Healthy Relationships Act

A SCIENCE-BASED PRIORITY TO HELP YOUTH SUCCEED

The **Healthy Relationships Act** inspires youth with skills to help them escape poverty and build strong future families as they also learn to avoid all the consequences of sexual activity.

It empowers youth to build healthy relationships as they personalize the "success sequence" in their own lives.* In addition to the personal benefits, Sexual Risk Avoidance (SRA) education also protects taxpayers from the economic costs associated with non-marital teen pregnancy and birth, diagnosis and treatment of sexually transmitted disease (STD) and treatment for possible emotional effects of teen sex.

Background

The risk avoidance model is applied to address a variety of health risk behaviors, including smoking, underage drinking and illicit drug use. In other words, typical federal public health policy promotes behaviors that will result in the best health outcomes. Until recently, the risk avoidance approach was also more broadly applied to teen sex. In 2009, Congress, upon the request of the President, eliminated all funding for the sexual risk avoidance approach, ending a long history of bipartisan support. Later that year, however, a small portion of the funding was reauthorized with a bipartisan amendment reestablishing the Title V Abstinence Education state block grant program. In 2011, the Competitive Abstinence Education (CAE) Program was begun with a tiny $5 million in funding. In 2015, a new program, the Sexual Risk Avoidance Education (SRAE) Program was begun and funded at $10 million within the FY2016 Omnibus Spending Bill to replace the CAE Program. This bill inserted key portions of the Healthy Relationships Act to define the new program. Currently, there exists a troubling $100 million to $10 million federal funding disparity between Sexual Risk Reduction (SRR) contraceptive-centered and Sexual Risk Avoidance (SRA) education.

Purpose of the Legislation

The Healthy Relationships Act will fill gaps in current sex education policy:

- **Improves Understanding of the Advantages of SRA.** The term "abstinence education" is often misunderstood, despite the fact that the approach is effective, science-based, and resonates with teens. This bill revises and improves the legislative language and definition in order to reflect public health priorities and emerging social science research.

- **Changes Priority in Sex Ed Policy.** The bill begins to bring funding parity to sex education approaches by establishing priority on programs that help teens wait for sex.

- **Closes Loopholes in Implementing SRA Education.** The current Administration has identified loopholes in the current legislative language for sexual risk avoidance education, thereby permitting its misuse for purposes other than for what it is intended by Congress. This bill stops this abuse.

- **Offers Choice to Communities.** This bill gives communities another option for sex education. Since most federal sex education monies are currently used to fund programs that are explicit Sexual Risk Reduction (SRR) programs that still put teens at risk, this bill offers a refreshing alternative that gives youth the practical skills to succeed.

- **Adds No New Money to the Budget.** The bill will not increase the federal budget, but will fund the program through monies already allocated in the HHS Prevention and Public Health Fund.

*Success sequencing involves youth progressing through this series of behavioral benchmarks that increases their chances for avoiding poverty: completing school, securing a job, and marrying before bearing children.

To cosponsor this legislation, please contact:
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3. LARC Proponents Underemphasize its Lack of Protection Against STDs

LARC promotion nearly disregards the very real STD epidemic among young adults, in which, the CDC reports that 15-24 year olds comprise about 50% of all STD cases, yet only make up about 25% of the sexually active population. Top-line messaging implies that LARC = safe sex. LARC offers absolutely no protection against STDs, and this is especially problematic since risk compensation could increase STD rates among teens using LARC. In addition, dual LARC/condom usage is much more unlikely among teens. As the NIH stated regarding contraception: "Adolescents are at even higher risk of inconsistent contraceptive use than are other populations." [7] A recent survey of teens reinforced the concerns of NIH. The Teens Speak Out survey revealed that a sizeable percentage of teens (about one in three) say they would not commit to dual use of a condom with LARC. [8] And these sentiments are born out in a March 2016 JAMA article that revealed that teens who used LARC were 60% less likely to use condoms than were those who used the birth control pill. The researchers suggest: "Users of highly effective LARC methods may no longer perceive a need for condoms even if they have multiple sexual partners, which places them at risk for sexually transmitted infections." [9]

It is sexual delay that has the greatest impact on decreasing number of lifetime partners, preventing pregnancy, decreasing STD rates, and increasing condom use when sexually active. Teens need to understand that sexual delay is the best way to avoid acquiring a disease and any information on contraception must be presented in a way that does not normalize teen sex. Current LARC messaging fails to do so.

4. LARC Use: Increased Risk for Teen Girls

The American Congress of Obstetricians and Gynecologists (ACOG), report acknowledged that little research has been conducted on teen LARC (IUD) use and revealed: "Concern exists about the risk for expulsion from nulliparity and for STIs from sexual behavior in younger age groups." [10] This means that women and girls who have never given birth are more likely to be at increased risk for expelling the contraceptive device and for acquiring a sexually transmitted disease. Up to 1 in 5 are at risk for expulsion, so as a teen pregnancy prevention method, LARC fails to consistently deliver.[11]

There is also conflicting research on the cause of a slightly increased risk of pelvic inflammatory disease (PID) after LARC (IUD) insertion but it cannot be ignored, especially among young girls who already have increased risks due to their immature reproductive system. [12]

Summary

Ascend is concerned about the content and context of the LARC-for-teens campaign. Teens deserve more than LARC to assure optimal sexual health. They deserve the information and skills to avoid all sexual risk and achieve optimal health - not merely preventing teen pregnancy.

[1]CDC (2015). Press release: Few teens use the most effective types of birth control. Atlanta: Author. Retrieved on Feb. 3, 2016 at http://www.cdc.gov/media/releases/2015/p0407-teen-pregnancy.html)

[2]Arias, I. (2015, July 20). CDC expert commentary: Long-Acting Reversible Contraception: It's Recommended for Teens. Medscape.

[3]Arias, I. (2015, July 20). CDC expert commentary: Long-Acting Reversible Contraception: It's Recommended for Teens. Medscape.

[4]CDC (2015) Vitalsigns: Preventing teen pregnancy: A key role for health care providers. Retrieved March 21, 2016 at http://www.cdc.gov/vitalsigns/larc/
Source for Vitalsigns: Title X Family Planning Annual Reports, United States, 2005-2013
CDC (2015) Vital Signs: Trends in use of LARC among teens aged 15-19 years seeking contraceptive services: US 2005-2014. MMWR 64:13:363-369.

[5]Barna Group (2015). Teens speak out. Ventura: Author.

[6]Steiner RJ, Liddon N, Swartzendruber AL, Rasberry CN, Sales JM. (2016, March). Long-Acting Reversible Contraception and Condom Use Among Female US High School Students: Implications for
Sexually Transmitted Infection Prevention. JAMA Pediatr. Published online March 14, 2016.

[7]McNicholas, C., & Peipert, J. F. (2012). Long-Acting Reversible Contraception (LARC) for Adolescent. Current Opinion in Obstetrics & Gynecology, 24(5), 293–298. Retrieved on February 3, 2016 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4183267/

[8]Barna Group (2015). Teens speak out. Ventura: Author.

[9]Steiner RJ, Liddon N, Swartzendruber AL, Rasberry CN, Sales JM. (2016, March). Long-Acting Reversible Contraception and Condom Use Among Female US High School Students: Implications for
Sexually Transmitted Infection Prevention. JAMA Pediatr. Published online March 14, 2016.

[10]ACOG Women's Health Care Physicians (2012. Reaffirmed, 2014). Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices. Washington, DC: Author. Retrieved on February 3, 2016 at http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception.

[11]ACOG Women's Health Care Physicians (2012. Reaffirmed, 2014). Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices. Washington, DC: Author. Retrieved on February 3, 2016 at http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception

[12]LARC) for Adolescent. Current Opinion in Obstetrics & Gynecology, 24(5), 293–298. Retrieved Feb. 3, 2016 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4183267/

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