Ethical Considerations of Comprehensive and Abstinence Based Sex Education for Adolescents

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MPH 560

Concordia University

February 2015
Abstract

Nearly half of American adolescents are or have been sexually active. This sub-population of the United States needs intervention to achieve healthier measures of sexual behavior, disease, and pregnancy and birth rates. The topic of sexual education is complex: Different states offer a broad range of laws and curriculum guidelines, and parents and federal government are also among the many stakeholders contributing to this issue. A public health ethics framework is used to explore some of the many ethical questions surrounding types, content, and implementation of sexual education. Finally, communitarian values are mentioned as a vital contribution to the process of curriculum development, implementation, and evaluation.
The topic of human sexuality is unparalleled in its ability to elicit strong emotion and controversy. Adolescent sexuality is even thornier and many parents might hope that their teenagers choose to abstain from sex until later (or until marriage), or at least practice monogamy with 100% use of contraceptives. Unfortunately, in the United States this is not currently the case. In 2013 in the U.S. 46.8% of high school students reported having had sex at least once, and 34% reported sex in the last three months. Of the recently sexually active nearly half (40.9 %) did not use a condom during their last encounter. In addition, 15% of high school students reported having had four or more sexual partners (“CDC - Sexual Behaviors,” 2014). Globally, the U.S. has high rates of teen birth and abortion compared with other developed nations (Barr, Moore, Johnson, Forrest, & Jordan, 2014).

With sexual activity comes the possibility of a broad range of health implications such as pregnancy, Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STIs), and even abuse and self-esteem issues. Adolescents are no exception as each year thousands of young people under age 24 contract HIV (Centers for Disease Control and Prevention, 2012), millions contract STIs and over 400,000 teens gave birth in 2009 (“CDC - Sexual Behaviors,” 2014). Mothers under 19 and their children have poorer health and social outcomes than when the mother is older at birth (Santelli et al., 2006). Clearly adolescent sexual activity serves as a fundamental cause of disease and other health burdens, and needs to be addressed with appropriate measures.

In the United States, school based sexual education is a common public health intervention. However, the existence, content, funding, and development of “sex ed” often bring up controversy and ethical questions because of the inherent moral, religious,
and health implications of the education and behavior in question. Although national health strategies and task forces recommend HIV, STI, and pregnancy interventions for students (Center for Disease Control and Prevention, 2012), in practice the requirements and content for sex education vary greatly by state. Many states have no legal mandate for sex education in schools, and each state sets its own curriculum and parental consent requirements (National Association of State Boards of Education, n.d.).

U.S. school based programs fall into one of two broad categories: abstinence only and comprehensive or abstinence plus. (Collins, Alagiri, & Summers, 2002). Strict abstinence only programs aim to do what the name implies, teach only abstinence from sex as the best way to avoid unwanted pregnancy, HIV, and STIs. The programs (or state guidelines for them) sometimes avoid teaching topics such as contraception, condom use, abortion or homosexuality (National Association of State Boards of Education, n.d.).

Comprehensive programs and abstinence plus programs acknowledge that many teens will engage in sexual activity and teach about condom and contraceptive use as well as information on STIs, HIV, and abortion. Often these programs still emphasize abstinence as one or the best option (Collins et al., 2002). Many state guidelines and individual curriculums fall somewhere in between these broad categories. In general, all of the programs aim to reduce sexually risky behaviors among teens, therefore reducing such outcomes as HIV and STI transmission, teen pregnancies, and abortion. Abstinence only programs also aim to defer sexual activity entirely until older or married.

An important step in discussing the ethics of any public health decision is identifying the stakeholders (Jennings, Kahn, Mastroianni, & Parker, 2003). In evaluating sexual education, primary stakeholders include students receiving the education, their
parents, and teachers or others who will be implementing the program. Local healthcare providers who care for adolescents may want to know or contribute to the content their patients are receiving for continuity of care. Public health professionals who will be developing curriculum are a very important part of the ethical discernment process. Community leaders, including religious, business, or cultural representatives may want input into value and practice formation for the next generation. Taxpayers who will be paying for the program may have opinions or concerns about where their money is going. Finally, local and state politicians and/or lobbyists often need to consider sex education issues for their platforms, and the federal government has famously exercised its influence by funding only sex education programs matching their own ethical values (Stein, 2010).

With such a wide range of stakeholders and options for programming, choosing an ethically appropriate program for a group of students can be challenging. Some of the values at stake are individual religious and moral beliefs of stakeholders, respect of those beliefs, community participation and empowerment, effectiveness of programming, and social and distributive justice for all who will be receiving the interventions. As a guide, Kass calls for a six-step framework to explore the ethical considerations of public health programs. Steps include elucidating goals, effectiveness, burdens and benefits, and fairness of the proposed program (Kass, 2001).

1. **What are the public health goals of the proposed programs?**

   The Centers for Disease Control and Prevention (CDC) identify four benchmarks that a well-planned HIV/STD program can achieve: delay of first intercourse, reduction in number of sexual partners, decrease in unprotected sex, and increase in condom use.
To truly achieve public health goals, these benchmarks should be followed by an actual decrease in HIV/STI rates. Other goals could include reductions in teen pregnancy, birth, and abortion rates, and an increase in knowledge, decision-making skills and self-esteem related to sexuality.

2. How effective is the program in achieving its stated goals?

The effectiveness of comprehensive and abstinence only programs is a source of much research, speculation, and debate, and the data are often confusing to interpret. True abstinence is 100% effective to prevent STIs and unwanted pregnancy, but does abstinence based education actually achieve its goals? Toups and Holm (2002) reviewed a number of abstinence based program evaluations and found evidence of lower sexual activity and pregnancy rates in program participants. However, other research has been contradictory. One cohort study of so-called virginity pledgers (adolescents pledging to stay virgins) found that the pledgers did delay sexual intercourse for an average of 18 months. However, they were less likely to use contraception when they began having intercourse, and six years later had similar rates of STIs to their peers (Santelli et al., 2006). In other words, the positive results were not long lasting and the pledgers were ultimately more compromised in their use of contraceptives.

Stanger-Hall and Hall (2001) found that teen pregnancy and birth (but not abortion) actually increased in states that recommend more abstinence-based education. The results were still significant even though confounded by measures of socio-economic status and race of students. They also found that states with more comprehensive sex education had the lowest teen pregnancy rates. The World Health Organization reported in 1993 that comprehensive programs that covered abstinence, contraception, and STD
prevention were the most effective in reducing risky sexual behavior in young people (Starkman N & Rajani N, 2002). Overall, the research seems to show that comprehensive programs are more effective, however the highly charged political and religious nature of the topic opens the door for bias in reporting. Any sexual education program should be rigorously evaluated for results, including long-term follow-up of participant outcomes. Additionally, the CDC (2011) has found that programs with adequately trained instructors, age-appropriate content, and “components on skill-building, support of healthy behaviors in school environments, and involvement of parents, youth-serving organizations, and health organizations” have been proven to be effective and recommends incorporating these traits into program development.

3. What are the known or potential burdens of the program?

Some significant burdens of sexual education programs are use of resources, clash with the values of students, parents and other stakeholders, and lack of distributive justice. Specialized teacher training is an important part of program effectiveness (Center for Disease Control and Prevention, 2011), but this takes time and money. While no parent wants to see their child burdened with a disease, unplanned pregnancy, or coercion into sexual activity, many parents also do not want their children taught in a way that contradicts their family values, whether their values are liberal or conservative, Christian, or secular. Since not every state mandates a certain type or any programming, some parents and students may want the education and find that their school district doesn’t offer it or doesn’t offer the type they would like. This represents a lack of distributive justice in what is available for students.

4. Can burdens be minimized? Are there alternative approaches?
The CDC reports that if HIV/STD programs are designed effectively, they are also cost-effective, saving $2.65 in medical costs and lost productivity for every dollar invested (Center for Disease Control and Prevention, 2011). The 2009 federal Labor-Health and Human Services, Education and Other Agencies appropriations bill provides $114 million for evidence-based teen pregnancy prevention; over the last few decades the bulk of federal funding has been for abstinence-only programs that were restricted in some content areas such as contraception (Stanger-Hall & Hall, 2011). Concerning informed consent options for parents, as of 2011 all but five states have an opt-out policy, and those five have opt-in programming (Stanger-Hall & Hall, 2011). All states then theoretically give parents full autonomy over their child’s education, so that no child will have to undergo education that clashes with parental values. States such as Idaho view sexuality education as being inseparable from the local home and church environments, and allow local school boards to choose a program (or no program) with the goal of supplementing the teachings and values of local families, churches, and culture (National Association of State Boards of Education, n.d.). Although this policy leaves the possibility of offering no or inadequate education, it also shows admirable communitarian traits and respect for culture (Ataguba & Mooney, 2011).

In states without mandates, some school districts don’t offer education. Alaska for example has no mandate, and in 2010 only 65.9% of high school students received education on how to prevent HIV, STIs, and pregnancy (Center for Disease Control and Prevention, 2012). An alternative might be to supplement education through programs offered elsewhere, such as through community health centers, churches, or other community based programs. A successful chlamydia reduction pilot program for youth in
Florida partnered with other entities such as the local health department, a community center, churches, and a Boys and Girls Club. The program also included curriculum to teach parents how to become their children’s “primary sexuality educators” (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB prevention, 2012). Chlamydia rates for the affected county went from 2nd in the state in 2008 to 40th in 2012.

5. Is the program implemented fairly?

States that don’t mandate sexual education are not fairly implementing their programming by definition, as they leave it up to the individual school boards who may or may not choose to offer education. The above-mentioned trend concerning higher teen pregnancy rates in abstinence only states also reveals some discrimination against minority teens. The states with abstinence only education tend to have higher numbers of black teens (Stanger-Hall & Hall, 2011). If abstinence only education is truly contributing to higher pregnancy and birth rates, then the black adolescents are not receiving as effective of interventions as their white counterparts. Young black and Hispanic women also disproportionately account for 75% of HIV infections among women (Collins et al., 2002), another reason to reexamine the effectiveness of interventions in these states.

Some states, including Arizona and Alabama, require that sex ed emphasize only an ideal of heterosexual behavior and specify that homosexual behaviors cannot be promoted or taught as acceptable (National Association of State Boards of Education, n.d.). While this does represent the view of many in the U.S., the likelihood is that teens identifying as LGBT in these schools or states will not receive education that applies to their situation. Given that young men who have sex with men (MSM) and bisexual and transgendered persons are especially at risk for HIV (Collins et al., 2002), the danger is
real that these programs will deny education to the adolescents most likely to be at risk. The curriculums may also stigmatize LGBT youth depending on what is taught about homosexuality. Under Alabama state law sex ed must teach that “homosexuality is not a lifestyle acceptable to the general public and that homosexual conduct is a criminal offense under the laws of the state” (National Association of State Boards of Education, n.d.).

6. How can the benefits and burdens of a program be fairly balanced?

If teachers are required to have specialized training to teach sexuality topics, they should be compensated or other professionals brought in to teach. Parents and other stakeholders should be given ample opportunity to bring their concerns and preferences about sex ed, and minority opinions should be respected and not stigmatized. I believe that all states should mandate some form of sexual education, but preference should be given to evidence based programs. Unfortunately the federal government continues to fund abstinence only programs even when comprehensive and abstinence plus programs prove more effective. Effective programs run from other community organizations might be a option for underserved populations or areas.

The public health code of ethics also mentions some communitarian (Ataguba & Mooney, 2011) concerns and values. Any proposed program should respect the rights, beliefs, and cultural practices of community members and involve their input during development and implementation. In addition the program should empower vulnerable community members and public health professionals should provide the information need for the community to make decisions (Thomas C, Sage, Dillenberg, & Guillory, 2002). Ataguba and Mooney (2011) talk about the need for communities to take ownership of
health problems and their solutions. Sexual health and activity of adolescents is a topic that may take very well to a communitarian approach due the highly social, cultural, and religious context of sexuality in general.

For Americans, the broad majority (90%) of middle and high school parents believe it important for their children to receive sexual education in school, with only 7% disagreeing. Support for abstinence only curriculums is low at 15%; most parents want their children to learn about controversial topics such as abortion (85%), homosexuality (77%), and instructions for and availability of contraceptives (86%). Interestingly, they also want teens to learn about delaying sex (95%) and how to make sexual choices based on individual values (91%) (Santelli et al., 2006). The most ethically appropriate curriculums will seek to respect the wishes of the surrounding communities and even consult them in the development phases. Some communities might fall on the extreme liberal or conservative side of the spectrum concerning sexual values. In these cases, programming might need to shift to respect these values while still accommodating those who disagree and the most vulnerable students.

In Sarasota County, FL, a school board had engaged Planned Parenthood speakers to teach on certain topics for sexual education in their schools. Some parents and board members began to voice complaints after hearing of the Planned Parenthood involvement due to the organization’s association with abortion. Eventually the school board adapted a compromise to offer classes with and without the speakers, and also held an open meeting for parents to bring their opinions and concerns. And in Poudre, CO, an advisory board worked hard to bring together a curriculum that was “relevant for 10th- graders while conforming to community norms.” Their goal was to meet the needs of all students
including those who are gay, Christian, sexually active, and abstinent (Vail, 2005). These
eamples show how community members can help influence or even develop
curriculums that meet their needs and reflect community values.

The United States consistently lags behind other developed nations on measures
of teen pregnancies and STIs. Ethical questions and dilemmas surround the choice,
availability, and outcomes of sex education for adolescents, but some conclusions are
clear. Comprehensive and abstinence plus programs appear to be more effective in
achieving public health goals, but parents need to have opportunity to contribute and
maintain some autonomy over their children’s education. Because states are free to set
their own requirements, sexual education is not equally available to all students. Some
sub-populations such as the LGBT population may have even less access. To ethically
choose a curriculum, one must discern the stakeholders, look at effectiveness, and
consider local values and culture. An ethical curriculum will also consider the needs and
input of all students and parents and attempt to address them without discrimination.
References


