NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

04-13

STATEMENT OF POLICY

Comprehensive Sexuality Education

Policy

The National Association of County and City Health Officials (NACCHO) supports funding and implementation of comprehensive sexuality education (CSE) programs that are:

- Age and developmentally appropriate for students in kindergarten through twelfth grade;
- Evidence-based or evidence-informed;
- Medically accurate;
- Culturally and linguistically responsive;
- Inclusive of physical, mental, emotional, and social dimensions of human sexuality;
- Inclusive of diverse gender expressions, identities, and sexual orientations;
- Aligned with evidence-based or evidence-informed state and national health education standards and the National Sexuality Education Standards: Core Content and Skills, K-12;
- Designed to provide students with knowledge and skills to reduce risk behaviors that lead to HIV, STIs, and unintended pregnancy; and
- Designed to help students increase protective behaviors such as routine reproductive health care, condom use and other contraceptive practices, HIV and STI testing, and abstinence.

NACCHO calls for the elimination of funding streams at federal, state, and local levels for abstinence only until marriage education, also known as sexual risk avoidance education.

In addition, NACCHO encourages local health departments to partner with school districts and youth-serving agencies to expand their HIV, STI, and unintended pregnancy prevention efforts in school, school-linked, and community settings by providing: access to and interpretation of data that enables the prioritization of high-need schools; guidance in the identification, development, and implementation of curricula meeting the standards set above; and professional development to ensure sexuality educators are competent in delivering selected curricula. NACCHO also supports the provision of and referral to sexual and reproductive health services for adolescents and the promotion of CSE programs among community members.

Justification

A large proportion of American youth are engaging in behaviors that can result in HIV, STIs, and unintended pregnancy. In the United States, nearly half (41.2 percent) of high school students have had sex, 11.5 percent of whom have had sex with four or more people during their

lifetime.[1] Nearly a third of high school students reported being sexually active (i.e., had sex during the three months prior to being surveyed), but did not consistently use contraception. [1] Among high school students who were sexually active, 13.8 percent reported that they had not used any method to prevent pregnancy during last sexual intercourse, and 56.9 percent reported that either they or their partner had used a condom during last sexual intercourse. [1] Nearly 27 percent reported that either they or their partner had used birth control pills, an IUD, implant, shot, patch, or ring to prevent pregnancy before their last sexual intercourse, a significant increase from 2011-2015.[1]

It is critical to provide youth with comprehensive sexuality education (CSE) to help ensure that they are equipped with the knowledge and skills to make healthy and safe decisions as they transition into adulthood. Research indicates that CSE programs that include information about HIV, STI, and pregnancy prevention are effective in reducing sexual risk behaviors among youth, including delaying first sexual intercourse; reducing the number of sex partners; decreasing the number of times students have unprotected sex; and increasing condom use.[2,3,4] Moreover, CSE in schools is cost effective. An economic analysis of a school-based CSE program found that with every dollar invested in the program, $2.65 is saved in medical costs and lost productivity.[5]

Rigorous evaluations have found that abstinence-only-until-marriage (AOUM) programs, also known as sexual risk avoidance programs, are not effective in delaying the initiation of sexual intercourse or changing other sexual risk behaviors, such as condom and contraception use.[6] Additionally, there is no evidence to support the claim that focusing exclusively on abstinence as a method of prevention increases abstinence among program participants.[6] In addition to being scientifically flawed, abstinence-only-until-marriage education can be viewed as being ethically negligent, as it deprives youth of the human right to access complete and accurate sexual health information.[7] Moreover, as AOUM programs are largely heteronormative and stigmatize same-sex loving and gender non-conforming individuals, they can contribute to negative mental health outcomes often experienced by LGBTQ adolescents.[6]

Sexually active adolescents who do not have the knowledge, skills, or resources to utilize protective behaviors are at risk for STIs, HIV, and unintended pregnancy. The Centers for Disease Control and Prevention (CDC) estimates that nearly 20 million new STIs occur every year, half among young people aged 15–24.[8] Reported cases of chlamydia and gonorrhea are highest in individuals between the ages of 15 and 24, with young women being particularly impacted by chlamydia.[8] Higher prevalence of STIs among young people may be indicative of impediments to testing and treatment including inability to pay, lack of transportation, long waiting times, conflicts between clinic hours and school and work schedules, stigma, and concerns about confidentiality.[8] Each of these infections is a potential threat to an individual's immediate and long-term health and well-being.[8] Additionally, STIs have a substantial economic impact. The CDC estimates that STIs cost the nation almost $16 billion in health care costs annually.[9]

Nation-wide, one in five new HIV infections occur in youth aged 13–24.[10] The highest rates of HIV diagnoses are among persons 25-29 years old (33.4), with the second highest among those 20-24 years old (31.2).[10] While HIV infections fell by 18 percent among young gay and bisexual males from 2008-2014, most new HIV diagnoses among youth occur among this population (81

percent), with young men of color bearing a disproportionate burden; in 2015, 79 percent of newly diagnosed males were black or Hispanic/Latino.[11] Half of youth living with HIV (approximately 50 percent) are not aware of their HIV status;[11] therefore, they do not receive treatment, putting them at risk for sickness and potentially early death, and increasing the likelihood of transmitting the virus to others.[12] Nationwide, 10.2 percent of high-school students had ever been tested for HIV, a significant decrease from 2011 that further highlights the need for CSE, including HIV/AIDS prevention education.[1]

The teen birth rate is currently at a historic low of 22 births per 1,000 females, having declined 64 percent since its peak in 1991; however, racial and ethnic disparities persist.[13] Compared to the birth rate of non-Hispanic white teens, the birth rates of Hispanic/Latina and non-Hispanic black teens are about two times higher, and those of American Indian/Alaskan Native are about one and a half times higher.[13] As a result of reduced educational attainment and employment due to the lack of financial and public support for pregnant and parenting teens, teen mothers and their children are at risk for long-term health, economic, and social consequences associated with poverty and inadequate health care.[14, 15] Teen childbearing in the United States cost approximately $9.4 billion in 2010, the last year for which data are available, largely due to increased costs for health care, foster care, incarceration, and lost tax.[16]

CSE also leads to positive outcomes not directly related to sexual health. CSE programs that are aligned with the National Sexuality Education Standards, particularly those implemented in elementary and middle school, include content and skills designed to improve young people's social and emotional learning (SEL), such as identifying healthy ways to show feelings, recognizing and managing emotions, learning healthy ways to communicate differences of opinion, and exploring tenets of healthy relationships.[17] SEL programs have been associated with significant reductions in dropout rates,[18] as well as higher social and emotional competencies; improved attitudes towards self, others, and school; positive social behavior; fewer conduct problems; lower emotional distress; and improved academic performance.[19]

Additionally, sexuality education that is inclusive of gender diverse and sexual minority students increases perception of school safety[20, 21] and results in better school attendance.[21] CSE, along with other policies and practices that promote safe and healthy environments for all adolescents, can reduce reports of depression and suicidal attempts.[22, 23, 24, 25]

Despite the glaring lack of effectiveness of AOUM programs, funding requirements and policies in support of it, as well as perceived or actual controversy related to its replacement by evidence-informed programming, has decimated the provision of school-based CSE. The percentage of schools requiring instruction about human sexuality fell from 67 percent in 2000 to 48 percent in 2014, and those requiring instruction about HIV prevention declined from 64 percent to 41 percent.[6] In 2014, three-quarters of high schools and half of middle schools and junior-high schools taught abstinence as the best way to avoid HIV, STIs, and pregnancy. In high schools, 61 percent of teachers taught about birth control methods, and 35 percent taught about the correct condom usage, while in middle and junior-high schools, those numbers were 23 percent and 10 percent respectively.[6] Moreover, statistics regarding the provision of sexual health education do not take into consideration the quality of such education; only 38.8 percent of districts require HIV prevention educators to receive professional development on the topic, and 32.2 percent of districts require the same of pregnancy prevention educators.[26]

Only 24 states and the District of Columbia mandate sex education, and just 22 states mandate both sex education and HIV education.[27] Twenty-seven states and the District of Columbia mandate that, when provided, sex education and HIV education programs meet certain requirements; however, only 13 states require that the instruction be medically accurate, and even fewer require that the program provide culturally responsive education.[27] Additionally, many states do not require that programs include information about contraception and other safe sex practices.[27]

CSE is supported by professional organizations in the medical, scientific, education, and public health fields, including the American Academy of Pediatrics,[28] the Society for Adolescent Health and Medicine,[7] the American College of Obstetricians and Gynecologists,[29] the National Education Association,[30] the American Medical Association,[31] and the Institute of Medicine.[31] Parents, youth, and a large majority of the American public also support comprehensive sexual health education for young people.[32]

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