

112TH CONGRESS  
1ST SESSION

# S. 578

To amend title V of the Social Security Act to eliminate the abstinence-only education program.

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## IN THE SENATE OF THE UNITED STATES

MARCH 15, 2011

Mr. LAUTENBERG (for himself, Mr. FRANKEN, Mr. SANDERS, Mr. BEGICH, Mr. WYDEN, Mr. WHITEHOUSE, Mr. KERRY, and Mrs. MURRAY) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title V of the Social Security Act to eliminate the abstinence-only education program.

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 “Repealing Ineffective  
5 and Incomplete Abstinence-Only Program Funding Act of  
6 2011”.

7 **SEC. 2. FINDINGS.**

8 Congress makes the following findings:

1           (1) The United States has one of the highest  
2       teen pregnancy rates in the developed world. Be-  
3       tween 1990 and 2005, the United States teenage  
4       pregnancy rate declined 41 percent. For the first  
5       time in more than a decade, the rate rose 3 percent  
6       in 2006. At the same time, teens were receiving less  
7       information about contraception in schools and their  
8       use of contraceptives was declining.

9           (2) While young people in the United States  
10      aged 15 to 25 make up only  $\frac{1}{4}$  of the sexually active  
11      population, they contract about  $\frac{1}{2}$  of the 19,000,000  
12      sexually transmitted infections (STIs) which occur  
13      annually. Young people ages 13 to 29 account for  
14      nearly  $\frac{1}{3}$  of the estimated 56,300 new HIV infec-  
15      tions each year. Every hour, 1 young person is in-  
16      fected with HIV. In 2008, the Centers for Disease  
17      Control and Prevention estimated that 1 in 4 young  
18      women between the ages of 14 and 19 and nearly 1  
19      in 2 African-American young women are infected  
20      with at least one of the four most common STIs.

21          (3) Abstinence-only-until-marriage programs  
22      have been discredited by a wide body of evidence, in-  
23      cluding most recently in a congressionally mandated  
24      study in 2007 which found these programs ineffec-  
25      tive in stopping or delaying teen sex, reducing the

1        number of reported sexual partners, reducing re-  
2        ported rates of pregnancy or sexually transmitted in-  
3        fections, or otherwise beneficially impacting young  
4        people's sexual behavior. The Institute of Medicine  
5        of the National Academy of Sciences recommends  
6        the termination of such programs because they rep-  
7        resent "poor fiscal and public health policy."

8            (4) Leading medical and public health profes-  
9        sional groups, including the American Medical Asso-  
10       ciation, the American Academy of Pediatrics, the So-  
11       ciety of Adolescent Health and Medicine, the Amer-  
12       ican College of Obstetricians and Gynecologists, the  
13       American Nurses Association, the American Public  
14       Health Association, and the American Psychological  
15       Association, oppose an abstinence-only-until-mar-  
16       riage approach as antithetical to the principles of  
17       science. These organizations all stress the need for  
18       sexuality education that includes messages about ab-  
19       stinence and also provide young people with informa-  
20       tion about contraception for the prevention of teen  
21       pregnancy, HIV/AIDS, and other STIs.

22            (5) Since 1996, the United States has spent  
23        over \$1,500,000,000 in Federal funding on absti-  
24       nence-only-until-marriage programs that fail to  
25       teach teens how to prevent unintended pregnancy or

1 STIs, including HIV. Particularly during the Na-  
2 tion's worst economic disaster since the Great De-  
3 pression, government funding should only support  
4 evidence-based programs.

5 (6) According to the results of a 2005–2006  
6 nationally representative survey of United States  
7 adults published in the Archives of Pediatric & Ado-  
8 lescent Medicine, more than 8 in 10 (82 percent) of  
9 those polled, regardless of political ideology, support  
10 comprehensive sex education that is medically accu-  
11 rate and age-appropriate and includes information  
12 about both abstinence and contraception for protec-  
13 tion against unintended pregnancy and STIs, includ-  
14 ing HIV.

15 (7) There is strong evidence that more com-  
16 prehensive approaches to sex education help young  
17 people both to withstand the pressures to have sex  
18 too soon and to have healthy, responsible, and mutu-  
19 ally protective relationships when they do become  
20 sexually active. More comprehensive sex education  
21 has been found to be effective in delaying sexual  
22 intercourse, increasing contraceptive use, and reduc-  
23 ing the number of partners among teens.

24 (8) Strong evidence indicates that sex education  
25 programs that promote both abstinence and the use

1 of contraception does not increase sexual behavior.  
2 Studies show that when teens are educated about  
3 and have access to contraception, levels of contrac-  
4 tion use at first intercourse increase while levels of  
5 sex stay the same.

6 (9) Teens who receive sex education that in-  
7 cludes both abstinence and contraception are more  
8 likely than those who receive abstinence-only-until-  
9 marriage messages to delay sexual activity and use  
10 contraception when they do become sexually active.  
11 Research from the United States shows that teens  
12 who practice contraception consistently in their first  
13 sexual relationship are more likely to continue doing  
14 so than those who use no method or who use a  
15 method inconsistently.

16 (10) The Personal Responsibility Education  
17 Program (PREP) funds programs that are required  
18 to provide information on both abstinence and con-  
19 traception for the prevention of pregnancy and STIs,  
20 including HIV/AIDS, with a substantial emphasis on  
21 both abstinence and contraceptive use. Programs  
22 must also address adulthood preparation topics such  
23 as healthy relationships, adolescent development, fi-  
24 nancial literacy, educational and career success, and  
25 healthy life skills. Funded programs are required to

1 be evidence-based or replicate elements of evidence-  
 2 based programs that have been proven on the basis  
 3 of rigorous scientific research to change behavior.

4 **SEC. 3. ELIMINATION OF ABSTINENCE-ONLY EDUCATION**  
 5 **PROGRAM.**

6 (a) IN GENERAL.—Title V of the Social Security Act  
 7 (42 U.S.C. 701 et seq.) is amended by striking section  
 8 510.

9 (b) RESCISSION.—Amounts appropriated for each of  
 10 fiscal years 2010 and 2011 under section 510(d) of the  
 11 Social Security Act (42 U.S.C. 710(d)) (as in effect on  
 12 the day before the date of enactment of this Act) that are  
 13 unobligated as of the date of enactment of this Act are  
 14 rescinded.

15 (c) REPROGRAM OF ELIMINATED ABSTINENCE-ONLY  
 16 FUNDS FOR THE PERSONAL RESPONSIBILITY EDUCATION  
 17 PROGRAM (PREP).—Section 513(f) of the Social Security  
 18 Act (42 U.S.C. 713(f)) is amended by striking “for each  
 19 of fiscal years 2010 through 2014” and inserting “for fis-  
 20 cal year 2010, \$75,000,000 increased by an amount equal  
 21 to the unobligated portion of funds appropriated for each  
 22 of fiscal years 2010 and 2011 under section 510(d) that  
 23 are rescinded under subsection (b), and \$125,000,000 for  
 24 each of fiscal years 2012 through 2014”.

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