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Position Paper

## Promoting Sexual Consent Principles in the Sexual and Reproductive Health Care of Adolescents and Young Adults

Society for Adolescent Health and Medicine

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### ABSTRACT

Mutual sexual consent is an essential component of healthy sexual relationships. The ability to communicate with a partner about any physical/sexual contact, including kissing, touching, or sexual intercourse, is necessary for a mutually respectful relationship. Healthcare clinicians (HCCs) and health education programs should stress the importance of sexual consent and recognize the frequency of nonconsensual sexual activity and sexual violence among adolescents and young adults (AYAs). HCCs and those who work with youth need to be aware of the cultural context and norms along with legal parameters for sexual consent in their geographic area. Infrastructure support, including programs to develop clinician skills, time for thoughtful and sensitive discussions about sexual consent, and community referral options, is necessary for HCCs to be able to have the skills and time to review the important aspects of sexual consent with their patients. Research is needed to advance evidence-based practices to prevent nonconsensual sexual contact among AYAs and to effectively disseminate and implement best practices.

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### SAHM Positions

1. Healthcare clinicians (HCCs) need to ensure that all adolescents, young adults, and the general public fully comprehend, value, and implement sexual consent principles.

2. Comprehensive sexual and reproductive health (SRH) education programs, informed by evidence-based research, should include elements that increase adolescents' and young adults' (AYAs) ability to successfully implement sexual consent principles.

3. HCCs and educators should discuss sexual consent as an integral component of healthy sexual relationships, especially with marginalized and vulnerable AYAs.

4. HCCs who work with AYAs need to routinely assess for nonconsensual sexual contact and directly provide or connect AYAs to support services for victims of sexual violence.

5. All HCCs and educators need to be cognizant of the multiple legal aspects of sexual consent in their geographic area.

6. HCCs need to educate the public about the importance of discussing sexual consent with youth and advocate for AYAs who

report nonconsensual sexual contact to prevent further sexual violence and to promote healing and recovery.

7. Infrastructure support by professional organizations, and hospital and insurance systems, need to be in place to ensure HCCs have the training, skills, and time to counsel AYAs on sexual consent principles.

8. Additional research needs to be conducted to increase evidence-based practices to prevent the occurrence of nonconsensual sexual contact among AYAs and on the effective dissemination and implementation of best practices.

### Statement of the Problem

The 2021 Youth Risk Behavior Survey of high school students in the United States (US) demonstrated that approximately 14% of females and 4% of males have experienced nonconsensual sexual activity [1]. Furthermore, up to one-third of adolescent females and one-fifth of adolescent males have experienced sexual violence in middle-income to high-income countries [2]. Nonconsensual sexual contact or unwanted sexual contact that includes penetration, is sexual assault or rape, respectively and a source of trauma [3]. Thus, HCCs, other individuals who serve youth, and the public need to understand the importance of sexual consent. Health education programs do not universally discuss sexual consent, and many HCCs lack the knowledge, skills, time, and resources to address sexual consent.

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Additionally, cultural and religious barriers to discussing sexual consent, sexual activity, and contraception need to be addressed. Recommendations are needed to emphasize how HCCs and others who serve youth can promote consent as an essential component of respectful and healthy sexual relationships, and advocate for system supports and research to promote evidence-based interventions.

## Methods

This position paper was based on a comprehensive review of the international scientific literature that was published in English, reports and technical guidance from national and international organizations, and consensus opinion among the interprofessionals.

### *Positions and Recommendations*

**Position #1:** HCCs need to ensure that all adolescents, young adults, and the general public fully comprehend, value, and implement sexual consent principles.

HCCs are uniquely positioned to support the sexual health and development of AYAs. They can play an important role in helping AYA understand the definition of sexual consent, and the critical importance of obtaining consent from and providing consent to their sexual partners. Sexual consent is one's voluntary, sober, and conscious willingness to engage in a particular sexual activity including kissing, hugging, touching, manual penetration, and sexual intercourse (oral, vaginal, or anal) with a particular person within a particular context [4]. Those who use licit and illicit substances or drugs that alter consciousness are unable to give sexual consent. Consenting and asking for consent are reflective of setting personal boundaries, respecting partners' boundaries, and asking for confirmation if unclear. All individuals must agree to any sexual activity—every single time—for it to be consensual. Enthusiastic consent is a newer model that focuses on a positive expression of consent; the presence of a “yes” rather than the absence of a “no.” Enthusiastic consent can be expressed verbally, with additional nonverbal cues such as positive body language like smiling, maintaining eye contact, and nodding [5].

HCCs also can help AYAs understand that it can be very difficult, if not impossible, to voluntarily consent to any sexual act in the context of power imbalances, coercive persuasion, manipulation, or threats. Coercion can be so nuanced that the involuntary nature of the sexual act at that time may not be recognized by either party until later. Persons who have experienced abuse, sexual violence, or oppression can benefit from HCCs skilled in trauma-informed care. Consent education needs to include how to avoid situations where unwanted sexual contact can occur. HCCs need to ensure that AYAs know that consent can be changed (withdrawn) at any point and cannot be assumed.

**Position #2:** Comprehensive SRH education programs, informed by evidence-based research, should include elements that increase AYAs ability to successfully implement sexual consent principles.

Comprehensive sex education (CSE) programs have been shown to increase condom and contraceptive use, reduce sexual risk-taking, decrease intimate partner violence, and promote the development of healthy relationships [6]. Many CSE programs follow a human rights and gender equity–based approach [7,8], with sexual consent as an essential component. Curriculum-based CSEs can be administered in and out of school and use

interactive teaching methods to review the cognitive, emotional, physical, and social aspects of sexuality and healthy relationships [7,9]. International guidance on sexuality education emphasizes that education regarding consent is critical for building pleasurable and respectful sexual relationships and protecting the vulnerable from harm [8]. Zambia is the first country to adopt the CSE-recommended indicators in its nationwide sexuality education program [8]. The National Sex Education Standards 2020 developed by the US advocacy group Sexual Information and Education Council of the US (SIECUS), also identifies consent as an integral part of education on healthy relationships [10].

**Position #3:** HCCs and educators should discuss sexual consent as an integral component of healthy sexual relationships, especially with marginalized and vulnerable AYAs.

It is crucial that HCCs and educators continually instruct youth about sexual consent, ideally before the onset of sexual activity and with a compassionate healing-centered approach, especially for AYAs who may have experienced nonconsensual sexual contact. While some colleges and universities offer sexual consent education, most elementary and secondary sex education curricula do not address this topic [11]. Youth need to understand the age at which they can legally offer and accept consent for sexual activity. Confusion exists among youth about the meaning, communication, and implications of providing sexual consent as part of a healthy sexual relationship. HCCs and educators need to clearly define these aspects of sexual consent, normalize open communication between patients and partner(s) about their sexual boundaries before engaging in sexual activity, and learn about and be able to discuss their state/region specific laws regarding age of consent.

Discussions of sexual consent need to acknowledge the sociocultural context and personal factors, including historical oppression due to ingrained power dynamics, and personal histories of abuse or nonconsensual sexual contact. Concurrently, while supporting youth self-efficacy in preventing nonconsensual sexual contact, HCCs and educators should promote healing and recovery from prior experiences of nonconsensual sexual contact.

Marginalized youth warrant specific consideration, since they are at a greater risk for nonconsensual sexual activity and may have fewer opportunities to receive help [12–15]. A recent systematic review demonstrated that youth who are homeless, indigenous, sexual or gender minorities, poverty-affected, system-involved, rural residing, or have a disability or a refugee background experience more barriers and less engagement with healthcare when compared with their peers [15]. Such youth may have limited understanding of the health system, experience disproportionate stigma and fear toward help-seeking, and may face clinical environments that lack cultural sensitivity or are discriminatory [15]. HCC and educators, when discussing sexual consent, should focus on modifiable factors, promote resilience, develop practical skills in sexual self-efficacy, facilitate open communication with supportive adults about relationships and sex, build community connectedness, provide support and referrals for youth who are disentangling from controlling relationships, and address other adversities voiced by youth [12,13,16]. Educational materials and clinic displays should include multicultural and gender-diverse relationships to support inclusivity [12,13].

**Position 4:** HCCs who work with AYAs need to routinely assess for nonconsensual sexual contact and directly provide or connect AYAs to support services for victims of sexual violence.

HCCs need to create clinical environments that facilitate confidential care and empower youth to feel comfortable sharing personal experiences [12,17]. As mandated reporters, HCCs need to clearly explain the assurances and limitations of confidentiality. Decisions to break confidentiality and report to outside agencies need to consider the youth's safety, proactively discussed with the youth to preserve trust, and adherent to the local reporting laws [12,13].

Nonconsensual sexual activity is a risk for all youth. Routine screening for nonconsensual sexual contact can be introduced after establishing a therapeutic alliance and providing a safe and confidential context for the discussion. HCCs may need to inquire about specific sexual behaviors, transactional sexual activity, and substance use (including coercion of such use) that alters one's control of situations. Screening discussions must be accompanied by follow-through interventions as indicated, such as brief counseling on identified risk behaviors, referrals through warm hand-offs to trauma-focused mental health and community services, and follow-up visits [13]. All youth can receive universal education about preventing nonconsensual situations for oneself and one's peers, and discussion of condom negotiation strategies [12]. In scenarios of contraception manipulation or coercive relationships, clinicians may offer harm reduction strategies such as long-acting contraception that is more easily under the patient's control, and advanced provision of emergency contraception. Additional interventions include skill-building, isolation reduction techniques, substance use treatment, education about privacy safeguards on social media, and referrals to specialty services [12,13].

**Position #5:** All HCCs and educators need to be cognizant of the multiple legal aspects of sexual consent in their geographic area.

HCCs and educators need to have a detailed understanding of cultural attitudes and their impact on local laws related to the legally defined age of sexual consent to work proactively with the local legal system. While laws aim to protect youth from abuse or coercion, and to prevent the harmful consequences of sexual activity at a young age [18], the legal age for sexual consent varies by geography and for different sexual acts. There are no international standards regarding the minimum age for sexual consent, although the United Nations Convention on the Rights of the Child states 13 years to be on the low end [18]. Legal age of sexual consent can range from 16 to 18 years in the US depending on the state [19], 16 years in Canada [20], 14–18 years in different European countries [21], and 18 years in India [22]. Close-in-age exemptions are found in some localities and are highly variable across countries and localities within countries.

Statutory rape is usually used by law enforcement to refer to sexual intercourse with a person under the age of sexual consent. Criminal penalties exist for various sexual acts between adults and minors and between minors of widely differing ages [18,19]. "Close-in-age exemptions" may protect a partner who is only somewhat older than the underage youth from prosecution. The rationale for these exemptions is that overly strict interpretation of the legal age of consent may lead to inadvertent criminalization of consensual sexual activity between youth. In some localities, larger age gaps between sexual partners are considered unlawful due to potential coercion and unbalanced power dynamics.

Under the legal framework of many countries and certain states within the US, underage sexual activity is one example of abuse that HCCs, teachers, and counselors are mandated to

report to their country's designated agencies. For some complicated cases which the legality is not always clear, a more delicate balance between requirements to report to local agencies and the continuation of a therapeutic relationship with the youth may be needed. An interprofessional focus by all involved parties on the mutual goal of youth safety is warranted [23]. When appropriate, agencies that support survivors of abuse should be involved.

**Position #6:** HCCs need to educate the public about the importance of discussing sexual consent with youth and advocate for AYAs who report nonconsensual sexual contact to prevent further sexual violence and promote healing and recovery.

AYAs and their parents/guardians generally have limited conversations about sexual consent [24,25]. HCCs can support caregivers and become involved in their communities beyond the patient encounter, by educating the public and those that work with youth about sexual consent and the need for healing-centered approaches for AYAs who have experienced nonconsensual sexual contact. This role is even more important in regions without clear legal definitions of age of consent or regions that have adopted a young legal age of consent. Educational messages that focus on consensual sexual behaviors and the effect of alcohol and illicit drugs on one's capacity to consent can promote healthy relationships and prevent sexual harassment [26]. Studies suggest that alcohol-related gatherings are associated with an increase in sexual assaults or risky sexual behaviors [27]. HCCs can support and advocate for youth who have experienced nonconsensual sexual activity. Advocacy efforts could include serving on school health advisory committee to ensure nonconsensual sexual activity is addressed in school health programs, and meeting with legislators to discuss, pass, or strengthen laws penalizing perpetrators of sexual violence. By identifying and addressing individual, relationship, and community risk factors, as well as broader social and health policies, these advocacy efforts can reduce inequities that contribute to sexual violence.

**Position #7:** Infrastructure support by professional organizations, and hospital and insurance systems need to be in place to ensure HCCs have the training, skills, and time to counsel AYAs on sexual consent principles.

Infrastructure support will be critical to support the success of HCCs and educators in promoting the core principles of sexual consent, through professional education, direct patient care, involvement in their local legal systems, and advocacy. The World Health Organization recognizes sexual health as a basic human right, and as a necessary condition to enable the achievement of reproductive health. Accordingly, infrastructure support needs to focus on a more holistic promotion of sexual well-being, rather than a limited view of sexual ill-health [28]. The US Centers for Disease Control and Prevention offers a technical package to guide communities to prevent sexual violence through a multi-sector approach involving public health, health care, education, justice, and social services [29].

The infrastructure for sexual consent training based on the fundamental principles of gender, rights, and social determinants needs to start early during health professional school and continue throughout the routine curriculum of clinical training [30]. Continuing education courses for HCCs working with AYAs need to include sexual consent content from youth-friendly and trauma-sensitive approaches that respect the existing social-cultural fabric of their particular local environment. The infrastructure in health systems billing systems need to support adequate time for providers to counsel patients and utilize

healing-centered practices that support reproductive/sexual autonomy, by reimbursing for such counseling activities. In settings where electronic medical records are utilized, sexual consent topics can be built into patient visit templates to serve as reminders to busy providers.

Besides advocating for infrastructure support, professional organizations involved in SRH health for AYAs need to recognize the importance of sexual consent and normalize the inclusion of this topic in their specialty fields. A comprehensive strategy to promote sexual well-being necessarily includes robust foundational support to form linkages between stakeholders.

**Position #8:** Additional research needs to be conducted to increase evidence-based practices to prevent the occurrence of nonconsensual sexual contact among AYAs and on the effective dissemination and implementation of best practices.

While there has been increased interest in raising awareness about sexual consent principles, research examining the ways in which AYAs define, understand, and communicate sexual consent is limited [29,31]. Definitions of consent vary and need to be distinguished from instances of sexual coercion. Differences between the concepts of desire and will in a sexual act also need to be clarified. Studies of sexual health interventions or sexual violence prevention programs have been largely restricted to convenience samples of college-aged students, and with few specifically describing and measuring sexual consent as an intervention component [32,33]. Future studies may focus on standard measures of sexual consent that have been developed [34]. Studies of sexual consent need to be conducted among populations that are diverse in geography, gender identity, sexual orientation, marital status, socioeconomic status, age, race/ethnicity, previous sexual prejudices and experiences, health status, and cultural/community context. Future studies need to be diverse in the audience in which the intervention is targeted (e.g., individuals, HCCs, educators, public policy); the method of delivery (classroom-based, community-level, media campaigns, interactive computers/game designs); focus of the content (aimed at increasing knowledge, attitudes, communication skills, etc.); and the amount of exposure that is necessary for the intervention to be effective. In addition, development of indices to measure the effectiveness of interventions would help in determining the further direction of research [35].

## Summary

Sexual consent is an essential element of healthy sexual relationships. HCCs and others who work with youth can educate AYAs on the fundamental aspects of sexual consent but need the skills and infrastructure support to do so effectively. HCCs need to ensure confidentiality while recognizing the multiple cultural and legal aspects of sexual consent and laws for legal age of consent in their area. Comprehensive sexual education programs that include the topic of sexual consent are another important avenue to educate youth. Public knowledge and support of principles of consent in sexual relationships will reinforce the activities of professionals who work with youth to promote SRH. Continued effort to address the root causes of sexual violence,

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oppression, and power imbalances is needed so all individuals can consent to sexual contact without influence.

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