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) calls for the elimination of funding at federal, state, and local levels for abstinence only until marriage education, also known as sexual risk avoidance education. 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;
- Ethical, rights-based, and centered on a reproductive justice framework that addresses the intersections of race, gender, class, ability, nationality, and sexuality;
- Inclusive of physical, mental, emotional, and social dimensions of human sexuality;
- Inclusive of diverse gender expressions, identities, and sexual orientations;
- Inclusive of and accessible by youth with atypical education and/or developmental needs, including neurodivergent youth and youth with disabilities, as well as youth in alternative settings such as virtual learning;
- 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, affirmative consent, condom use and other contraceptive practices, HIV and STI testing, and abstinence.

Local health departments play a vital role in the provision of school- and community-based CSE and skills-building interventions for adolescents, including out-of-school youth. NACCHO calls on 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 and resources to ensure sexuality educators are competent in delivering supportive, age- and culturally-appropriate, and inclusive curricula. NACCHO also encourages local health departments to have staff dedicated to sexual health education and, where applicable, support for

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school-based health centers. Furthermore, NACCHO supports the provision of and referral to sexual and reproductive health services for adolescents and the promotion of CSE programs among community members, including out-of-school youth. Local, state, and federal public health practitioners should engage communities to promote public dialogue about healthy sexuality in a variety of settings.

Justification

A large proportion of American youth are engaging in behaviors that can result in HIV, STIs, and unintended pregnancy. In the United States, over one-third (38.4 percent) of high school students have had sex, 8.6 percent of whom have had sex with four or more people during their lifetime.[1] Nearly a third of high school students in 2019 reported being sexually active (i.e., had sex during the three months prior to being surveyed), but did not consistently use contraception.[2] Among high school students who were sexually active, 10.3 percent reported that they had not used any method to prevent pregnancy during last sexual intercourse, and only 54.3 percent reported that either they or their partner had used a condom during last sexual intercourse.[2] Approximately 31 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.[2]

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.[3,4,5] 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.[6]

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.[7] Additionally, there is no evidence to support the claim that focusing exclusively on abstinence as a method of prevention increases abstinence among program participants.[7] 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.[8] 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.[7]

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 26 million new STIs occur every year, half among young people aged 15–24.[9] 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.[9] 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.[10] Each of these infections is a potential threat to an individual's immediate and long-term health and well-being.[9] Additionally, STIs have a substantial economic impact. The CDC estimates that STIs cost the nation almost $16 billion in health care costs annually.[11]

Nationwide, one in five new HIV infections occurs in youth aged 13–24.[12] The rate of HIV diagnoses among this population fell from 20.2 in 2015 to 14.3 in 2019, though the rate of HIV diagnoses remains highest among persons 25-34 years old (30.1).13 While HIV infections fell by 15 percent among young gay and bisexual males from 2014-2018, most new HIV diagnoses among youth occur among this population (81 percent), with young men of color bearing a disproportionate burden; in 2018, 78 percent of newly diagnosed gay and bisexual males were black or Hispanic/Latino.[13] Half of youth living with HIV (approximately 55 percent, lower than any other age group) are not aware of their HIV status;[13] 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.[14] Nationwide, 9.4 percent of high-school students in 2019 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 (ages 15-19) is currently at a historic low of 16.7 births per 1,000 females in 2019, having declined 60 percent from 2007 and 73 percent since its peak in 1991.[15] However, racial and ethnic disparities persist, and the teen birth rate in the U.S. remains higher than two-thirds of other high income countries according to the World Bank.[16] Compared to the birth rate of non-Hispanic white teens in 2019, the birth rates of Hispanic/Latina and non-Hispanic black teens are about two times higher, and those of American Indian/Alaskan Native and Native Hawaiian or other Pacific Islander teens are about two and a half times higher.[15] 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.[17, 18] 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.[19]

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.[20] SEL curriculum have been associated with significant reductions in dropout rates, 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. [21,22]

Additionally, sexuality education that is inclusive of gender diverse and sexual minority students increases perception of school safety and results in better school attendance.[23, 24] CSE, along with

other policies and practices that promote safe and healthy environments for all adolescents, can reduce reports of depression and suicidal attempts.[25, 26, 27, 28] Consent education, an element of many CSE programs, has also been shown to be a protective factor against sexual assault.[29] As of 2021, only 13 states require school-based sex education to cover consent as part of their sexuality curriculums. [30] This growing trend is especially important considering the disproportionate rates of sexual violence experienced by gender diverse and sexual minority students and the documented connection between violence victimization and elevated suicide risk among this population.[31, 32]

It is furthermore crucial that CSE curriculum is accessible by and inclusive of students of all abilities, including youth with autism spectrum disorders or attention-related, intellectual, or learning disabilities. Research shows that adolescents with intellectual and developmental disabilities (I/DD) know much less about sex than peers without disabilities, which increases this population's vulnerability to sexually transmitted diseases, unwanted pregnancy, and sexual abuse.[33] Children with I/DD are almost 5 times more likely than their peers without disabilities to experience sexual abuse and in some cases may not understand what is happening or their right to bodily autonomy, or otherwise lack the support to communicate an assault to a trusted person.[34, 35] Moreover, stakeholders should ensure that consent-based CSE is available in and appropriately tailored to settings accessible by students with disabilities and other alternative learning needs, such as distance/remote learning or community-based education. As distance learning becomes increasingly common in part due to public health emergencies such as the COVID-19 pandemic, CSE remains a crucial element of adolescent development and must adapt to consequent changes in both educational needs and sexual behaviors.[36, 37] In distance/remote learning as well as in other delivery methods, it is imperative that programs consider privacy needs and limitations of students who may be learning from home, community, or work settings. Local health departments can support the provision of CSE in schools as well as in community settings such as libraries, youth centers, and faith-based institutions for out-of-school youth.

Local health departments play a vital role in the provision of school- and community-based CSE and skills-building interventions for adolescents, including out-of-school youth. More than half of local health departments have staff dedicated to health education; within schools, local health departments may support school-based health centers (SBHCs) which provide sexual health services and informal sexuality education and counseling, and often partner with local education agencies to develop, review, and teach CSE curriculum.[38] Health departments may also provide training or support to educators and SBHCs in implementing safe and supportive strategies for CSE, such as ensuring that curriculum and resources are LGBTQ-friendly.[38] Additionally, local health departments are a source of crucial epidemiologic and risk behavior data used to determine priority schools or populations in which specific CSE topics are especially important.[38] In the community, local health departments are instrumental in conducting outreach to out-of-school youth and providing training, resources, and funding to community-based organizations & non-academic agencies to provide CSE for youth using their services. Often key to many of these strategies are youth advisory boards and workgroups convened by local health departments to inform their community and school-based CSE programming.[38]

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. Only 33 states and the District of Columbia mandate sex education, and 34 states require schools to stress abstinence in sex education or HIV/STI instruction.[39] Sixteen states require instruction on condoms or contraception when sex education or HIV/STI education is provided; however, fifteen states do *not* require sex ed or HIV/STI instruction to be any of the following: age-appropriate, medically accurate, culturally response, or evidence-based/evidence-informed.[39] Additionally, only ten states have policies including discussion of sexual health for LGBTQ+ youth, and eight states explicitly require instruction that discriminates against LGBTQ+ people.[39] 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.[40]

Policies that mandate the provision of AOUM are directly in contrast with overwhelming parental and student support for CSE.[41] A 2018 survey found that 89 percent and 98 percent of parents feel it is important to have sex education taught in middle and high school, respectively.[42] Despite disproportionate political attention on parents opposed to CSE curriculums, in reality, this education supports young people in connecting and communicating with positive adults in their lives about sexual health. Local health departments, educators, and other stakeholders should provide parents and caregivers with tools to address sexual health with the adolescents in their care.

CSE is supported by professional organizations in the medical, scientific, education, and public health fields, including the American Academy of Pediatrics,[43] the Society for Adolescent Health and Medicine,[7] the American College of Obstetricians and Gynecologists,[44] the National Education Association,[45] the American Medical Association,[46] and the National Academies of Sciences, Engineering, and Medicine.[47]

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