Comprehensive Sexuality Education vs. Abstinence-Only Sexuality Education: The Need for Evidence-Based Research and Practice

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Teen pregnancy has declined due to stagnating sexual activity rates and increases in contraceptive use. Still, between 800,000 and 900,000 adolescents become pregnant each year in America. Many who become parents during adolescence are unable to achieve positive health, economic, and social well-being outcomes, particularly around educational success. This article reviews the empirical literature regarding the effectiveness of comprehensive and abstinence-only sexuality education, which heavily supports the provision of comprehensive sexuality education. It also examines the essential role that Title X, the national family planning policy, can play in increasing implementation of comprehensive sexuality education programs both within schools and in the community. School social workers can better serve the individuals and the communities they work with by increasing their knowledge of effective prevention programs and advocating policies that support such programs.

Keywords: *adolescents; advocacy; evidence-based practice; sexuality education; social policy*

The Centers for Disease Control and Prevention (2000) report that 800,000 to 900,000 adolescents under the age of twenty become pregnant each year. This fact is particularly distressing considering the centers' assertion that "Adolescent pregnancy and childbearing have been associated with adverse health and social consequences for young

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women and their children" (Centers for Disease Control and Prevention, 2000, p. 605). Fortunately, as the Centers for Disease Control and Prevention (2000) point out, the rates of adolescent pregnancy are declining. This decline is attributed to stagnating rates of sexual activity and an increase in the use of contraceptives, such as condoms and long-lasting hormonal methods. Much of the credit for declining adolescent pregnancy rates goes to public family planning programs funded under Title X of the Public Health Services Act. The Centers for Disease Control and Prevention (1999) also report that the comprehensive reproductive health services (including comprehensive sexuality education programs) that receive this funding prevent an estimated 1.3 million unintended pregnancies.

In this article, the empirical evidence on outcomes for pregnant adolescents is reviewed and the efficacy research on comprehensive and abstinence-only sexuality education is examined. Title X of the Public Health Services Act, the public policy most relevant to sexuality education, is described. Finally, I make recommendations for school social workers who are interested in approaching sexuality education from an advocacy and policy position.

Outcomes Associated with Adolescent Parenthood

There is extensive research documenting the negative outcomes associated with adolescents having children. Often these outcomes limit either the adolescent parent or the child from succeeding in educational settings. These measures can be broken into three categories: health, social, and economic measures.

A number of studies have identified negative health outcomes for children. King (2003) reports that the infants of adolescents are twice as likely to be born preterm, with low birth weight, or small for gestational age as babies born to adult women, and three times more likely to die in infancy. King posits that because adolescents are still growing, they may compete with their fetuses for nutrients. It is important for school social workers to be aware that those born preterm are more likely to exhibit cognitive, educational, and behavioral difficulties in school (Anderson, Doyle, & the Victorian Infant Collaborative Study Group, 2003).

Some studies have identified adolescent parenthood as a risk factor for child maltreatment, perhaps due to the higher likelihood of other negative factors. Zelenko, Huffman, Brown, Daniels, Lock, Kennedy, and Steiner (2001) report that low-birth-weight and premature babies born to adolescent parents are at higher risk for abuse and neglect. They also

assert that adolescent mothers who have sick infants may have negative feelings toward their babies as well as unrealistic expectations regarding their babies' development. Andreozzi, Flanagan, Seifer, Brunner, and Lester (2002) found that adolescent mothers of eighteen-month-old children were at enhanced risk of committing child abuse. Elders and Albert (1998) report that up to 66 percent of pregnant adolescents have histories of sexual abuse, and the risk of abuse and neglect for babies born to sexually abused teens is much higher than for babies born to teens who are not abused. Not surprisingly, Jones (1994) found that children who experienced abuse and neglect were much more likely to display emotional problems, achievement difficulties, and maladaptive behaviors in educational settings.

Adolescent parents and their children are at enhanced risk of negative developmental and social consequences. Hillis, Anda, Dube, Felitti, Marchbanks, and Marks (2004) note that the infants of adolescent mothers tend to have poorer cognitive development and more behavioral problems later in life. Andreozzi et al. (2002) looked at negative social outcomes for teenage mothers and their children and found that adolescent mothers of eighteen-month-old children have lower self-esteem, experience more stress as parents, and live in lower-quality home environments. Notably, low self-esteem has been linked to poor educational coping strategies and the internalization of problem behaviors; as such, school social workers may have the opportunity to intervene directly with such pregnant youths (Aunola, Stattin, & Nurmi, 2000). Moore, Morrison, and Greene (1997) report that the children of adolescent parents are less likely than other children to live in environments that are stimulating. According to Weinman, Smith, Geva, and Buzi (1998), adolescent mothers "have few psychological and social resources, are cognitively immature, and tend to adopt more punitive ways to discipline their children" (p. 288). Teenage parenting has negative economic effects on the parents, the children, and society. In 1994, the Center for Population Options revealed that nearly $34 billion in public money was spent on direct health-care costs, welfare, Medicaid, and food stamps for adolescent parents and their children (Solomon & Liefeld, 1998). Consistent with previous studies, Yampolskaya, Brown, and Greenbaum (2002) report that teen mothers are more likely to drop out of school and less likely to pursue higher education than teens who do not have babies. They also find that adolescents who have children are at higher risk of living in poverty and being on welfare than adolescents who do not have children. This is of particular importance to school social workers, who

frequently observe the deleterious effects of family poverty on educational achievement (for a review, see Jozefowicz-Simbeni & Allen-Meares, 2002). Using data from the 1982 National Survey of Family Growth, Turner, Grindstaff, and Phillips (1990) found that teenage parents were at risk of experiencing long-term poverty. They report that teenage pregnancy is associated with larger family size, single parenthood, less earned income, and lower job satisfaction.

Klepinger, Lundberg, and Plotnick (1999) found that teenage parenting results in less accumulation of human capital, which they measure as completing high school, obtaining higher education or job training, and getting early job skills. This affects the earning capacity of young mothers; white teenage mothers earn 23 percent less, and black teenage mothers 13 percent less, than those who are not teenage parents.

Comprehensive and Abstinence-Only Sexuality Education

The current debate focuses on the provision of abstinence-only education versus comprehensive sexuality education for adolescents. Increasingly, public funds are allocated to abstinence-only education, including programs established under the Adolescent Family Life Act and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Simultaneously, Title X funds comprehensive sexuality education for adolescents. Proponents of abstinence-only education believe that they can instill important moral values through such programs, which will then affect adolescent behaviors. They also believe that comprehensive sexuality education promotes sexual promiscuity. Those in favor of comprehensive sexuality education assert that while postponing sexual activity is optimal, adolescents have the right to be educated on how to protect themselves if they choose to become sexually active.

Comprehensive Sexuality Education

The Sexuality Information and Education Council of the United States advocates comprehensive sexuality education rather than abstinence-only education (Nadler, 1997). In 1996, the council emphasized that comprehensive sexuality education should cover “sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles” (Elia, 2000, p. 341).

The American Academy of Pediatrics (2001) asserts that comprehensive sexuality education should be provided for children and youths in fifth grade through high school. They argue that effective comprehensive

sexuality education combines necessary skills in communication and negotiation, information on STIs and pregnancy prevention, and referrals to reproductive health resources and programs. They promote abstinence as the best option, and contraceptives as the next best option.

Considering the statistics, it appears that contraceptive use is the next best choice after abstinence. According to research by the Alan Guttmacher Institute, increased use of contraceptives explains 75 percent of the decline in teenage pregnancy between 1988 and 1995, compared to abstinence, which explains the remaining 25 percent (Dailard, 2000). The Children's Aid Society–Carrera Program, one of the most successful comprehensive sexuality programs, is multifaceted, encompassing sex education and access to reproductive health services as well as providing opportunities for tutoring, sports, arts, and jobs. Philliber, Kaye, and Herrling (2001) conducted a rigorous study of the program and found that it significantly reduces pregnancy rates, delays initiation of sexual activity, and improves contraceptive use among teenage girls.

Kirby's (2001) report on programs targeting pregnancy prevention provides a summary of effective program structures. Such programs (1) provide accurate basic information about the risks of sexual activity and ways to avoid intercourse or use methods of protection against pregnancy and STIs; (2) use approaches that influence other health-related behaviors and target important sexual antecedents; (3) include activities that address social pressures that influence sexual behavior; (4) allow participants to practice communication, negotiation, and refusal skills; (5) involve participants by personalizing the information; (6) use behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students; (7) last a sufficient length of time; and (8) use trained teachers or peer leaders who believe in the program. Kirby's report indicates that effective teen pregnancy programs provide comprehensive sexuality education rather than relying only on abstinence-only education.

Some refer to comprehensive sexuality education as abstinence-plus education. Huberman and Berne (1995) point out that students enrolled in seven different abstinence-plus education programs were more likely than controls to abstain from sex for one to two years. This outcome is one that the Division of Adolescent and School Health of the Centers for Disease Control and Prevention has included in its protocol for evaluating school-based sexuality curricula, along with rates of condom use and unprotected sex. All the programs that were found to be successful when measured against their outcome standards were comprehensive in scope, not abstinence-only programs (Huberman & Berne, 1995).

Banks and Wilson (1989) report that in their study of African American youths, the majority indicated having learned about birth control from "friends and others" rather than from teachers or counselors (p. 245). The researchers posit that schools and community agencies share responsibility for providing reliable contraceptive information to youths. Bar-Cohen, Lia-Hoagberg, and Edwards (1990) found that adolescents who had access to school-based clinics sought out family planning services within two months of sexual activity, which is significantly sooner than their peers who do not have access to such services in school (and who, according to estimates, sought out such services fifteen to twenty-two months after initial sexual activity).

Jemmott, Jemmott, and Fong (1998) conducted a randomized controlled trial that looked at middle school-age African American youths who participated in either an abstinence-only intervention or a comprehensive safe-sex intervention. The researchers found that the comprehensive safe-sex intervention was more effective in reducing sexual activity and increasing consistent use of contraceptives than either the abstinence-only intervention or no intervention at all.

Abstinence-Only Sexuality Education

Abstinence-only sexuality education has also found financial support through federal legislation, particularly through the Adolescent Family Life Act and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The federal government has established an eight-point definition of abstinence-only education. According to federal law, abstinence-only education programs eligible for financial support focus on the social, psychological, physiological, and health benefits that come from abstinence; teach that abstinence is the expected standard for all unmarried individuals; teach that having children outside marriage leads to negative consequences for the individual, family, and community; teach young people how to avoid unwanted sexual advances and how alcohol and drug use can impair the healthy use of judgment; and focus on the importance of being self-sufficient before engaging in sexual activity (Dailard, 2002).

Research has suggested that abstinence-only education can be helpful for children in elementary and early middle school by providing information on the benefits of abstaining from sexual activity as well as how to ward off pressure to engage in unwanted sexual activity. Abstinence-only education can also provide support for those teens who choose not to engage in sexual activity. Saul (1998) reports that a

Planned Parenthood affiliate in Michigan received Adolescent Family Life Act funding for an abstinence-only education program that helped seventh graders postpone sexual activity and fend off unwanted sexual pressure. In an evaluation of Pennsylvania's abstinence-only education programs, Smith, Dariotis, and Potter (2003) found that four out of thirteen abstinence-only education programs had a positive effect on postponing sexual activity among children in elementary and early middle school. They indicated that after eighth grade, the programs offered positive reinforcement and support for those adolescents who were choosing to be abstinent.

The efficacy of abstinence-only approaches has been of concern, especially for older adolescents. Pennsylvania's abstinence-only programs were ineffective in delaying the onset of sexual activity in older teens and did not establish values that would lead to abstinence (Smith et al., 2003). Huberman and Berne (1995) reported on five studies that examined three abstinence-only education programs and found no significant gains in abstinence.

Conceptually related to abstinence-only educational approaches are the popular movements to encourage youths to make public promises that they will remain virgins. Bearman and Bruckner (2001) found that such pledges did delay sexual intercourse for approximately eighteen months. However, once sexually active, youths who made virginity pledges were 33 percent less likely to use contraceptives than youths who did not pledge to remain virgins. Further, those who pledged virginity were more likely than their peers to engage in high-risk sexual behaviors, including anal and oral sex.

The last finding is of special concern to social workers, public health professionals, and those in related fields for whom adolescent health is paramount. This finding leads to questions regarding the content of abstinent-only education programs. A study that examined curriculum content found that eight of twenty-one abstinence-only education programs omitted basic health information, provided incorrect information, and/or presented a negatively biased view of certain groups of individuals, such as lesbian, gay, bisexual, and transgender individuals, as well as youths who have already had children (Wilson, Goodson, Pruitt, Buhi, & Davis-Gunnels, 2005). Questionable content may explain some of the apparent lack of efficacy of abstinence-only education.

Title X: A Closer Look

It is vital that school social workers understand the policies and programs that directly affect adolescents. In areas in which school-based

comprehensive sexuality education is unavailable, it is important to be aware of other appropriate community services that are available. Title X services received by single women ages fifteen through nineteen prevent an estimated 385,800 unplanned pregnancies, 154,700 births, and 183,300 pregnancy terminations (Friedman, 2005).

History of Title X

In 1969, President Nixon signed Title X, the nation's largest family planning initiative, as part of the Public Health Service Act. Initially, bipartisan support existed for this national family planning legislation because it focused on the social goals of reducing poverty and dependence on welfare, as well as bettering the health and social well-being of women and children (Gold, 2001). The Title X Family Planning Act (2000) "makes provisions for educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children."

In recent decades, Title X has met with considerable opposition from special interest groups, conservative legislators, and political administrations. The opposition has particularly focused on the provision of family planning services to adolescents. This may be partly related to the fact that the original legislation did not explicitly target family planning initiatives for adolescents. Rather, Title X provisions changed over time, particularly in 1977, when the court ruled in *Cary v. Populations Services International* that it was unlawful to deny nonprescription contraceptives to minors under the age of sixteen (Friedman, 2005). The Alan Guttmacher Institute (2005) reports that 667,734 clients under age eighteen and 716,399 clients ages eighteen and nineteen utilized Title X services in 2004. What has resulted is an ongoing debate regarding the provision of family planning services for adolescents, and questions relating to the role of public policy in improving the sexual health of adolescents by reducing unintended pregnancies and sexually transmitted infections.

Policy Structure

Title X provides family planning services for low-income individuals and families. The statute defines low-income individuals and families as those who have an income at or below 100 percent of the federal poverty level (Title X Family Planning Act, 2000). The legislation states that Title X providers must provide a schedule of discounts based on the individual's ability to pay. If an individual has an income at 250 percent of or above the federal poverty level, the provider will charge the client full

price for the service rendered. Notably, the majority (92%) of clients have an income below 250 percent of the federal poverty level, which allows them to receive discounted or free services (National Family Planning and Reproductive Health Association, 2004). Adolescents are usually eligible for discounted or free services since their individual financial resources, rather than their families' resources, are considered.

Family planning services are mandated to be comprehensive. As a result, family planning providers offer a wide array of services related to reproductive health, including diagnostic testing for STIs, screening for breast and cervical cancer; education on safe-sex methods, contraceptives, infertility testing, and counseling; and referrals for social and health services (National Family Planning and Reproductive Health Association, 2004). Further, the services offered must be received voluntarily and cannot discriminate on the basis of age, race, sex, religion, prior pregnancies, or marital status (Title X Family Planning Act, 2000). Title X grantees cannot provide abortions with federal money, though the organization can use other sources of funding to provide these services. Counseling and information offered with Title X funds must cover a full range of topics, including prenatal care and delivery, infant care, foster care, adoption, and pregnancy termination. If an individual inquires about pregnancy termination, providers must provide neutral and nondirective information (Title X Family Planning Act, 2000). The Title X statute mandates that providers keep all services delivered to clients confidential.

Title X providers must also encourage adolescents to speak with their parents about family planning decisions (Friedman, 2005). Opponents have argued that encouragement is not enough. They assert that providers should notify parents prior to serving adolescents (Jones, Purcell, Singh, & Finer, 2005). Research has revealed, however, that parental notification policies deter youths from seeking out family planning services and thus are a major barrier to service provision (Reddy, Fleming, & Swaim, 2002).

Federal funding for Title X services goes through the Department of Health and Human Services, and the Office of Family Planning is responsible for implementation of Title X services (Gold, 2001). The Office of Population Affairs is responsible for collecting data on and reviewing the utilization of Title X services annually (Alan Guttmacher Institute, 2005). The Department of Health and Human Services offers grants to public and nonprofit private entities that can demonstrate a need for family planning services in their geographic and/or catchment areas (Title X Family Planning Act, 2000). Oftentimes state health departments and regional agencies receive grants and then subcontract with local service

providers (Friedman, 2005). The legislation gives the secretary of the Department of Health and Human Services the authority to decide how much to give a project, based on its estimated need. However, the legislation also mandates that once a final necessary amount is negotiated, at least 90 percent of that amount must be appropriated to the grantee. The Department of Health and Human Services most often funds projects for three to five years before proposal resubmission is required. Title X grants are awarded based on the number of patients served, particularly low-income patients; the adequacy of the facility and staff; the capacity to effectively use federal funding; the need of the organization; the need of the local community; and the availability of other community resources (Title X Family Planning Act, 2000).

Since the 1980s, Title X appropriations have fluctuated based on the political ideology of the administration. During the 1980s, President Reagan attempted to completely repeal Title X and give family planning responsibility to the states. His proposal was not accepted, but he was able to cut the funding appropriated for Title X substantially during his administration. Funding levels did not rebound until President Clinton was in office. More recently, however, President Bush has been very explicit in his support of funding abstinence-only initiatives rather than comprehensive sexuality education for adolescents under Title X (Friedman, 2005).

Frost, Frohwirth, and Purcell (2004) estimate that current appropriations are 60 percent lower than what they were in 1980, when adjusted for inflation. In 2004, $278 million was appropriated for Title X services (National Family Planning and Reproductive Health Association, 2004). This investment is essential, considering that Title X services play a key role in reducing public costs that result from adolescent parents' need for public support. The National Family Planning and Reproductive Health Association (2004) states that "investments in discretionary programs often lead to savings in mandatory spending" (p. 1). Indeed, this may be particularly true for family planning services for adolescents, considering that "for every dollar that the federal and state governments spend on family planning services, three dollars are saved in Medicaid costs for pregnancy-related and newborn care" (Gold, 2001, p. 4). Currently there is no monitoring system to track how much is spent specifically on services for adolescents.

Rather than operating on a fee-for-service basis, Title X entities operate on an entitlement basis. This means that services are provided to everyone who walks through the door, regardless of ability to pay. Thus, most Title X entities require multiple funding sources in order to cover their budgets. Alternative sources of public funding come from the federal, state, and local levels (National Family Planning and Reproductive

Health Association, 2004). Private funding sources also play a key role in supporting family planning entities.

Implications

Considering our limited resources and great need, it is imperative that we advocate local, state, and national policies that will support and maintain comprehensive sexuality education programs, both school and community based. With Title X as the primary national family planning policy structure, school social workers can lobby for specific policies that will influence the youths they serve within educational institutions. The following recommendations offer ideas for those who want to take an advocacy role.

- Request that an adequate amount of national categorical funding for comprehensive sexuality education programs/abstinence-plus education be authorized each year.
- Advocate comprehensive sexuality education programs within schools, and partner with local community providers to secure professional training.
- Create monitoring and evaluation procedures to ensure that Title X comprehensive sexuality education programs meet the criteria recommended by Kirby (2001).
- Advocate the discontinuation of abstinence-only education programs under the Adolescent Family Life Act and Section 510 of the Social Security Act (i.e., welfare reform law), which cannot demonstrate a significant delay in sexual initiation and reduction in pregnancy and STI rates and disseminate incorrect and/or biased information.
- Recommend the reallocation of such funding to Title X for abstinence-plus education programs, specifically those targeting preteen and elementary school–age youths.
- Seek out grant funding opportunities for schools serving particular minority groups, such as African American and Latina adolescents, who have consistently higher birth rates (99.3 per 1,000 and 106.7 per 1,000, respectively) than their white counterparts (39.3 per 1,000) (Kaplan, Erickson, & Juarez-Reyes, 2002).
- Ensure accessibility to Title X family planning services as well as comprehensive sexual education programs to diverse populations in multiple settings (i.e., family planning clinics, hospitals, schools, school-based clinics, and health clinics).

- Create alternative options for the utilization needs and preferences of male adolescents, since they are less likely than their female counterparts to use services at family planning clinics (Raine, Marcell, Rocca, & Harper, 2003).

Conclusion

In this analysis, I have illustrated the disadvantages that adolescent parents and their children experience as a means to highlight the gravity of this social problem. I have reviewed the empirical literature and presented evidence that supports comprehensive sexuality education as a method for reducing risky sexual behaviors and their negative consequences among adolescents. I have discussed the policy structure of Title X and its role in ensuring the sexual and reproductive health of adolescents. Finally, I have made recommendations for how we can support comprehensive sexuality education programs through advocacy.

The topic of sexuality education is most likely to remain controversial, and with controversy often comes misinformation. School social workers and other helping professionals providing care to adolescents will be best served by looking to empirical research to improve their understanding of the negative implications of risky sexual behavior for adolescents and their communities, as well as research that effectively evaluates sexuality education programs. The dissemination of this knowledge will give adolescents increased opportunities to make healthy and informed decisions about their sexual and reproductive health needs.

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