111TH CONGRESS
1ST SESSION

S. 611

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

IN THE SENATE OF THE UNITED STATES

MARCH 17, 2009

Mr. LAUTENBERG (for himself, Mr. KERRY, Mr. DURBIN, Mr. MENENDEZ, Mr. BROWN, and Mr. KENNEDY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Responsible Education About Life Act''.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) Leading public health and medical professional organizations, including the American Medical

Association (''AMA''), the American Medical Student Association (''AMSA''), the American Nurses Association (''ANA''), the American Academy of Pediatrics (''AAP''), the American College of Obstetricians and Gynecologists (''ACOG''), the American Public Health Association (''APHA''), the Institute of Medicine (''IOM'') and the Society of Adolescent Medicine (''SAM''), stress the need for sex education that includes messages about abstinence and provides young people with information about contraception for the prevention of teen pregnancy, HIV/AIDS, and other sexually transmitted diseases (''STDs'').

(2) A 2005 statement from the APHA urged that ''The U.S. Congress should authorize and fully fund legislation that promotes comprehensive sexuality education programs which include information about both abstinence and contraception, include parent-child communications components; and teach goal-setting, decision-making, negotiation, and communication skills'' and that ''sexual health information disseminated by federal agencies, be medically and scientifically accurate and based on theories and strategies with demonstrated evidence of effectiveness.'' In a 2006 statement, APHA reiterated that

it ''has strongly supported comprehensive sexuality education that includes information about concepts of healthy sexuality, sexual orientation and tolerance, personal responsibility, risks of HIV/AIDS and other STDs and unwanted pregnancy, access to reproductive health care, and benefits and risks of condoms and other contraceptive methods. Sexuality education should be non-judgmental and support parent-child communication and should not impose religious or ideological viewpoints upon students.''.

(3) The SAM stated in a 2006 position paper that ''SAM supports a comprehensive approach to sexual risk reduction including abstinence as well as correct and consistent use of condoms and contraception among teens who choose to be sexually active.'' In addition, ''Efforts to promote abstinence should be provided within health education programs that provide adolescents with complete and accurate information about sexual health, including information about concepts of healthy sexuality, sexual orientation and tolerance, personal responsibility, risks of HIV and other STDs and unwanted pregnancy, access to reproductive health care, and benefits and risks of condoms and other contraceptive methods.''.

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

(5) There is strong evidence that more comprehensive sex education can effectively help young people delay sexual initiation, even as it increases contraceptive use among sexually active youth. According to a report published by the National Campaign to Prevent Teen and Unplanned Pregnancy, ''two-thirds of the 48 comprehensive programs that supported both abstinence and the use of condoms and contraceptives for sexually active teens had positive behavioral effects''. Many either delayed or reduced sexual activity, reduced the number of sexual partners, or increased condom or contraceptive use.

(6) There is no evidence that federally funded abstinence-only-until-marriage programs are effective in stopping or delaying teen sex. A recent, congressionally mandated evaluation of federally funded abstinence-only programs by Mathematica Policy Research found that these programs have no beneficial

impact on whether young people abstain, when they first have sex, or their number of sexual partners.

(7) Comprehensive sexuality education programs respect the diversity of values and beliefs represented in the community and will complement and augment the sexuality education children receive from their families and faith communities.

(8) The median age at first intercourse is 16.9 years for boys and 17.4 years for girls. However, most do not marry until their middle or late 20s. This means that young adults are at risk of unwanted pregnancy and STDs for nearly a decade. Therefore, teens need access to full, complete, and medically and factually accurate information regarding sexuality, including contraception, condoms, STD/HIV prevention, and abstinence.

(9) From the early 1990s through the early 2000s, teen pregnancy and birth rates in the United States all declined dramatically—primarily, but not exclusively, because of increased and more effective contraceptive use among sexually active teens. These declines have since stalled, however, and new data from the Centers for Disease Control and Prevention's National Center for Health Statistics (''NCHS'') indicate that teen birthrates are on the

rise. NCHS reports a 3-percent national increase between 2005 and 2006 (from 40.5 to 41.9 births per 1,000 females aged 15–19).

(10) Teen pregnancy rates are much higher in the United States than in many other developed countries—twice as high as in England and Wales or Canada, and eight times as high as in the Netherlands or Japan.

(11) The decline in the teen birthrate between 1991 and 2004 resulted in saving taxpayers $6,700,000,000 in associated health care, child welfare, and other such costs in 2004 alone, reducing the cost to taxpayers. Investing in effective programs that improve teen sexual behavior by delaying sexual activity, improving contraceptive use among teens, and reducing teen pregnancies would contribute to reducing the taxpayer costs associated with teen childbearing.

(12) Ethnic and racial minority groups have been disproportionately affected by early pregnancy and parenthood. Fifty-three percent of Latina teens and 51 percent of African-American young women will become pregnant at least once before they turn 20, as compared to only 19 percent of non-Hispanic White young women.

(13) The United States has one of the highest rates of sexually transmitted diseases among industrialized nations. There are approximately 19,000,000 new cases of sexually transmitted diseases each year, almost half of them occurring in young people ages 15 to 24. According to the Centers for Disease Control and Prevention, these sexually transmitted diseases impose a tremendous economic burden with direct medical costs as high as $14,100,000,000 per year.

(14) Recent estimates suggest that while 15- to 24-year-olds represent 25 percent of the sexually active population, they acquire nearly half of all new STDs. Each year, one in four sexually active teenagers contracts a sexually transmitted disease.

(15) Nearly 15 percent of the 56,000 annual new cases of HIV infections in the United States occurred in youth ages 13 through 24 in 2006. An average of one young person every hour of every day is infected with HIV in the United States.

(16) African-American and Latino youth have been disproportionately affected by the HIV/AIDS epidemic. Although African-American adolescents ages 13 through 19 represent only 17 percent of the adolescent population in the United States, they ac-

counted for 70 percent of new HIV/AIDS cases reported among teens in 2005. Latino adolescents ages 13 through 19 accounted for 17 percent of AIDS cases among teens, the same as their proportion of the U.S. population in 2005. Although Latinos ages 20 through 24 represent only 18 percent of the young adults in the United States, they accounted for 22 percent of the new AIDS cases in 2005.

(17) Another study found that teens who reported previous discussions of sexuality with parents were seven times more likely to feel able to communicate with a partner about HIV/AIDS than those who did not have such discussions with their parents. Parental involvement is also a leading protective factor for dating violence prevention.

(18) Incorporating teen dating violence prevention into health education and sexuality education is imperative given the widespread experience of violence in dating relationships. Approximately one in three teens reports some kind of abuse in a romantic relationship, including emotional and verbal abuse. Young women who experience dating violence have sex earlier than their peers; are much less likely to use birth control; and engage in a wide variety of

high-risk behaviors including multiple partners, sex with older men, and drug and alcohol abuse. Young women who are victims of dating violence are four to six times more likely than nonabused girls to become pregnant.

SEC. 3. ASSISTANCE TO REDUCE TEEN PREGNANCY, HIV/AIDS, AND OTHER SEXUALLY TRANSMITTED DISEASES AND TO SUPPORT HEALTHY ADOLESCENT DEVELOPMENT.

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

(b) REQUIREMENTS FOR SEX EDUCATION PROGRAMS.—A program of sex education described in this subsection is a program that—

(1) is age appropriate and medically accurate;

(2) stresses the value of abstinence while not ignoring those young people who have had or are having sexual intercourse;

(3) provides information about the health benefits and side effects of all contraceptive and barrier methods used—

(A) as a means to prevent pregnancy; and

(B) to reduce the risk of contracting sexually transmitted disease, including HIV/AIDS;

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

(5) teaches young people the skills to make responsible decisions about sexuality, including how to avoid unwanted verbal, physical, and sexual advances and how to avoid making verbal, physical, and sexual advances that are not wanted by the other party;

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

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

(8) does not teach or promote religion.

(c) ADDITIONAL ACTIVITIES.—In carrying out a program of sex education, a State may expend funds received under this section to carry out educational and motivational activities that help young people to—

(1) gain knowledge about the physical, emotional, biological, and hormonal changes of adolescence and subsequent stages of human maturation;

(2) develop the knowledge and skills necessary to ensure and protect their sexual and reproductive health from unintended pregnancy and sexually transmitted disease, including HIV/AIDS, throughout their lifespan;

(3) gain knowledge about the specific involvement and responsibility of each individual in sexual decisionmaking;

(4) develop healthy attitudes and values about adolescent growth and development, body image, gender roles, racial and ethnic diversity, sexual orientation, and other subjects;

(5) develop and practice healthy life skills including goal-setting, decisionmaking, negotiation, communication, and stress management;

(6) promote self-esteem and positive interpersonal skills focusing on relationship dynamics, including, but not limited to, friendships, dating, romantic involvement, marriage, and family interactions; and

(7) prepare for the adult world by focusing on educational and career success, including developing

skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

SEC. 4. SENSE OF CONGRESS.

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

SEC. 5. EVALUATION OF PROGRAMS.

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

(b) NATIONAL EVALUATION.—

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

(2) PURPOSES.—The purpose of the national evaluation under paragraph (1) shall be the determination of—

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

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

(C) the effectiveness of such programs in preventing sexually transmitted disease, including HIV/AIDS;

(D) the effectiveness of such programs in increasing contraceptive knowledge and contraceptive behaviors when sexual intercourse occurs; and

(E) a list of best practices based upon essential programmatic components of evaluated programs that have led to success described in subparagraphs (A) through (D).

(3) GRANT CONDITION.—A condition for the receipt of a grant under section 3 is that the State involved agree to cooperate with the evaluation under paragraph (1).

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

(A) not later than the end of each of fiscal years 2010 through 2013, an interim report on the national evaluation under paragraph (1); and

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

(c) INDIVIDUAL STATE EVALUATIONS.—

(1) IN GENERAL.—A condition for the receipt of a grant under section 3 is that the State involved agree to provide for the evaluation of the programs of sex education carried out with the grant in accordance with the following:

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

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

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

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

(iii) the effectiveness of such programs in preventing sexually transmitted disease, including HIV/AIDS; and

(iv) the effectiveness of such programs in increasing contraceptive knowledge and contraceptive behaviors when sexual intercourse occurs.

(2) LIMITATION.—A condition for the receipt of grant funds under section 3 is that the State involved agree that not more than 10 percent of such

funds will be expended for evaluation under paragraph (1).

SEC. 6. NONDISCRIMINATION CLAUSE.

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

SEC. 7. DEFINITIONS.

For purposes of this Act:

(1) The term ''age appropriate'' means, with respect to topics, messages, and teaching methods, those suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

(2) The term ''eligible State'' means a State that submits to the Secretary an application for a grant under section 3 that is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this Act.

(3) The term ''HIV/AIDS'' means the human immunodeficiency virus, and includes acquired immune deficiency syndrome.

(4) The term ''medically accurate'', with respect to information, means information that is supported by research, recognized as accurate and objective by leading medical, psychological, psychiatric, and public health organizations and agencies, and, where relevant, published in peer review journals.

(5) The term ''Secretary'' means the Secretary of Health and Human Services.

(6) The term ''State'' means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Virgin Islands, and any other territory or possession of the United States.

SEC. 8. AUTHORIZATION OF APPROPRIATIONS.

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

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

(1) 7 percent of such amounts for administrative expenses related to carrying out this Act for that fiscal year; and

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

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