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Position paper

Abstinence-Only-Until-Marriage Policies and Programs: An Updated Position Paper of the Society for Adolescent Health and Medicine

The Society for Adolescent Health and Medicine

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A B S T R A C T

Abstinence from sexual intercourse can be a healthy choice for adolescents, particularly if an adolescent is not ready to engage in sex. However, government programs exclusively promoting abstinence-only-until-marriage (AOUM) are problematic from scientific and ethical viewpoints. Most young people initiate sexual intercourse as adolescents or young adults, and given a rising age at first marriage around the globe, increasingly fewer adolescents wait until marriage to initiate sex. While theoretically fully protective, abstinence intentions often fail, as abstinence is not maintained. AOUM programs are not effective in delaying initiation of sexual intercourse or changing other behaviors. Conversely, many comprehensive sexuality education programs successfully delay initiation of sexual intercourse and reduce sexual risk behaviors. AOUM programs inherently provide incomplete information and are often neglectful to sexually active adolescents; lesbian, gay, bisexual, transgender, and questioning adolescents; pregnant and parenting adolescents; and survivors of sexual assault. Promotion of AOUM policies by the U.S. government has undermined sexuality education in the United States and in U.S. foreign aid programs to prevent HIV infection. In many U.S. communities, AOUM programs have replaced more comprehensive approaches to sexuality education.

In 2006, the Society for Adolescent Health and Medicine (SAHM) released a position paper on adolescents and U.S. government (USG) policies and programs promoting abstinence as a sole option for young people. The 2006 position paper (and an accompanying review paper in *Journal of Adolescent Health*) provided an overview of scientific and human rights concerns with USG programs and policies that promote abstinence-only-until-marriage (AOUM). Since 2006, considerable scientific evidence has accumulated and many health and medical professional groups have rejected the focus on AOUM. Although USG funding for domestic AOUM was cut by over two thirds in federal Fiscal Year (FY) 2010, funding increased in FY 2012 and again starting in FY 2015. We have updated our 2006 review paper on AOUM programs; the updated review provides additional details and references [1]. The goal of this revised position paper was to update the scientific and human rights evidence about AOUM programs and refine SAHM's recommendations regarding AOUM programs.

Position paper approved by the Society for Adolescent Health and Medicine's Board of Directors, June 2017.

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Positions of the Society for Adolescent Health and Medicine

Based on our review, SAHM believes

1. Young people have a right to accurate and complete information to protect their lives and their health.
2. Abstinence can be a healthy choice, but adolescents should decide for themselves when they are ready to initiate sex. An adolescent's choice of abstinence or sexual activity should never be coerced.
3. Young people should be empowered to become full partners in the development and implementation of comprehensive sexuality education programs.
4. Education for adolescents regarding abstinence is best provided within health education programs that provide adolescents with complete and accurate information about sexual and reproductive health.
5. Sexuality education should be comprehensive, medically accurate, and culturally competent; promote healthy sexuality; and prepare young people to make healthy sexual

decisions. Instruction in sexuality education should include essential concepts and issues such as sexual orientation, sexual health, gender identity and power dynamics, intimate partner violence and sexual exploitation, healthy relationships, social and structural determinants, personal responsibility, risks for HIV and other sexually transmitted infections (STIs) and unwanted pregnancy, access to sexual and reproductive health care, and the benefits and risks of condoms and other contraceptive methods.

6. Health educators and health care providers should provide comprehensive information to young people.
7. Governments and schools should eliminate censorship of information related to human sexuality, including sexual orientation and gender identity.
8. Sexuality education curricula and programs should be based on scientific principles and evidence from research. Government policy regarding sexual and reproductive health education should be science based. The focus on evidence-based interventions in current U.S. federal programs to prevent adolescent pregnancy represents an important scientific advance over prior federal efforts which focused on abstinence only and ignored the evidence base. The USG and other governments should increase support for development and evaluation of programs to promote adolescent sexual and reproductive health, including school-based interventions, media efforts, and clinic-based interventions.
9. United States government programs promoting abstinence-only-until-marriage are ethically flawed, are not evidence-based, and interfere with fundamental human rights to complete and accurate health information. U.S. federal funding for such programs should be eliminated and Title V, Section 510(b) of the Social Security Act, including subsections A–H, should be repealed. Current funding for abstinence-only-until-marriage programs should be replaced with funding for programs that offer comprehensive, medically accurate sexuality education.
10. "Abstinence-only-until-marriage" as a basis for adolescent health policy and programs should be abandoned.

Background

The U.S. federal government began supporting sexual abstinence promotion programs in 1981. Funding was greatly expanded after 1996 and focused on exclusionary programs (i.e., abstinence only), which restricted the provision of other information [1]. Between 1982 and federal FY 2017, the USG has spent over $2 billion on AOUM programs in the United States [2]. Between 2004 and 2013 PEPFAR (the largest AOUM funder) has invested over $1.4 billion in sub-Saharan Africa [3]. The USG continues to fund AOUM programs which must have the exclusive purpose of promoting abstinence outside of marriage [3–5]. Programs cannot in any way advocate contraceptive or condom use or discuss contraceptive methods except to emphasize their failure rates. The definition of abstinence included in the Title V AOUM program states, in part, "that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity" and "that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects" [5].

Given concerns about program efficacy and restrictive federal program requirements, U.S. states began refusing federal AOUM funding beginning in 2004. (California has never accepted AOUM funding.) By 2009, nearly half of the states had chosen not to take federal support. After 2009, the emphasis of federal funding shifted to evidence-based interventions to prevent adolescent pregnancy. In FY 2016, U.S. Congress created a new AOUM funding mechanism, the "Sexual Risk Avoidance Education" program. Sexual Risk Avoidance Education is defined as "voluntarily refraining from nonmarital sexual activity" and teaching the "benefits associated with self-regulation." [5].

Review of Scientific Evidence

While the goal of AOUM programs is to delay initiation of sexual intercourse until marriage, this goal ignores global demographic trends in age at marriage. While considerable diversity exists among and within nations in the age at first sex, age at marriage is rising dramatically [6]. This global trend is related to social factors including rising access to education and restrictions on child marriage. Thus, the rising age at marriage has led to a substantial increase in premarital sex. In the United States, the gap between the median age at first intercourse and first marriage is enormous—8.7 years for women and 11.7 years for men [7].

While proponents for AOUM programs suggest that sexual activity outside of marriage is likely to have harmful psychological and physical effects, we find no evidence that consensual sex between adolescents is psychologically harmful. The risks associated with adolescent sexual activity are influenced by the policy context. In countries where adolescents have access to contraceptive education and counseling, and medical care, adolescent, pregnancy rates are much lower than in the United States.

The USG funding requirements suggest that abstinence from sexual intercourse is "the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems." This is a misleading and potentially harmful message, as it conflates theoretical effectiveness of intentions to remain abstinent and the actual practice of abstinence. In practice, abstinence intentions often fail to prevent pregnancy and STIs.

Considerable evidence has accumulated on the lack of efficacy for AOUM curricula. A 2007 Cochrane review of abstinence-only programs for preventing HIV infection in high-income countries found that they were ineffective [8]. The most comprehensive review of program efficacy is a 2012 meta-analysis by the U.S. Centers for Disease Control and Prevention which examined 66 comprehensive risk reduction programs and 23 abstinence programs. Comprehensive risk reduction programs had favorable effects on self-reported current sexual activity, number of sex partners, frequency of sexual activity, use of protection (condoms and/or hormonal contraception), frequency of unprotected sexual activity, STIs, and pregnancy [9]. In contrast, the meta-analysis of risk avoidance (AOUM) programs found insufficient evidence of a change in adolescent abstinence, other sexual behaviors, or other sexual health outcomes [9]. In addition, the major program evaluation of U.S.–based abstinence-only programs conducted for the USG found that youth in AOUM programs were no more likely than participants in control groups to abstain from sex, and if they were sexually active, the two groups had similar sexual behaviors including the number of partners and the age at initiation [10].

Public and Professional Support for Sex Education

The goal of education about human sexuality is to raise sexually healthy adults [1]. Healthy development requires

complete information, open and honest conversations, and support for decision-making about sex and relationships.

Public opinion polls in the United States suggest strong support for comprehensive approaches to sex education—including abstinence, education about condoms and contraception, and access to condoms and contraception for sexually active adolescents. In a 2014 nationally representative survey, 74% of adults supported federal money going to programs proven to delay sex, improve contraceptive use, and/or prevent adolescent pregnancy [11].

Similarly, health professionals have overwhelmingly supported comprehensive sexuality education. The major associations of physicians and public health workers have endorsed comprehensive approaches to sexuality education; many have specifically taken positions against AOUM programs that limit sexual and reproductive health information for young people [1] National public health goals, established by the U.S. Department of Health and Human Services [12], call for increasing the share of adolescents receiving formal instruction about birth control methods, prevention of HIV/AIDS and STIs, and abstinence.

Negative Impact of AOUM Programs

In many U.S. communities, school-based AOUM programs have replaced more comprehensive forms of sex education. Surveys on health education practice in the United States provide evidence of an erosion of comprehensive sexuality education in high schools and middle schools. For example, in 1995, 81% of adolescent males and 87% of adolescent females reported receiving formal instruction about birth control methods; by 2011–2013, this had fallen to 55% of males and 60% of females [13]. Marked disparities in access to comprehensive sex education also occur by state and district [13].

AOUM policies by the USG have also influenced global HIV prevention efforts [3,14], primarily through requirements of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR required grantees to devote at least 33% of prevention spending (and two thirds of funds for sexual transmission) to abstinence-until-marriage programs. Human rights groups also found that USG policy was a source for misinformation and censorship in PEPFAR countries [15]. The U.S. emphasis on AOUM may also have reduced condom availability and access to accurate information on HIV/AIDS in some countries [15]. The emphasis within PEPFAR prevention shifted to science-based programming after 2008 with the dropping of specific funding for AOUM [3].

AOUM programs do not meet the needs of and may be harmful to sexual minority youth, as these programs are largely heteronormative and often stigmatize other sexualities as deviant [16]. Stigma and discrimination can contribute to health problems such as suicide, feelings of isolation and loneliness, risk for HIV infection, substance abuse, and violence among sexual minority youth [17]. By excluding sexual minorities, AOUM programs may produce feelings of rejection and being disconnected to school. The sexual health needs of lesbian, gay, bisexual, transgender, and questioning students are not the same as the needs of students involved in opposite-sex relationships.

Many AOUM programs reinforce gender stereotypes about female passivity and male aggressiveness. Rigid gender beliefs and gender power imbalance are associated with risky sexual health behaviors including reduced likelihood of condom and contraceptive use [18]. In contrast, programs that critique gender norms and gender-based power imbalances positively impact sexual and reproductive health knowledge, attitudes, behaviors, and health outcomes [18].

AOUM programs ignore the realities of adolescents who have experience of sexual abuse or exploitation. These young people cannot easily choose abstinence and may be made to feel guilty for their experiences rather than supported by the education and health care systems.

AOUM programs also ignore sexually experienced adolescents. Many sexually experienced adolescents 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. Federal guidelines for AOUM programs have associated sexual abstinence with virtuosity and therefore implicitly associate sexual activity—whether or not by choice—with negative health outcomes including guilt about sex. Finally, these programs often fail to acknowledge students who are pregnant or parenting. Thus, AOUM programs systematically ignore or stigmatize many young people.

Human Rights Concerns and Ethical Obligations of Health Professionals

Sexual and reproductive rights are grounded in a constellation of fundamental human rights guarantees, including the right to life, health, access to accurate health information, privacy, information, freedom from discrimination, and freedom from cruel, inhumane, and degrading treatment—among others. These rights are found in universally accepted human rights documents—and are also defined and expanded upon in later international human rights 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 [19]. Moreover, these rights are addressed in regional human rights treaties and interpretive statements, as well as in political consensus documents.

Thus, access to 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, which extend to state-supported health education and health care services [20]. These international treaties and statements clearly define the important responsibility of governments to provide accurate and complete information on sexual health to their citizens.

The U.S. AOUM program is also at odds with commonly accepted notions of medical ethics. Just as adolescents have the right to accurate and complete information from teachers and health educators, health care providers have ethical obligations to provide accurate health information in caring for patients [1]. Such ethical obligations are part of respect for persons and reflected in clinical counseling and in the practice of informed consent; similar ethical obligations apply to health educators [1].

AOUM programs exclude accurate information about contraception, misinform by overemphasizing or misstating the risks of contraception, fail to require the use of scientifically accurate information, and promote ideas of questionable value. They are commonly provided to those adolescents who are already sexually active and to lesbian, gay, bisexual, transgender, and questioning youth, ignoring their pressing needs for accurate information to protect their health. Ultimately, AOUM programs

undermine public health goals and the safe transition of young people into sexually healthy adults.

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