

Position paper

Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine

Summary

Abstinence from sexual intercourse represents a healthy choice for teenagers, as teenagers face considerable risk to their reproductive health from unintended pregnancy and sexually transmitted infections (STIs) including infection with the human immunodeficiency virus (HIV). Remaining abstinent, at least through high school, is strongly supported by parents and even by adolescents themselves. However, few Americans remain abstinent until marriage, many do not or cannot marry, and most initiate sexual intercourse and other sexual behaviors as adolescents. Abstinence as a behavioral goal is not the same as abstinence-only education programs. Abstinence from sexual intercourse, while theoretically fully protective, often fails to protect against pregnancy and disease in actual practice because abstinence is not maintained.

Providing “abstinence only” or “abstinence until marriage” messages as a sole option for teenagers is flawed from scientific and medical ethics viewpoints. Efforts to promote abstinence should be based on sound science. Although federal support of abstinence-only programs has grown rapidly since 1996, the evaluations of such programs find little evidence of efficacy in delaying initiation of sexual intercourse. Conversely, efforts to promote abstinence, when offered as part of comprehensive reproductive health promotion programs that provide information about contraceptive options and protection from STIs have successfully delayed initiation of sexual intercourse. Moreover, abstinence-only programs are ethically problematic, being inherently coercive and often providing misinformation and withholding information needed to make informed choices. In many communities, abstinence-only education (AOE) has been replacing comprehensive sexuality education. In some communities, AOE has become the basis for suppression of free speech in schools. Abstinence-only education programs provide incomplete and/or misleading information about contraceptives, or none at all, and are often insensitive to sexually active teenagers. Federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning youth,

as federal law limits the definition of marriage to heterosexual couples.

Schools and health care providers should encourage abstinence as an important option for teenagers. “Abstinence-only” as a basis for health policy and programs should be abandoned.

Background

Abstinence from sexual intercourse is an important behavioral strategy for preventing STIs and unwanted pregnancy among adolescents and adults. Sexually active teenagers face considerable risk to their reproductive health from unintended pregnancy and STIs including infection with HIV. Although health professionals often are primarily concerned with the potentially serious consequences of adolescent sexual behavior, we also recognize that sexuality is integral to human nature and has many positive mental health consequences.

Abstinence, as the term is used by program planners and policymakers, is often not clearly defined in behavioral terms, nor is the term used consistently. Abstinence may be defined in behavioral terms, such as “postponing sex” or “never had vaginal sex,” or refraining from further sexual intercourse if sexually experienced. Programmatically, abstinence is also frequently defined in moral terms, using language such as “chaste” or “virgin,” and framing abstinence as an attitude or a commitment in addition to a behavior [1]. Federal regulations for state abstinence education funding adopt a moral definition of abstinence, requiring that abstinence education “teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity” [2].

Although abstinence until marriage is the goal of many abstinence policies and programs, few Americans wait until marriage to initiate sexual intercourse. Recent data indicate that the median age at first intercourse for women was 17.4 years, whereas the median age at first marriage was 25.3 years [3,4]. For men, the corresponding median age at first intercourse was 17.7 years, whereas the age at first marriage was 27.1 years [3,4].

Although advocates of abstinence-only government policy have suggested that psychological harm is a consequence of sexual behavior during adolescence, there are no scientific data suggesting that consensual sex between adolescents is harmful. Mental health problems are associated with early sexual activity, but these studies suggest that sexual activity is a consequence not a cause of these mental health problems [5–8]. We know little about how the decision to remain abstinent until marriage may promote personal resilience or sexual function/dysfunction in adulthood.

Opinion polls suggest considerable support for abstinence as a public health goal, but also indicate strong support for education about contraception and for access to contraception for sexually active teenagers [9]. Most teens (94%) and adults (91%) think it is somewhat or very important for society to give teens a strong message that they should not have sex until they are at least out of high school [9]. However, most adults (75%) and teens (81%) want young people to receive more information about both abstinence and contraception [9].

Current federal policy and programs

The federal government has greatly expanded support for abstinence-only programs since 1996. This support includes funding to states provided under Section 510 of the Social Security Act, originally enacted in 1996, and under Community-Based Abstinence Education projects, funded through the Special Projects of Regional and National Significance (SPRANS) program established in 2000. These programs focus on a restricted vision of abstinence promotion and prohibit disseminating information on contraceptive services, sexual orientation and gender identity, and other aspects of human sexuality [10]. Federal funding language promotes a specific moral viewpoint, not a public health approach. These federal programs present questionable and inaccurate opinions as fact, and specifically prohibit information about healthy alternatives to abstinence such as condom and other contraceptive use.

Section 510 programs must have as their “exclusive purpose” the promotion of abstinence outside of marriage for people of any age and may not in any way advocate contraceptive use or discuss contraceptive methods except to emphasize their failure rates [10]. Section 510 provides an eight-point definition of abstinence-only education. Under Section 510, abstinence education is defined as *an educational or motivational program which:*

1. has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
2. teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;

3. teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
4. teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;
5. teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
6. teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;
7. teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
8. teaches the importance of attaining self-sufficiency before engaging in sexual activity.

The initial implementation of Section 510 has allowed funded programs to emphasize different aspects of these eight points as long as the program did not contradict any of them. The intent of the SPRANS program has been more rigid: to create “authentic” abstinence-only programs, in response to concerns that states were using funds for “soft” activities such as media campaigns instead of direct classroom instruction and were targeting younger adolescents. Programs funded under SPRANS must teach all eight components of the federal definition, they must target 12–18-year-olds, and, except in limited circumstances, they cannot provide young people they serve with information about contraception or safer-sex practices, even with their own nonfederal funds. Funding for this program also bypasses the 510 program’s state approval processes and makes grants directly to community-based organizations, including faith-based organizations. Virtually all the growth in funding since FY2001 has come in the SPRANS program.

Evaluations of abstinence-only education and comprehensive sexuality education programs in promoting abstinence

To demonstrate efficacy, evaluations of specific abstinence promotion programs must address a variety of methodological issues including clear definitions of abstinence, appropriate research design, measurement issues including social desirability bias, the use of behavioral changes and not just attitudes as outcomes, and biological outcomes such as STIs [11]. Two recent reviews [12,13] have evaluated the evidence supporting abstinence-only programs and comprehensive sexuality education programs designed to promote abstinence. Neither review found scientific evidence that abstinence-only programs demonstrate efficacy in delaying initiation of sexual intercourse. Likewise, research on adolescents taking virginity pledges suggest that failure rates

for the pledge are very high, especially when biological outcomes such as STIs are considered [14]. Although it has been suggested that abstinence-only education is 100% effective, these studies suggest that, in actual practice, efficacy may approach zero.

A recent Congressional committee report [15] found evidence of major errors and distortions of public health information in common abstinence-only curricula. Eleven of the 13 curricula contained false, misleading, or distorted information about reproductive health, including inaccurate information about contraceptive effectiveness and risks of abortion. The report found that several of the curricula handle stereotypes about girls and boys as scientific fact (e.g., portraying girls as weak or dependent or men as sexually aggressive and lacking emotional depth) or blur religious and scientific viewpoints.

A rigorous national evaluation of abstinence-only education is currently being conducted with support from the Department of Health and Human Service's Office of the Assistant Secretary for Planning and Evaluation [16].

Adverse impact of abstinence-only policies on sexuality education and other public programs

Although health professionals have broadly supported comprehensive sexuality education [17–20], increasingly abstinence-only education is replacing more comprehensive forms of sex education in the nation's schools. Recent reports describe teachers and students being censured for responding to questions or discussing sexuality topics that are not approved by the school administrators [21]. Data from the School Health Policies and Programs Study in 2000 found that 92% of middle and junior high schools and 96% of high schools taught abstinence as the best way to avoid pregnancy, HIV, and STIs; only 21% of middle schools and 55% of high schools taught how to correctly use a condom [22]. Between 1988 and 1999, there was a sharp decline in the percentage of teachers who supported teaching about birth control, abortion, and sexual orientation and in the percentages who actually taught these subjects [23]. In 1999, 23% of secondary school sexuality education teachers taught abstinence as the only way to prevent pregnancy and STIs, compared with only 2% who had done so in 1988. In 1999, one-quarter of sex education teachers said they were prohibited from teaching about contraception. Similar declines in school-based sexuality education are reported by teens [3]. In 2002, about one-third of teens 15–19-year-olds reported not having received any formal instruction about methods of birth control before turning 18.

Likewise, federal funding requirements in the Title X program and for HIV/AIDS prevention programs have increasingly focused on abstinence promotion [24]. Such requirements have redirected efforts from other important objectives.

Abstinence-only policies by the U.S. government have

also influenced global HIV prevention efforts. The President's Emergency Plan for AIDS Relief (PEPFAR), focusing on 15 HIV-afflicted countries in sub-Saharan Africa, the Caribbean and Asia, requires grantees to devote at least 33% of prevention spending to abstinence-until-marriage programs. The U.S. government policy has become a source for misinformation and censorship in these countries and also may have reduced condom availability and access to accurate HIV/AIDS information [25].

Abstinence-only sex education and sexually active and GLBTQ youth

Programs geared to adolescents who have not yet engaged in coitus systematically ignore sexually experienced adolescents, a group with different reproductive health needs who likely require a different approach to abstinence education [26]. Sexually experienced teens need access to complete and accurate information about contraception, legal rights to health care, and ways to access reproductive health services, none of which are provided in abstinence-only programs.

Likewise, federally funded abstinence-until-marriage programs discriminate against gay, lesbian, bisexual, transgender and questioning (GLBTQ) youth because federal law limits the definition of marriage to heterosexual couples. Approximately 2.5% of high school youth self-identify as gay, lesbian or bisexual [27] and as many as one in 10 teenagers struggle with issues regarding sexual orientation [28]. GLBTQ adolescents often are fearful of rejection or discrimination due to their orientation; they are frequently subjected to harassment, discrimination, and violence. Homophobia may contribute to health problems such as suicide, feelings of isolation and loneliness, HIV infection, substance abuse and violence among GLBTQ youth [29]. Abstinence-only sex education classes are unlikely to meet the health needs of GLBTQ youth, as they largely ignore issues surrounding homosexuality (except when discussing transmission of HIV/AIDS), and often stigmatize homosexuality as deviant and unnatural behavior [30].

The human right to sexual health information

Although abstinence is often presented as the moral choice for teenagers, the current federal approach to abstinence-only funding raises serious ethical and human rights concerns. Abstinence-only education policies have implications at a public and individual level. Access to complete and accurate HIV/AIDS and sexual health information is a basic human right and is essential to realizing the human right to the highest attainable standard of health. Governments have an obligation to provide accurate information to their citizens and eschew the provision of misinformation; such obligations extend to state-supported health education and health care services [31]. These legal guar-

antees are found in a number of international treaties, which provide that all people have the right to “seek, receive and impart information and ideas of all kinds,” including information about their health [32–34]. Access to accurate health information is a basic human right that has also been described in international statements on reproductive rights such as the Programme of Action of the International Conference on Population and Development—Cairo, 1994 [35]. These international treaties and statements clearly define the important responsibility of governments to provide accurate and complete information on sexual health to their citizens.

Ethical obligations of health care providers and health educators

Health care providers and health educators have ethical obligations to provide accurate health information. Patients and students have rights to accurate and complete information from health professionals. Health care providers may not withhold information from a patient in order to influence their health care choices. It is unethical to provide misinformation or withhold information about sexual health that teens need in order to protect themselves from STIs and unintended pregnancy. Withholding information on contraception to influence adolescents to become abstinent is inherently coercive and may cause teenagers to use ineffective (or no) protection against pregnancy and STIs. Current federal abstinence-only legislation is ethically problematic, as it excludes accurate information about contraception, misinforms by overemphasizing or misstating the risks of contraception, and fails to require the use of scientifically accurate information while promoting approaches of questionable value. Additionally, “abstinence until marriage” curricula are commonly provided to those teens who are already sexually experienced and to GLBTQ youth, ignoring their pressing needs for accurate information to protect their health. These ethical obligations to provide complete and accurate information also are the basis for the strong support among medical professionals for comprehensive sexuality education in schools [17–19] and recent state legislative attempts to require that these sexuality education programs provide medically accurate information {e.g., Cal. Education Code § 51933}.

Positions of the Society for Adolescent Medicine (SAM)

- Abstinence is a healthy choice for adolescents. The choice for abstinence should not be coerced. 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.

- 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 STIs and unwanted pregnancy, access to reproductive health care, and benefits and risks of condoms and other contraceptive methods.
- Individualized counseling about abstinence and sexual risk reduction are important components of clinical care for teenagers.
- Health educators and clinicians caring for adolescents should promote social and cultural sensitivity to sexually active youth and gay, lesbian, bisexual, transgendered and questioning youth. Health education curricula should also reflect such sensitivity.
- Governments and schools should eliminate censorship of information related to human sexual health.
- Government policy regarding sexual and reproductive health education should be science-based. Governments should increase support for evaluation of programs to promote abstinence and reduce sexual risk, including school-based interventions, media efforts and clinic-based interventions. Such evaluations should utilize rigorous research methods and should assess the behavioral impact as well as STIs and pregnancy outcomes. The results of such evaluations should be made available to the public in an expeditious manner.
- Current U.S. federal law and guidelines regarding abstinence-only funding are ethically flawed and interfere with fundamental human rights. Current federal funding requirements as outlined in Subsections A–H of Section 510 of the Social Security Act should be repealed. Current funding for abstinence-only programs should be replaced with funding for programs that offer comprehensive, medically accurate sexuality education.

Endorsement

This position paper has been endorsed by the American College Health Association.

Prepared by:

John Santelli, M.D., M.P.H.
*Heilbrunn Department of Population & Family Health
 Mailman School of Public Health
 Columbia University
 New York, New York*

Mary A. Ott, M.D.
*Section of Adolescent Medicine
 Department of Pediatrics
 Indiana University School of Medicine
 Indianapolis, Indiana*

Maureen Lyon, Ph.D.
 Division of Adolescent and Young Adult Medicine
 Children's National Medical Center
 and Department of Pediatrics
 George Washington University Medical Center
 Washington, D.C.

Jennifer Rogers, M.P.H.
 American College of Preventive Medicine
 Washington, D.C.

Daniel Summers, M.D.
 Mt. Sinai Adolescent Health Center
 Mount Sinai School of Medicine
 New York, New York

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