American Medical Association – Medical Student Section
Ad Hoc Committee on Public Health
Issue Brief: Adolescent Sexual Health Education

Executive Summary

The need for adolescent sex education is widely accepted, but discussion of approaches to sexual health education generates much debate in communities nationwide. Congressional welfare reform offered a recent impetus towards abstinence-only reproductive health curricula in U.S. public schools.[1] Though few Americans doubt the importance of encouraging today's teenagers to delay initiation of sexual activity, conflict remains as to the inclusion or exclusion of condom and contraceptive discussions in educational efforts. Some endorse a broad "social development" approach to reproductive health education, viewing a strong family unit, peer mentorship, and high educational aspirations as an indirect means to decrease high-risk adolescent behavior.[1] Realized teenage behavioral outcomes are the ultimate evaluative measure for reproductive health education strategies. Current AMA policy opposes the sole use of abstinence-only education in U.S. public schools, favoring instead a comprehensive approach that stresses the importance of abstinence while teaching about contraceptive choices and safe sex behaviors.

Background

Discussion of approaches to sexual health education generates much controversy among adolescent-serving professionals and communities across the United States. The need for youth-targeted sex education is widely accepted; teenage pregnancy and sexually transmitted infections (STIs) are widely accepted as significant public health problems with long-term ramifications. Furthermore, in recent years, the relationships between adolescent sexual activity and psychological wellness grow increasingly recognized. However, conflict remains between key players and aspects of the sexual health education debate, i.e., political mandates, financing mechanisms, religious beliefs, parental wishes, adolescent needs, and the U.S. public school system.

Since 1991, teenage pregnancy rates have steadily declined.[1] Despite this decrease, U.S. teens continue to have the highest birth rate and among the highest STI rates of industrialized countries.[2] As many teenage mothers lack the financial—and emotional—ability to care for their young children, greater than 75% receive public assistance within five years of giving birth.[1] If healthcare expenses, food and housing subsidies, workforce training, and foster care costs are included in expense calculations, the total societal cost of these young families is estimated at $7 billion/year.[1]

In 1996, Congress enacted the Personal Responsibility and Work Opportunities Reconciliation Act, more commonly known as "welfare reform." Attached to this legislation was an amendment to Title V of the Social Security Act, which appropriated $250 million over a five-year period for state-sponsored "abstinence-only" education. Five years later, in 2001, the Surgeon General released a "Call to Action to Promote Sexual Health and Responsible Sexual Behavior," emphasizing a nationwide need for improved access, quality, and outcomes of social interventions that promote responsible sexual behaviors in adolescents.[1]

Concrete approaches to sexual health education are diverse in breadth and support. Regardless of philosophical and moral differences, each approach must be

weighed in terms of its resultant benefit to adolescent behavior and outcomes. This issue brief explores three major sexual health education strategies used throughout the United States, considering each in the context of behavioral outcomes in American teenagers.

Abstinence-Only Education

Welfare reform was a recent impetus for educational efforts that teach abstinence as the only absolute means to avoid pregnancy and STIs. This approach does not address notions of condom or contraceptive use, based on the principle that such information undermines – and even contradicts – the abstinence-only message.[1]

Historically, evangelical Christians and numerous other religious groups offer strong support for this educational strategy.[3] In 2003, a National Public Radio (NPR) poll found that 15% of Americans supported abstinence-only sexual education in their public schools. Among junior high and high school principals, 30% reported that their schools teach such curricula. Survey data also revealed significant controversy surrounding the true definition of "abstinence," particularly surrounding issues of homosexuality, masturbation, and oral or anal sex.[3]

One of the most significant evaluations of abstinence-only initiatives centers on the Postponing Sexual Involvement (PSI) program, a five-session course taught by trained adults and teenagers in 31 counties throughout California. Over 7000 students of diverse racial and socioeconomic backgrounds were randomized into control and abstinence-only education intervention groups, and then followed for 17 months. At follow-up, there was no significant difference in pre- and post-intervention self-reported behavior measures, including initiation of sex, frequency of intercourse, number of sexual partners, condom use, contraceptive use, and pregnancy rates.[1]

At the first five-year mark of the Title V funding cycle, state-funded evaluations showed measurable success in improving adolescent attitudes towards abstinence.[2] Independent, federally funded research by Mathematica Policy Research, Inc., and the University of Pennsylvania supported this notion, finding that most participants reported positive feelings about their abstinence-only educational experiences.[1] However, both state-sponsored and independent studies show mixed results in terms of actual behavioral outcomes and intent to abstain.[2] In fact, abstinence-only programs may decrease condom and contraceptive use in sexually active teenagers.[2] The American Academy of Family Practice states that most published studies of abstinence-only education are inconclusive at best, with significant threats to internal and external validity that preclude development of evidence-based curriculum strategies.[1]

Youth Social Development Program

Adolescent social development programs are wide in breadth and loosely defined. However, these programs are all designed to enhance the social and psychological skills needed to avoid high-risk behaviors, such as early sexual activity. The notion of social development builds on the premise that teenagers who delay sexual activity have greater family support, stronger parent-child relationships, higher educational goals, and more opportunities for open communication with peers and adults alike.[1]

Numerous programs with this core approach are used throughout the United States, with variable success. In Washington State, the Seattle Social Development Project aims to strengthen adolescent social skills and parent-child relationships. Though the program lacks a specific sexual health education component, the intervention focuses on teacher and parent training in areas of general problem solving, child behavior management at home and in the classroom, and substance use prevention. In program

evaluation, 18 Seattle elementary schools were randomly assigned to control and intervention arms, with long term follow-up when students reached the age of 21 years. The intervention group showed statistically significant delay in onset of first sexual experience, decrease in lifetime sexual partners, and lower total pregnancy rates. When this data is stratified by ethnicity and gender, the program benefits are magnified within African American and female participants.[1]

In New York City, the Children's Aid Society Carrera Program utilized a similar approach within the context of after-school programs for 13- to 15-year-olds in the city's most disadvantaged communities. At three-year follow-up, female students showed decreased rates of sexual activity and pregnancy. However, no statistically significant difference between control and intervention groups was found in sexual and reproductive behavior measures of male students.[1]

Evaluations of social development curricula on youth reproductive health behavior are limited. The overwhelming majority of literature is positive in nature. However, these programs are poorly defined in scope and often lack a specific sexual health educational component. Though this approach may indirectly decrease rates of high-risk adolescent behavior, including early and/or unprotected sexual activity, one can easily argue that the social development model would have greater efficacy if complemented by an evidence-based educational component with specific reproductive health focus.

Comprehensive Sexual Health Initiative

An overwhelming majority of Americans agree that abstinence must be presented to teenagers as the most effective way to prevent pregnancy and STIs.[3] However, debate arises as to appropriate discussion of condom and contraceptive use. While proponents of abstinence-only education feel that such topics only detract from the central message of abstinence, others feel that safe sexual practices deserve discussion as the most appropriate strategies for those who do not abstain. "Comprehensive" sexual health education focuses on responsible sexual decisions, including abstinence and safe sex practices.[1, 3] In so doing, the challenge of this approach is to present contraceptive and safe sex information in an accurate, culturally competent, and age-congruent manner.[1]

The Centers for Disease Control (CDC) studies of adolescent reproductive health education endorse five "programs that work" to improve teenage sexual behavior outcomes. Each named program is comprehensive in approach; no abstinence-only efforts were cited by the agency.[4] In 2001, the National Campaign to Prevent Teen Pregnancy reviewed 28 experimental studies of comprehensive sexual health programs throughout the United States. This review found that the vast majority of such programs do not effect adolescent initiation of sexual behaviors, number of sexual partners, condom use, or contraception use.[1] A similar study in Fulton County, Pennsylvania, found no statistically significant difference in sexual attitudes, intentions, or behaviors at three year follow up of middle-school students randomized into abstinence-only and comprehensive sexual education groups.[2]

Recommendations

To explore these educational approaches, teenage behavioral outcomes must be held as the ultimate evaluative measure. In this spirit, the American Medical Association (AMA) opposes the sole use of abstinence-only education in U.S. public schools (H-170.968), instead endorsing federal funding for comprehensive sex education that stresses the importance of abstinence while teaching about contraceptive choices and safe sex

behaviors (H-170.968). While the AMA acknowledges that the primary responsibility for family life education should lie in the home, it also recognizes the needed role of the school system to complement this foundation (H-170.968). Furthermore, for developmentally and physically disabled youth, a well-recognized vulnerable population, targeted counseling and comprehensive sexual health education is sincerely encouraged (D-170.996). Similar endorsements are echoed by numerous other well-respected healthcare agencies, including the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP).[1]

Though abstinence-only programs likely improve teenage attitudes towards delayed initiation of sexual activity, attitudes and realized behaviors often do not correlate.[2] By no means does the AMA endorsement lessen the important role of abstinence in adolescent education. It merely augments this notion with discussion of condom and contraceptive use for teenagers who choose not to abstain.

The broad notion of youth social development education certainly holds merit; however, such programs are currently poorly defined and easily complemented by age-appropriate and culturally competent comprehensive sexual health curricula. In fact, this dual approach is a likely next step in evidence-based reproductive health education. However, until studied further, AMA policy will continue to endorse a unilateral comprehensive approach to reproductive health education.

References

1. As-Sanie, S., Gantt, A., and Rosenthal M. "Pregnancy Prevention in Adolescents," *American Family Physician* 70:8 (15 October 2004).
2. Hauser, D. "Five Years of Abstinence-Only-Until-Marriage Education: Assessing the Impact," Advocates for Youth, Title V State Evaluations. Available from: www.advocatesforyouth.org.
3. "Sex Education in America," NPR/Kaiser/Kennedy School Poll. Kaiser Family Foundation, publication #7015. Available from: www.kff.org.
4. "The Effectiveness of Abstinence-Only Education," Politics & Science—Investigating the State of Science Under the Bush Administration. Government Reform Minority Office. Available from: http://oversight.house.gov/features/politics_and_science/example_abstinence.htm.
5. "HIV Infection in Adolescents and Young Adults in the U.S.," National Institute of Allergy and Infectious Diseases, National Institutes of Health, U.S. Department of Health and Human Services, May 2006. Available from: http://www.niaid.nih.gov/factsheets/hivadolescent.htm.