

111TH CONGRESS
1ST SESSION

H. R. 1551

To provide for the reduction of adolescent pregnancy, HIV rates, and other sexually transmitted diseases, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 17, 2009

Ms. LEE of California (for herself, Mr. MCGOVERN, Mrs. CAPPS, Mr. MCDERMOTT, Mr. BERMAN, Ms. HIRONO, Mr. HINCHEY, Mr. CROWLEY, Mrs. MALONEY, Ms. DELAURO, Mr. DOYLE, Ms. SLAUGHTER, Mr. FARR, Mr. FATTAH, Mr. ACKERMAN, Ms. WASSERMAN SCHULTZ, Mrs. NAPOLITANO, Mr. GRIJALVA, Mr. KUCINICH, Mr. LANGEVIN, Mr. LARSEN of Washington, Ms. SCHAKOWSKY, Mr. DAVIS of Illinois, Ms. NORTON, Mr. BLUMENAUER, Ms. MCCOLLUM, Mr. BRADY of Pennsylvania, and Mrs. DAVIS of California) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To provide for the reduction of adolescent pregnancy, HIV rates, and other sexually transmitted diseases, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Responsible Education
5 About Life Act”.

1 **SEC. 2. FINDINGS.**

2 The Congress finds as follows:

3 (1) Leading public health and medical profes-
4 sional organizations, including the American Medical
5 Association (“AMA”), the American Medical Stu-
6 dent Association (“AMSA”), the American Nurses
7 Association (“ANA”), the American Academy of Pe-
8 diatrics (“AAP”), the American College of Obstetri-
9 cians and Gynecologists (“ACOG”), the American
10 Public Health Association (“APHA”), the Institute
11 of Medicine (“IOM”) and the Society of Adolescent
12 Medicine (“SAM”), stress the need for sexuality
13 education that includes messages about abstinence
14 and provides young people with information about
15 contraception for the prevention of teen pregnancy,
16 HIV/AIDS, and other sexually transmitted infections
17 (“STIs”).

18 (2) A 2005 statement from the APHA urged
19 that “The U.S. Congress should authorize and fully
20 fund legislation that promotes comprehensive sexu-
21 ality education programs which include information
22 about both abstinence and contraception, include
23 parent-child communications components; and teach
24 goal-setting, decision-making, negotiation, and com-
25 munication skills” and that “sexual health informa-
26 tion disseminated by federal agencies, be medically

1 and scientifically accurate and based on theories and
2 strategies with demonstrated evidence of effective-
3 ness.” In a 2006 statement, APHA reiterated that
4 it “has strongly supported comprehensive sexuality
5 education that includes information about concepts
6 of healthy sexuality, sexual orientation and toler-
7 ance, personal responsibility, risks of HIV and other
8 STIs and unwanted pregnancy, access to reproduc-
9 tive health care, and benefits and risks of condoms
10 and other contraceptive methods. Sexuality edu-
11 cation should be non-judgmental and support par-
12 ent-child communication and should not impose reli-
13 gious or ideological viewpoints upon students.”.

14 (3) The SAM stated in a 2006 position paper
15 that “SAM supports a comprehensive approach to
16 sexual risk reduction including abstinence as well as
17 correct and consistent use of condoms and contra-
18 ception among teens who choose to be sexually ac-
19 tive.” In addition, “Efforts to promote abstinence
20 should be provided within health education programs
21 that provide adolescents with complete and accurate
22 information about sexual health, including informa-
23 tion about concepts of healthy sexuality, sexual ori-
24 entation and tolerance, personal responsibility, risks
25 of HIV and other STIs and unwanted pregnancy,

1 access to reproductive health care, and benefits and
2 risks of condoms and other contraceptive methods.”.

3 (4) Most Americans believe that sex education
4 should promote abstinence and provide information
5 about the effectiveness and benefits of contraception.
6 According to the results of a 2005–2006 nationally
7 representative survey of U.S. adults, more than 8 in
8 10 of those polled support comprehensive sex edu-
9 cation.

10 (5) There is strong evidence that more com-
11 prehensive sex education can effectively help young
12 people delay sexual initiation, even as it increases
13 contraceptive use among sexually active youth. Ac-
14 cording to a report published by the National Cam-
15 paign to Prevent Teen and Unplanned Pregnancy,
16 “two-thirds of the 48 comprehensive programs that
17 supported both abstinence and the use of condoms
18 and contraceptives for sexually active teens had posi-
19 tive behavioral effects”. Many either delayed or re-
20 duced sexual activity, reduced the number of sexual
21 partners, or increased condom or contraceptive use.

22 (6) There is no evidence that federally funded
23 abstinence-only-until-marriage programs are effec-
24 tive in stopping or delaying teen sex. A recent, con-
25 gressionally mandated evaluation of federally funded

1 abstinence-only programs by Mathematica Policy Re-
2 search found that these programs have no beneficial
3 impact on whether young people abstain, when they
4 first have sex, or their number of sexual partners.

5 (7) Comprehensive sexuality education pro-
6 grams respect the diversity of values and beliefs rep-
7 resented in the community and will complement and
8 augment the sexuality education children receive
9 from their families and faith communities.

10 (8) Most young people have sex for the first
11 time at about age 17, but do not marry until their
12 middle or late 20s. This means that young adults
13 are at risk of unwanted pregnancy and STIs for
14 nearly a decade. Therefore, teens need access to full,
15 complete, and medically and factually accurate infor-
16 mation regarding sexuality, including contraception,
17 condoms, STI/HIV prevention, and abstinence.

18 (9) From the early 1990s through the early
19 2000s, rates of teen pregnancy birth and abortion in
20 the United States all declined dramatically—pri-
21 marily, but not exclusively, because of increased and
22 more effective contraceptive use among sexually ac-
23 tive teens. These declines have since stalled, how-
24 ever, and new data from the Centers for Disease
25 Control and Prevention’s National Center for Health

1 Statistics (“NCHS”) indicate that teen birthrates
2 are on the rise. NCHS reports a 3-percent national
3 increase between 2005 and 2006 (from 40.5 to 41.9
4 births per 1,000 females aged 15–19).

5 (10) Teen pregnancy rates are much higher in
6 the United States than in many other developed
7 countries—twice as high as in England and Wales
8 or Canada, and eight times as high as in the Neth-
9 erlands or Japan.

10 (11) The decline in the teen birthrate between
11 1991 and 2004 resulted in saving taxpayers
12 \$6,700,000,000 in associated health care, child wel-
13 fare, and other such costs in 2004 alone, reducing
14 the cost to taxpayers from \$15,800,000,000 to
15 \$9,100,000,000. Investing in effective programs that
16 improve teen sexual behavior by delaying sexual ac-
17 tivity, improving contraceptive use among teens, and
18 reducing teen pregnancies would contribute to reduc-
19 ing the taxpayer costs associated with teen child-
20 bearing.

21 (12) Ethnic and racial minority groups have
22 been disproportionately affected by early pregnancy
23 and parenthood. Fifty-three percent of Latina teens
24 and 51 percent of African-American young women
25 will become pregnant at least once before they turn

1 20, as compared to only 19 percent of non-Hispanic
2 White young women.

3 (13) The United States has one of the highest
4 rates of sexually transmitted infections among indus-
5 trialized nations. There are approximately
6 19,000,000 new cases of sexually transmitted infec-
7 tions each year, almost half of them occurring in
8 young people ages 15 to 24. According to the Cen-
9 ters for Disease Control and Prevention, these sexu-
10 ally transmitted diseases impose a tremendous eco-
11 nomic burden with direct medical costs as high as
12 \$14,100,000,000 per year.

13 (14) Recent estimates suggest that while 15- to
14 24-year-olds represent 25 percent of the sexually ac-
15 tive population, they acquire nearly half of all new
16 STIs. Each year, one in four sexually active teen-
17 agers contracts a sexually transmitted infection.

18 (15) Nearly 15 percent of the 56,000 annual
19 new cases of HIV infections in the United States oc-
20 curred in youth ages 13 through 24 in 2006. An av-
21 erage of one young person every hour of every day
22 is infected with HIV in the United States.

23 (16) African-American and Latino youth have
24 been disproportionately affected by the HIV/AIDS
25 epidemic. Although African-American adolescents

1 ages 13 through 19 represent only 17 percent of the
2 adolescent population in the United States, they ac-
3 counted for 70 percent of new HIV/AIDS cases re-
4 ported among teens in 2005. Latino adolescents
5 ages 13 through 19 accounted for 17 percent of
6 AIDS cases among teens, the same as their propor-
7 tion of the U.S. population in 2005. Although
8 Latinos ages 20 through 24 represent only 18 per-
9 cent of the young adults in the United States, they
10 accounted for 22 percent of the new AIDS cases in
11 2005.

12 (17) Parental involvement is critical to any
13 healthy relationship program. A major study showed
14 that adolescents who reported feeling connected to
15 parents and family were more likely than other teens
16 to delay initiating sexual intercourse. Another study
17 found that teens who reported previous discussions
18 of sexuality with parents were seven times more like-
19 ly to feel able to communicate with a partner about
20 HIV/AIDS than those who did not have such discus-
21 sions with their parents. Parental involvement is a
22 leading protective factor for dating violence preven-
23 tion.

24 (18) Incorporating teen dating violence preven-
25 tion into health education and sexuality education is

1 imperative given the widespread experience of vio-
2 lence in dating relationships. Approximately one in
3 three teens reports some kind of abuse in a romantic
4 relationship, including emotional and verbal abuse.
5 Young women who experience dating violence have
6 sex earlier than their peers; are much less likely to
7 use birth control; and engage in a wide variety of
8 high-risk behaviors including multiple partners, sex
9 with older men, and drug and alcohol abuse. Young
10 women who are victims of dating violence are four
11 to six times more likely than nonabused girls to be-
12 come pregnant.

13 **SEC. 3. ASSISTANCE TO REDUCE TEEN PREGNANCY, HIV/
14 AIDS, AND OTHER SEXUALLY TRANSMITTED
15 DISEASES AND TO SUPPORT HEALTHY ADO-
16 LESCENT DEVELOPMENT.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services may award a grant to each eligible State,
19 for each of the fiscal years 2010 through 2014, to conduct
20 programs of sex education described in subsection (b), in-
21 cluding education on both abstinence and contraception
22 for the prevention of teenage pregnancy and sexually
23 transmitted diseases, including HIV/AIDS.

1 (b) REQUIREMENTS FOR SEX EDUCATION PRO-
2 GRAMS.—A program of sex education described in this
3 subsection is a program that—

4 (1) is age appropriate and medically accurate;

5 (2) stresses the value of abstinence while not ig-
6 noring those young people who have had or are hav-
7 ing sexual intercourse;

8 (3) provides information about the health bene-
9 fits and side effects of all contraceptive and barrier
10 methods used—

11 (A) as a means to prevent pregnancy; and

12 (B) to reduce the risk of contracting sexu-
13 ally transmitted disease, including HIV/AIDS;

14 (4) encourages family communication between
15 parent and child about sexuality;

16 (5) teaches young people the skills to make re-
17 sponsible decisions about sexuality, including how to
18 avoid unwanted verbal, physical, and sexual ad-
19 vances and how to avoid making verbal, physical,
20 and sexual advances that are not wanted by the
21 other party;

22 (6) develops healthy relationships, including the
23 prevention of dating and sexual violence;

24 (7) teaches young people how alcohol and drug
25 use can affect responsible decisionmaking; and

1 (8) does not teach or promote religion.

2 (c) ADDITIONAL ACTIVITIES.—In carrying out a pro-
3 gram of sex education, a State may expend funds received
4 under this section to carry out educational and motiva-
5 tional activities that help young people to—

6 (1) gain knowledge about the physical, emo-
7 tional, biological, and hormonal changes of adoles-
8 cence and subsequent stages of human maturation;

9 (2) develop the knowledge and skills necessary
10 to ensure and protect their sexual and reproductive
11 health from unintended pregnancy and sexually
12 transmitted disease, including HIV/AIDS through-
13 out their lifespan;

14 (3) gain knowledge about the specific involve-
15 ment and responsibility of each individual in sexual
16 decisionmaking;

17 (4) develop healthy attitudes and values about
18 adolescent growth and development, body image,
19 gender roles, racial and ethnic diversity, sexual ori-
20 entation, and other subjects;

21 (5) develop and practice healthy life skills in-
22 cluding goal-setting, decisionmaking, negotiation,
23 communication, and stress management;

24 (6) promote self-esteem and positive inter-
25 personal skills focusing on relationship dynamics, in-

1 including, but not limited to, friendships, dating, ro-
2 mantic involvement, marriage, and family inter-
3 actions; and

4 (7) prepare for the adult world by focusing on
5 educational and career success, including developing
6 skills for employment preparation, job seeking, inde-
7 pendent living, financial self-sufficiency, and work-
8 place productivity.

9 **SEC. 4. SENSE OF CONGRESS.**

10 It is the sense of Congress that, although States are
11 not required to provide matching funds to receive a grant
12 under this Act, they are encouraged to do so.

13 **SEC. 5. EVALUATION OF PROGRAMS.**

14 (a) IN GENERAL.—For the purpose of evaluating the
15 effectiveness of programs of sex education carried out with
16 a grant under section 3, evaluations shall be carried out
17 in accordance with subsections (b) and (c).

18 (b) NATIONAL EVALUATION.—

19 (1) IN GENERAL.—The Secretary shall provide
20 for a national evaluation of a representative sample
21 of programs of sex education carried out with grants
22 under section 3.

23 (2) PURPOSES.—The purpose of the national
24 evaluation under paragraph (1) shall be the deter-
25 mination of—

1 (A) the effectiveness of such programs in
2 helping to delay the initiation of sexual inter-
3 course and other high-risk behaviors;

4 (B) the effectiveness of such programs in
5 preventing adolescent pregnancy;

6 (C) the effectiveness of such programs in
7 preventing sexually transmitted disease, includ-
8 ing HIV/AIDS;

9 (D) the effectiveness of such programs in
10 increasing contraceptive knowledge and contra-
11 ceptive behaviors when sexual intercourse oc-
12 curs; and

13 (E) a list of best practices based upon es-
14 sential programmatic components of evaluated
15 programs that have led to success described in
16 subparagraphs (A) through (D).

17 (3) GRANT CONDITION.—A condition for the re-
18 ceipt of a grant under section 3 is that the State in-
19 volved agree to cooperate with the evaluation under
20 paragraph (1).

21 (4) REPORT.—The Secretary shall submit to
22 the Congress—

23 (A) not later than the end of each of fiscal
24 years 2010 through 2013, an interim report on

1 the national evaluation under paragraph (1);
2 and

3 (B) not later than March 31, 2015, a final
4 report providing the results of such national
5 evaluation.

6 (c) INDIVIDUAL STATE EVALUATIONS.—

7 (1) IN GENERAL.—A condition for the receipt
8 of a grant under section 3 is that the State involved
9 agree to provide for the evaluation of the programs
10 of sex education carried out with the grant in ac-
11 cordance with the following:

12 (A) The evaluation will be conducted by an
13 external, independent entity.

14 (B) The purposes of the evaluation will be
15 the determination of—

16 (i) the effectiveness of such programs
17 in helping to delay the initiation of sexual
18 intercourse and other high-risk behaviors;

19 (ii) the effectiveness of such programs
20 in preventing adolescent pregnancy;

21 (iii) the effectiveness of such pro-
22 grams in preventing sexually transmitted
23 disease, including HIV/AIDS; and

24 (iv) the effectiveness of such programs
25 in increasing contraceptive knowledge and

1 contraceptive behaviors when sexual inter-
2 course occurs.

3 (2) **LIMITATION.**—A condition for the receipt of
4 grant funds under section 3 is that the State in-
5 volved agree that not more than 10 percent of such
6 funds will be expended for evaluation under para-
7 graph (1).

8 **SEC. 6. NONDISCRIMINATION CLAUSE.**

9 Programs funded under section 3 shall not discrimi-
10 nate on the basis of sex, race, ethnicity, national origin,
11 disability, religion, sexual orientation, or gender identity.
12 Nothing in this Act shall be construed to invalidate or
13 limit rights, remedies, procedures, or legal standards avail-
14 able to victims of discrimination under any other Federal
15 law or any law of a State or a political subdivision of a
16 State, including title VI of the Civil Rights Act of 1964
17 (42 U.S.C. 2000d et seq.), title IX of the Education
18 Amendments of 1972 (20 U.S.C. 1681 et seq.), section
19 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794),
20 and the Americans with Disabilities Act of 1990 (42
21 U.S.C. 12101 et seq.).

22 **SEC. 7. DEFINITIONS.**

23 For purposes of this Act:

24 (1) The term “age appropriate” means, with re-
25 spect to topics, messages, and teaching methods,

1 those suitable to particular ages or age groups of
2 children and adolescents, based on developing cog-
3 nitive, emotional, and behavioral capacity typical for
4 the age or age group.

5 (2) The term “eligible State” means a State
6 that submits to the Secretary an application for a
7 grant under section 3 that is in such form, is made
8 in such manner, and contains such agreements, as-
9 surances, and information as the Secretary deter-
10 mines to be necessary to carry out this Act.

11 (3) The term “HIV/AIDS” means the human
12 immunodeficiency virus, and includes acquired im-
13 mune deficiency syndrome.

14 (4) The term “medically accurate”, with respect
15 to information, means information that is supported
16 by research, recognized as accurate and objective by
17 leading medical, psychological, psychiatric, and pub-
18 lic health organizations and agencies, and, where rel-
19 evant, published in peer review journals.

20 (5) The term “Secretary” means the Secretary
21 of Health and Human Services.

22 (6) The term “State” means the 50 States, the
23 District of Columbia, the Commonwealth of Puerto
24 Rico, the Commonwealth of the Northern Mariana
25 Islands, American Samoa, Guam, the Virgin Islands,

1 and any other territory or possession of the United
2 States.

3 **SEC. 8. AUTHORIZATION OF APPROPRIATIONS.**

4 (a) IN GENERAL.—For the purpose of carrying out
5 this Act, there is authorized to be appropriated
6 \$50,000,000 for each of the fiscal years 2010 through
7 2014.

8 (b) LIMITATION.—Of the amounts appropriated to
9 carry out this Act for a fiscal year, the Secretary may not
10 use more than—

11 (1) 7 percent of such amounts for administra-
12 tive expenses related to carrying out this Act for
13 that fiscal year; and

14 (2) 10 percent of such amounts for the national
15 evaluation under section 5(b).

○