a condom.

Therefore, the current state of scientific research indicates that when used correctly for each act of vaginal intercourse, condoms reduce the transmission of HIV by 80%.

Students are not provided with this data, and that is alarming indeed. Instead they are to led to believe that HIV can be transmitted only during “unprotected” intercourse.

Remind students that there are 2 ways to avoid...HIV: say no to sex, or use protection.

Unprotected sex can lead to serious problems...including HIV... So why do some young people take risks and have unprotected sex?

How is HIV transmitted? Unprotected sexual intercourse.

This stance — that only “unprotected” intercourse poses risks — underlies the following advice:

“Because it is not possible to tell if someone is HIV-positive just by looking at him or her, it is important to use a condom every time you have sex with someone who has not been tested in the past three months... Using a condom every time protects you from infection and helps give you peace of mind.”

With this reassurance, trusted authorities give students a green light to sex with someone whose HIV status is unknown, so long as a condom is used. This is an egregious display of irresponsibility. It also disregards, as do all of the examples cited, the Regents Policy Statement on HIV/AIDS Instruction, which
states, “...any written or oral instruction relating to condoms must fully and clearly disclose the various risks and consequences of condom failure.”

C. Students introduced to “three types of intercourse” without adequate explanation of medical risks involved.

Returning to the scientific research indicating that condoms reduce the transmission of HIV by 80%, note that the data refer only to when condoms are used correctly for every act of vaginal intercourse.

HealthSmart introduces students to “vaginal, oral and anal sex” in middle school. The HIV/AIDS curriculum guide recommends that teachers initiate discussion of the “types of intercourse” in grades 9 – 12, but in Grades 7 and 8, they should mention oral and anal intercourse only “in response to students’ questions”.

The issue of teaching students about behaviors considered immoral by some families and cultures will be addressed later in this report. The discussion that follows is limited to describing the current state of medical knowledge about condom use during anal intercourse and protection from HIV.

Aside from a small number of studies, there is no body of data that suggests a statistically significant HIV risk reduction with condom use for anal intercourse. Nearly all the data about condom protection refers to vaginal intercourse alone.

The importance of this point cannot be overstated. While intuitively one would expect condom use to decrease transmission of HIV during anal intercourse as well, the studies to support this have not been done. In 2005, over 270 physicians concerned about sex education in Montgomery County, Maryland, signed a petition for the Board of Education that stated,

... We the undersigned recognize that anal intercourse (A/I) is a particular high risk sexual practice and it is associated with the highest risk of HIV infection. We further recognize that “although there is strong evidence that condom use generally reduces sexual transmission of HIV, solid data showing the effectiveness of currently available condoms during A/I, a particularly high-risk sexual practice, still are lacking.

As physicians, we are concerned for the health of the students and recommend that... students [be warned] of the risks of anal intercourse and of the risks of condom failure during anal intercourse.109

Many teens do not recognize anal intercourse as risky; one study on urban minority females indicated 41% engaged in anal sex to avoid pregnancy and 20% thought HIV could not be transmitted through anal sex; some don’t even consider anal sex “sex.”111
Is there reason to believe that condoms are more likely to fail during anal intercourse compared to vaginal? Yes. This likelihood is acknowledged by the government body responsible for the safety and efficacy of medical devices. On the Food and Drug Administration’s website, the question is posed, “are condoms strong enough for anal intercourse?” Their answer:

_The Surgeon General (C. Everett Koop, Surgeon General 1982-1989) has said, “Condoms provide some protection, but anal intercourse is simply too dangerous to practice”_

_Condoms may be more likely to break during anal intercourse than during other types of sex because of the greater amount of friction and other stresses involved._

_Even if the condom doesn’t break, anal intercourse is very risky because it can cause tissue in the rectum to tear and bleed. These tears allow disease germs to pass more easily from one partner to the other._

Companies that manufacture condoms warn consumers about these dangers. Package inserts for Durex condoms caution users that “non-vaginal use of condoms can increase the potential for them to slip off or be damaged.” The following statement is found on boxes of _LifeStyles_ brand condoms, under the heading “Effectiveness”:

_Condoms are primarily intended for use in vaginal intercourse; other uses can increase the potential for breakage._

Of note is that _LifeStyle_ condoms are also re-branded as NYC Condoms and distributed by the NYC Department of Health and Mental Hygiene.

In Europe and the United Kingdom, concern about condom failure during anal intercourse led to the design of a sturdier version of the device, marketed specific to this use. Adding to the danger is the indisputable fact that anal intercourse itself is significantly more dangerous than vaginal intercourse for transmission of HIV.

For anatomical and physiological reasons, receptive anal intercourse has been estimated to be about thirty times riskier than receptive vaginal intercourse. New York City’s Department of Health announced in 2010,

> …women who have unprotected anal sex with an HIV-infected man even one time are about 30 times more likely to get HIV than if they had unprotected vaginal sex once._

Obviously the same elevated danger exists when the receptive individual is male.
All the publications reviewed in this analysis fail to adequately alert the student to the well-established dangers of anal intercourse, with or without a condom. Instead, students are instructed, again and again, that HIV is transmitted through “unprotected sexual intercourse — vaginal, oral, and anal.” With some exceptions, the emphasis is exclusively on condom use, implying that each act carries the same risk.

In a reading sheet (“HIV Facts”) for middle school: How do you get HIV? … by having unprotected sex (without a condom) with a person who has HIV. This includes vaginal, oral, or anal sex.\textsuperscript{21}

From a lesson for sixth graders: “WAYS HIV CAN BE TRANSMITTED”

– By unprotected sexual intercourse with an infected partner.\textsuperscript{22}

While there is acknowledgement, in some places, that anal penetration poses the highest risk for HIV transmission, students are never told that HIV infection can occur even with proper use of condoms. Furthermore, these acknowledgments are not found consistently throughout all the material, and they fail to provide the level of scientific detail that is provided with other topics.

D. Omission of HIV-related science

Starting in first grade, students learn how HIV damages the immune system.\textsuperscript{23} This topic reaches a sophisticated level by middle school, when students are familiarized with details such as the actions of B-cells, T-cells, and macrophages, and the dangers of opportunistic infections.\textsuperscript{24} The destructive effect of HIV on the immune system is a core component of the curriculum at every grade level.

For students to understand this biology deepens their knowledge of how the virus acts, and of infectious diseases in general. This knowledge may or may not play a role in students’ sexual choices.

There is no similar core component explaining the biology of the vagina and the rectum. Students remain ignorant of why anal penetration is so hazardous — again, according the New York City’s Department of Health, thirty times more dangerous.\textsuperscript{25} This represents a substantial omission. Each time students are led to believe that the risks of vaginal and anal penetration are alike (if not equal), the programs fail in their primary mission to educate students so that they can make informed choices.

Considering that there are more new cases of HIV infections in age 13-29 than any other group,\textsuperscript{26} it should be mandatory to provide students with facts about the anatomy and physiology of the vagina and the rectum.

Infection via anal intercourse is easier, students should be taught, for the following reasons: tears are common because the lining is only one cell thick,\textsuperscript{27} there is no elastic or lubrication,\textsuperscript{28} the pH is higher (a
condition that is friendlier to HIV, and M-cells are abundant in the lining of the rectum. M-cells are specialized cells of the lymphatic system that “swallow” HIV particles and deliver them to the immune system where infection occurs.

M-cells are highly significant in understanding HIV transmission because their functioning indicates that infection can potentially occur without the breaching of a barrier.

In contrast, protective factors are built in to the vagina; one of the functions of the vaginal lining is protection from infection. The lining is 20-45 cells thick, elastic tissue is abundant and allows for stretching, there is natural lubrication and a low pH that inactivates HIV, and vaginal mucus has anti-HIV proteins. There are no M-cells in the vagina, but Langerhans cells in the cervix may have the ability to destroy the virus.

These are all indisputable biological truths that are not open to debate. Students have a right to hear them.

In a brochure about HIV/AIDS published by the FDA in 1990, Surgeon General C. Everett Koop stated, “Condoms provide some protection, but anal intercourse is simply too dangerous to practice.” As mentioned, Dr. Koop’s statement remains on the FDA website to this day. Why, then, in 2011, is the act represented to New York City’s middle and high school students as just one more sexual option?

PART FIVE: Omission of medically accurate, up to date information

A. Human Papillomavirus, oral cancers, and spontaneous abortions

It has been known for years that the human papillomavirus (HPV), which causes cervical cancer, is also associated with the development of penile, anal, and oral cancer. Oral sex and open-mouthed kissing are linked to oral HPV infection, and in one study, people who reported having six or more oral-sex partners during their lifetime had a nearly ninefold increased risk of developing cancer of the tonsils or at the base of the tongue.

Evidence is mounting of an association between HPV infection in women and spontaneous abortions (miscarriage).

Millions of adolescents are infected with genital HPV and don’t know it. Students must be advised that delaying all sexual behavior, and keeping their lifetime number of partners as close to one as possible, is the best way to decrease their risk of cancers caused by HPV.

B. Chlamydia
Students learn that untreated Chlamydia can cause permanent damage to the reproductive organs. But they are reassured that this STD is easily treated and cured with antibiotics.\textsuperscript{140}

Unfortunately it’s not so simple. If the damage is already done before treatment begins, it cannot be reversed. For some reason, this truth is acknowledged only once in all the reviewed material.\textsuperscript{141} Students, especially girls (who are at higher risk of infertility due to Chlamydia than boys), must understand all the risks: Chlamydia infection is usually asymptomatic, and we don’t know how long it takes for damage to take place. Being tested for STDs once or twice a year may not suffice.\textsuperscript{142} Treatment with antibiotics may not suffice.\textsuperscript{143}

Chlamydia infection is complex and there are many unknowns. Providing young people with false reassurances is not the answer.

C. STD testing

\textit{When people who are at risk don’t get tested they may pass an STD to others without knowing it.}\textsuperscript{144}

This is correct, but the same may happen even when routine testing \textit{is} done. This is because routine testing does not include tests for herpes or HPV,\textsuperscript{145} and these common genital viruses are often asymptomatic.\textsuperscript{146} A person may have never experienced genital warts or herpes blisters, but may still be carriers of the viruses that cause those conditions.\textsuperscript{147} The ideal is for two people to delay sexual behavior and then remain in a monogamous union. Students must understand that the closer they can get to that ideal, the lower their risk of any STDs.

D. Biochemistry of human attachment

\textit{Oxytocin – Hormone that stimulates the uterus to contract and begin labor}\textsuperscript{148}

This definition is over one hundred years old—oxytocin was identified in 1906 by the English researcher Sir Henry Dale, who discovered its role in giving birth.\textsuperscript{149} Since that time, and especially in the past two decades, our understanding of this primarily female molecule has been transformed. We now know that oxytocin plays a leading role in the biochemistry of sexuality and human relationships. Any sex education program that omits recent discoveries about the actions of oxytocin cannot be considered comprehensive, medically accurate, science-based, or up to date.

In addition to its role in labor, delivery, and nursing, oxytocin promotes social bonds. It acts on the brain to fuel feelings of attachment, trust, and generosity.\textsuperscript{150} The brain’s reward center lights up; the circuits for critical assessment and fear dampen. Oxytocin tells the brain: it’s time to relax, feel good, trust, and connect.
Autism is a disorder of impaired social attachment. These individuals can be anxious in social situations; they make less eye contact; they have impaired ability to read facial cues. Current research demonstrates that some autistic people improve when given oxytocin.\textsuperscript{151}

Students must learn that this same hormone is released in the body during intimate behavior. Oxytocin is released in response to stimulation of the nipples and orgasm; intercourse is not necessary.\textsuperscript{152}

This is powerful information. Neuroscience is affirming what parents want children to grasp: sex is serious. Sex is complicated. You’ll get attached. You’ll get hurt. There are consequences, even when condoms are used.

At a time when casual, no-strings-attached sexuality is widespread among high school students,\textsuperscript{153} and young people are bombarded by cultural messages encouraging risky lifestyles, it’s critical to include the current science of oxytocin.

\textbf{PART SIX: Sexual Agendas}

A public school classroom is not the place to promote ideology. Students are in public school to learn facts and skills, not a specific worldview. The programs reviewed claim to teach “tolerance to the diversity of sexual values” within all communities.\textsuperscript{154} But that can only be achieved when controversy is acknowledged, and various points of view are given fair consideration. Unfortunately, this is not done.

Consider the “three types of intercourse.” Some families object to the notion of grouping the three acts together. They believe that intimacy related to procreation is unique. They want their children to share those beliefs. They may in fact regard anal intercourse as unacceptable; they may prefer their children remain unaware of this practice.

Consider as well that many families believe the only acceptable context for sexual behavior is within the sanctity of marriage. Their children are raised to value a paradigm of love and sexuality in which traditional religious beliefs are central. Yet in a section called “Understanding Love,” found in one book for students,\textsuperscript{155} those families’ views are ignored. The sole model of love presented to students is strictly secular.

Students are taught about “Robert Sternberg’s model of love.”\textsuperscript{156} In this model, there are “eight combinations or kinds of love,” and intimacy within the context of marriage is only one of many options. There is no mention whatsoever of the notion of a sanctified relationship. This in itself speaks volumes about the authors’ worldviews.

Educators sometimes argue that students must be made aware of the varieties of sexual expression so they may be aware of health risks. But this is not completely honest. The overarching goal is to influence students’ attitude about sexual behavior, so that they are open to, and tolerant of, all lifestyles.
It should be noted that “all lifestyles” means more than is probably assumed. The “solid and trustworthy” websites recommended to students endorse casual hookups, threesomes, sadomasochism, and more.¹⁵⁷ (See Appendix II, III, and IV)

Furthermore, students are led to believe that respect for all lifestyles is a “positive norm of healthy sexuality.” Respecting differences, they learn, is an important part of reproductive health.¹⁵⁸ According to this view, the argument could be made that the biggest sexual health epidemic that exists is one that is due to peoples’ attitudes.

Consider also another controversial topic – the question of when life begins. The curricula teach as fact that

*Implantation is the beginning of pregnancy.*¹⁵⁹

*Once the blastocyst has implanted in the uterine wall, the woman is in a state of pregnancy.*¹⁶⁰

But many would disagree. In fact the authoritative Stedman’s Medical Dictionary defines pregnancy as:

*The state of a female after conception and until the termination of the gestation.*¹⁶¹

Additionally, the science of embryology teaches that by the time implantation is complete, the embryo is already at Stage 5 of development.¹⁶²

Clearly the authors have an agenda: for students to have a positive attitude about emergency contraception. “Emergency contraception does not cause abortion,”¹⁶³ young people are instructed, as if no debate exists. But some families see the issue differently, and they wish to instill their values in their children.¹⁶⁴

If schools wish to address the question of when life begins, they must take care to do what they themselves promote with vigor – recognize and respect other views.

Another controversial matter: students are referred to “clinics” for information and services. Planned Parenthood is mentioned several times as a recommended resource. Students are reassured:

*You do not need parent’s permission to get services at a clinic…no one needs to know you are going…*¹⁶⁵

In an activity many parents would find objectionable, high school students are asked to find local clinics in the phone book, visit them, and record details of “services provided” – pregnancy test, emergency contraception, prenatal care, HPV vaccine, HIV test, STD test and treatment, IUD insertion, etc. – along with languages spoken at the clinic, and costs. The student is directed to attach a card or brochure from the clinic to the assignment sheet. (See Appendix V)
Students also indicate how to get to the clinic: on which bus or train; where they get on and off; whether a transfer is needed; how far the students has to walk from the last bus to the clinic. For the student who walks, drives or rides a bike to the clinic, they are to describe the route.

There’s a lot of detail in this assignment, but there is also a glaring omission: no mention of the abortions Planned Parenthood and other clinics provide. But this is consistent with the rest of the curricula: with all the elaborate discussion of reproductive and sexual health, the only mention of abortion is when the claim is made that emergency contraception doesn’t cause one.

One wonders how teachers deal with the elephant in the room. With 14,038 abortions a year in New York City in girls 19 and under (461 in girls under fifteen),166 students should be fully informed about the procedure and its risks. This would include discussion of the fact — recognized by every group on both sides of the debate — that abortion causes significant, long lasting emotional distress in some women and men.167 Adolescents should be aware that their young age alone places them at risk for emotional distress.168 They should also be made aware of the association of abortion and breast cancer.169

Another example of a specific ideological agenda in the curriculum: the redefining of “family”. Fourth graders are taught

A family is a group of persons related by blood, marriage, adoption, or commitment to each other…There is no “desirable” family configuration. Each person’s concept of family is personal and is usually based upon his or her experiences as part of a family.170

This “definition” represents a radical movement to change society, a movement that runs counter to the values that many parents wish to instill in their children. If schools wish to address this highly controversial topic, a more appropriate time and place would be to debate both sides of the issue in a high school current events class. The subject has no place in a curriculum whose purpose is to provide students with the knowledge and skills needed to avoid disease and pregnancy.
CONCLUSION

The sex education programs offered in the city’s public schools, while not without some strengths, are seriously flawed. The trouble begins at the outset with the way essential terms are defined: sexuality, sexual activity, abstinence.

We cannot expect teens to succeed at avoiding pregnancy and genital infections while telling them that sexual activity is a positive force in their lives, and that all they need to avoid, essentially, is “the exchange of body fluids.” We cannot expect them to delay intercourse, while teaching them that with condom use, they’ll avoid pregnancy, STDs and HIV. And surely we cannot expect all this while instructing them that, “only you know when you’re ready.”

It is the nature of adolescence to feel “ready” for just about anything.

The programs make promises, but fail to deliver the goods. They promise to provide students with all the up-to-date, accurate information they need to avoid risky behavior. They promise comprehensive, accurate information about condoms, and the transmission and prevention of HIV and other STDs. They claim to be on the same page as parents.

This report has documented the many ways the programs fall short. The efficacy of condoms is overstated, in some cases vastly so. The quantitative data about their use is absent. Sex is seen as risky only when it’s “unprotected.” Chlamydia is incorrectly described as “easily cured.” If STD test results come back ok, that means you don’t have an STD. These messages, and others, are repeated over and over, but the information is not accurate, comprehensive, and up-to-date. Even worse, critical life and death information is distorted or ignored. Students are left misinformed, and with a false sense of security. Surely, this is the last thing we want.

The approach to teen sex upon which these programs are based can harm children, inside and out. We need, instead, a different model for sex education in the 21st century. This model should have one goal: to keep young people out of the offices of doctors and therapists and to keep students free from unnecessary physical and emotional distress.

It will require straight talk with all the sobering facts. We are fighting a war against a horde of bugs, we should explain to students, and the bugs are winning. Sure, sex is great, but it’s an appetite, and just like all appetites, it must be restrained. You have urges, and those urges are healthy - but it is not always healthy for you to act on them.
We must make teens understand that sex is a very serious matter and that a single encounter can change their lives forever. Our message must be consistent and firm: the only responsible choice is to delay sexual behavior until adulthood. We must provide students with an ideal to strive for, one that offers them the healthiest option physically and emotionally. The healthiest ideal is to postpone sexual activity until adulthood, and, ideally, until marriage. Of course, students must be told, it’s not easily achieved. You, or some of your peers, might make mistakes. But just as in other areas of education, where the ideal is presented as the point of excellence towards which we encourage young people to strive, the same holds true with our sexual activity and choices. Keeping the ideal in front of young people and supporting them in achieving this should be the first priority of sexual education programs.

Adolescents look to adults for authoritative guidance. It is our responsibility to do precisely that – guide them with authority, firm rules, and high expectations. That is not accomplished by telling them “only you know when you’re ready.” When we provide that message, we fail young people. When we teach them to rely on latex, we fail again.

The rates of disease and distress are soaring. Will we respond to the crisis with honesty, authority, and courage? That is the question.
APPENDIX I
(from Reduce the Risk curriculum for Grades 9 -12)

Class 7 • Getting and Using Protection—I

Homework 7.1

Shopping Information Form

1. Name of store ____________________________

2. What protective products are sold here? (List 3 kinds of latex condoms and 1 kind of foam and the prices for each product. Indicate the types of condoms you saw.)

<table>
<thead>
<tr>
<th>Product</th>
<th>Brand Name</th>
<th>Price</th>
<th>Lubricated?</th>
<th>Reservoir (R) or Plain (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom:</td>
<td></td>
<td></td>
<td>Yes No</td>
<td>R P</td>
</tr>
<tr>
<td>Condom:</td>
<td></td>
<td></td>
<td>Yes No</td>
<td>R P</td>
</tr>
<tr>
<td>Condom:</td>
<td></td>
<td></td>
<td>Yes No</td>
<td>R P</td>
</tr>
<tr>
<td>Foam:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How comfortable would you be buying protection here?

1. very comfortable   2. somewhat comfortable   3. somewhat uncomfortable   4. very uncomfortable

4. Would you recommend that a friend buy protection here?   Yes   No

Write 2 sentences telling why or why not.

________________________________________________________________________

________________________________________________________________________

5. What are the store’s hours of business? ____________________________
APPENDIX II

www.GoAskAlice.com (referred to in HealthSmart curriculum for Grades 6-12)

   “I want to buy a vibrator but…”

   “Menage a trois?”

   “S/M role-playing”

   “Receiving anal sex? What does it mean?”

   “What’s fisting?”

   “Why do nice guys always finish last?”

   “Fantasizing in the wrong direction?”

   “Should I explore my sexuality?”

   “In fact, "normal" might not exist…”

    “Menage a trois?”

    “The pill? Where do I get it and do my parents have to know?”

    “Parental consent for abortion?”

    “S/M role-playing”
APPENDIX III

www.GoAskAlice.com (referred to in HealthSmart curriculum for Grades 6-12)
“I want a husband AND a wife” (excerpts)

Dear Alice,

I’m a bisexual female and I’ve been dating a girl … as much as I love her, I still feel like there is a male void in my life… I’ve been thinking that I would feel most comfortable in a committed relationship with a man and a woman. Do you think there's any hope in finding others who would be able to maintain this kind of relationship in a healthy manner?...

Dear Reader,

Humans are incredibly complicated creatures — the depth and complexities of our desires for companionship take many forms…There is hope for you to fulfill your relationship desires; in fact, many people choose to love more than one person at a time in a healthy, respectful manner.

...What you are describing… is coined polyamory…. People who practice polyamory often face stiff resistance to the idea that multiple committed partnerships can be healthy and functional relationships.

Polyamorous persons do not outright reject monogamy…, but emphasize that people can choose their dedication and intimacy levels with their partner(s), and can also choose to be faithful and committed to more than one person, like the situation you are envisioning.

Those in polyamorous relationships …believe that the human capacity for love can expand beyond simply one partner. Polyamory [is]… loving more than one person at a time with honesty and integrity, upholding many of the values ideally found in any healthy relationship. Here are some of the other underlying principles of polyamory…

• It is vital to accept and celebrate the reality that human nature does not dictate monogamy.

• Intimacy and sex between multiple simultaneous partners in polyamorous relationships is not an inherently wrong, bad, or unhealthy thing.

• Love is an infinite rather than finite commodity, and should be offered to your partners without conditional constraints to love only that one person.

• Polyamorous NYC may be a good place to start….

• Check out The Polyamory Handbook: A User’s Guide
• Another guide for non-traditional relationships is *The Ethical Slut*

• And finally, see the *Alternatives to Marriage Project’s* page on *Polyamory* for definitions and musings on the subject.

….With an open attitude and a reverence for honesty and communication, the more may very well make the merrier.

**APPENDIX IV**

**www.AdvocatesforYouth.org** *(referred to in *HealthSmart* curriculum for Grades 6-12)*

   “Advocates for Youth has served as a bold voice and respected leader in the field of adolescent reproductive and sexual health.”

   “Growth and Development, Ages Six to Eight—What Parents Need to Know,” “What Families Need to Do to Raise Sexually Healthy Children”

   “Growth and Development, Ages 13 to 17—What Parents Need to Know”

   “Gender is the collection of behaviors, dress, attitudes, etc., culturally assigned to people according to their biological sex.”

   “People can realize their sexual orientation and gender identity at any point during their lives.”

   “Traditionally, gender has meant either 'male' or 'female.' Gender is the collection of behaviors, dress, attitudes, etc., culturally assigned to people according to their biological sex. However, there is really a range of genders, including male and female, but also including gender queer or gender ambiguous, butch (man or woman), femme (man or woman), transgender (sometimes considered a gender), and many others.”
APPENDIX V
(from Reduce the Risk curriculum for Grades 9 -12)

Class 8 • Getting and Using Protection—II

Homework 8.1

Name: ___________________________

Visit or Call a Clinic

1. Name of clinic ___________________________

2. Address and phone number of clinic ___________________________

3. Clinic is open from _______ a.m. to _______ p.m. _______ days a week.

4. The following services are available at this clinic:
   ______ Birth control ______ STD test ______ HPV vaccine
   ______ Pregnancy tests ______ STD treatment ______ Prenatal care
   ______ HIV test ______ Counseling ______ Sterilization
   ______ Emergency contraception

5. A routine examination or consultation about birth control information costs $ _________.

6. Most states have laws that clinics can’t disclose information about clients without written consent, including whether or not clients visit the clinic. This is called “client confidentiality.” This clinic’s confidentiality policy is as follows:

7. Besides English, the following languages are spoken at this clinic: ___________________________

8. If you visited (rather than called) the clinic, answer this question: I felt the following level of comfort in this clinic (include such things as decor, friendliness of staff, reading material available in waiting room, etc.):

    1 Very comfortable  2 Comfortable  3 Fairly comfortable  4 Uncomfortable

9. Would you recommend that a friend visit this clinic for an exam or to talk about protection?

    Write 2 sentences telling why or why not.

10. Something I learned at this clinic is ___________________________

    Reminder: Attach a card or brochure from the clinic.

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Homework 8.2

Name: ____________________________

The Way to the Clinic

Bus or Train Route from School to the Clinic*
Which bus do you catch? Number or name of bus ____________________________
Where do you get on the bus? ____________________________
Do you need to transfer? Yes No
What are the transfers? ____________________________
Where do you get off? ____________________________
About how far did you have to walk from the last bus to the clinic?

Car, Bike or Walking Route from School to the Clinic*
Describe the route from your house or the school to the clinic. Give all street names and freeway numbers. Try to remember and write down other landmarks (such as a fast-food restaurant or a park) that cue you when to turn.

On the attached sheet of paper or map, I have described the:

_____ Car Route
_____ Bike Route
_____ Walking Route

*You may attach a map and mark the route.
ENDNOTES


6 Ibid., p. 59-60.


10 Middle adolescence is generally considered ages 15 – 17.


24 Ibid., p. 72.


28 Chase, Johanna, op. cit., p. 32-33.

29 Barth, Richard P. Reducing the Risk Student Workbook. op. cit., p. 47.


31 Ibid., p. 62.


35 “Talk About Sex” on www.siecus.org (site recommended by *Health Smart Health Facts: Abstinence*, page 149.)


38 Quackenbush, M et al. *Health Smart Health Facts Middle School Program: Reproductive Health & Pregnancy Prevention*, op. cit., p.157-158.


42 Ibid.


46 Ibid.


54 An unknown number of these represent pregnancies in married women from communities where starting a family at a young age is celebrated.


Table 4.10 Live Births and Pregnancy Rates to Teenagers (Age 15-19 Years) New York City, 2009


58 Quackenbush, M et al. Health Smart Health Facts Middle School Program: Reproductive Health & Pregnancy Prevention, op. cit., 65.

59 Quackenbush, M et al. Health Smart Health Facts: HIV & STD Prevention, op. cit., p.102


63 Winer, Rachel L. et al.,op. cit.


Dervuluk, Kim K., op. cit.


Quackenbush, M et al. Health Smart Health Facts: HIV & STD Prevention, op. cit., p. 23.

Ibid. p.1.

This would technically include deep kissing, which can transmit HPV, as discussed later in this report.


Ibid.


EM Levin et al.,(2009), op. cit.

Ibid.


84 Levin, EM et al., (2009), op. cit.


86 Barth, Richard P. Reducing the Risk: Building Skills to Prevent Pregnancy, STD & HIV, op. cit., p. 53-97

87 Ibid., p.185.


89 This criticism is least true of HIV/AIDS Curriculum: A Supplement to a Comprehensive Health Curriculum.


92 Ibid.

93 Barth, Richard P. Reducing the Risk Student Workbook, op. cit., p. 27.

94 Quackenbush, M et al. Health Smart Health Facts: HIV & STD Prevention, op. cit., p. 102.


98 Quackenbush, M et al. Health Smart Health Facts: HIV & STD Prevention, op. cit., p. 53.


102 Quackenbush, M et al. Health Smart Health Facts: Abstinence, op. cit., p. 58.


104 Ibid., p. xix.

105 Ibid., p. xiv.


120 Most notably all through HIV/ AIDS Curriculum: A Supplement to a Comprehensive Health Curriculum; also in a few instances in Health Smart Health Facts: HIV & STD Prevention.


Ibid., p.89-93.; see also Quackenbush, M et al. Health Smart Health Facts: HIV & STD Prevention, op. cit., p. 31-54.


Voeller, B., op. cit.


144 Quackenbush, Marcia et al. Health Smart Health Facts: HIV & STD Prevention, op. cit., p. 74.


153 Kerstin Uvnas Moberg, op. cit.


155 Quackenbush, M et al HealthSmart Health Facts: HIV & STD Prevention, op. cit., p. 108.


158 Quackenbush, M et al. *HealthSmart Health Facts Middle School Program: Reproductive Health & Pregnancy Prevention*, op. cit., p. 159.


160 Ibid., p.46.


166 Li, Wehui, Ph.D et al., op. cit.


