

AMERICAN ACADEMY OF PEDIATRICS

Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence

Sexuality Education for Children and Adolescents

ABSTRACT. Children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behavior as adults. Early, exploitative, or risky sexual activity may lead to health and social problems, such as unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus infection and acquired immunodeficiency syndrome. This statement reviews the role of the pediatrician in providing sexuality education to children, adolescents, and their families. Pediatricians should integrate sexuality education into the confidential and longitudinal relationship they develop with children, adolescents, and families to complement the education children obtain at school and at home. Pediatricians must be aware of their own attitudes, beliefs, and values so their effectiveness in discussing sexuality in the clinical setting is not limited.

ABBREVIATIONS. STD, sexually transmitted disease; HIV, human immunodeficiency virus; AIDS, acquired immunodeficiency syndrome; AAP, American Academy of Pediatrics.

BACKGROUND

Recent federal surveys for the Department of Health and Human Services have found a decline in sexual activity among adolescents 15 to 19 years of age in the United States during the last decade.¹ However, initiation of sexual intercourse during adolescence remains the norm for American youth.¹ Rates of hormonal contraception and condom use have risen throughout the last 5 years and adolescent birth rates have been decreasing,² yet the percentage of births to unmarried women of all ages, including adolescents, remains high.^{2,3} Among women 15 to 19 years of age, most pregnancies are unintended,^{3,4} and approximately 1 in 3 end in abortion.³

Overall rates of sexually transmitted diseases (STDs) in the United States are among the highest in the industrialized world. Every year, an estimated 1 in 4 (approximately 3 million) sexually active adolescents acquire an STD.⁵ Additionally, only 57% of the 1 in 3 adolescents who reported having been sexually active in the past 3 months reported that they had used barrier contraception the last time they had intercourse.⁶

Children most likely to engage in earlier sexual activity include children with learning problems or low academic attainment; children with other social,

behavioral, or emotional problems (including mental health disorders and substance abuse); those from low-income families; children of some ethnic minorities; victims of physical and sexual abuse; and children in families with marital discord and low levels of parental supervision.^{7,8} Risky sexual behaviors, defined as having multiple partners, having sex with strangers, or having intercourse without a latex condom, are also associated with alcohol consumption.^{7,8} Many gay, lesbian, and bisexual youth are also at high risk because of unsafe sexual practices with same or opposite sex partners and because of increased rates of depression, dropping out of school, homelessness (running away or being thrown out of the home), and substance abuse.⁹

In the Youth Risk Behavior Surveillance survey conducted by the Centers for Disease Control and Prevention, almost all (>90%) adolescents reported having received human immunodeficiency virus (HIV) prevention education in school in 1997, and many also reported discussing HIV and acquired immunodeficiency syndrome (AIDS) with a parent or guardian.⁶ However, the content of such discussions may not provide complete information. Additionally, school-based interventions do not provide confidential opportunities for individual risk assessments or targeted preventive counseling. Although as many as two thirds of adolescent patients reported wanting information about STDs and pregnancy from their physicians, many fewer have ever discussed these issues with their physician.¹⁰ In fact, fewer than half of primary care providers routinely ask adolescents about their sexual activity, and far fewer ask specifically about STDs, condom use, sexual orientation, number of partners, or sexual abuse,¹¹ despite the fact that care guidelines universally recommend obtaining comprehensive sexual histories from adolescents.¹²⁻¹⁴ Slightly more than half of adolescents who reported having a health care visit reported that they had an opportunity to talk alone (without a parent or other adult present) with their physician,¹⁵ and fear of disclosure was a major reason for adolescents having missed care they believed that they needed.¹⁶

SOURCES, CONTENT, AND EFFECTIVENESS OF SEXUALITY EDUCATION PROGRAMS

Sexuality education classes have become a routine part of junior high and high school curricula in many parts of the country.¹ Sexuality education is also often a component of community-based programs targeting pregnancy prevention, substance abuse prevention, violence reduction, youth development,

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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or reproductive health services. Several sexuality education programs that were evaluated using quasi-experimental or experimental designs had impact on the sexual behavior of adolescents.¹⁷ To delay onset of sexual debut, it is necessary to present programs to fifth and sixth graders. Abstinence-only programs have not demonstrated successful outcomes with regard to delayed initiation of sexual activity or use of safer sex practices.^{8,17} Effective programs tend to provide practical skills, such as exercising control and increasing communication and negotiation skills through role playing or interactive discussion. Programs that encourage abstinence as the best option for adolescents, but offer a discussion of HIV prevention and contraception as the best approach for adolescents who are sexually active, have been shown to delay the initiation of sexual activity and increase the proportion of sexually active adolescents who reported using birth control. Programs that have linked educational curricula with access to reproductive health services and comprehensive community-based interventions have also documented reductions in pregnancy rates.^{18–20} Despite these findings, among the 69% of public schools that provide district-wide sexuality education, 14% treat abstinence as an option for adolescents, 51% teach abstinence as the preferred option for adolescents but permit discussion about contraception as an effective means of protection against unintended pregnancy and STDs (an abstinence-plus policy), and more than 1 in 3 (35%) teach abstinence only, with discussion of contraception prohibited or limited to discussion of its lack of effectiveness.²¹

ROLE OF THE PEDIATRICIAN

The American Academy of Pediatrics (AAP) has published policy statements about sexuality and adolescence.^{22–24} Pediatricians are in an ideal position to provide longitudinal sexuality education to children and adolescents as part of preventive health care, and many tools are available to guide their efforts.^{22–24} Additionally, pediatricians' efforts may be useful in complementing school or community-based programs.

Unlike school-based instruction, discussion of sexuality with pediatricians provides opportunities for personalized information, for confidential screening of risk status, and for health promotion and counseling. Children and adolescents may ask questions, discuss potentially embarrassing experiences, or reveal highly personal information to their pediatricians. Families and children may obtain education together or in a separate but coordinated manner. Prevention and counseling can be targeted to the needs of youth who are and those who are not yet sexually active and to groups at high risk for early or unsafe sexual activity.^{7,8}

Recommendations for pediatricians are as follows:

1. Put sexuality education into a lifelong perspective. Actively encourage parents to discuss sexuality and contraception consistent with the family's attitudes, values, beliefs, and circumstances beginning early in the child's life. Do not impose

values on the family. Be aware of the diversity of family circumstances, such as families with same-sex parents. Guide these families or refer them to agencies or clinicians that can help them if they report difficulties or if you are not comfortable assisting them.

2. Encourage parents to offer sexuality education and discuss sex-related issues that are appropriate for the child's or adolescent's developmental level.
 - Use proper terms for anatomic parts.
 - Discuss masturbation and other sexual behaviors of all children, even those as young as preschool age, openly with parents.
 - Initiate discussions about sexuality with children at relevant opportunities, such as the birth of a sibling or pet. Encourage parents to answer children's questions fully and accurately. Offer parents resources to assist their communication efforts at home.
3. Provide sexuality education that respects confidentiality and acknowledges the individual patient's and family's issues and values.
 - Promote communication and safety within social relationships between partners.²⁵ Ask about special friendships and relationships and explore their character. Complement school-based sexuality education, which typically emphasizes unintended pregnancy, STDs, and other potential risks of sex. When appropriate, acknowledge that sexual activity may be pleasurable but also must be engaged in responsibly.
 - Address knowledge, questions, worries, or misunderstandings of children and adolescents regarding anatomy, masturbation, menstruation, erections, nocturnal emissions ("wet dreams"), sexual fantasies, sexual orientation, and orgasms. Information regarding availability and access to confidential reproductive health services and emergency contraception should also be discussed with early adolescents and with parents. During these discussions, also be open and nonjudgmental toward those with homosexual or bisexual experiences or orientation (see the AAP statement "Homosexuality and Adolescence"⁹).
 - Acknowledge the influence of media imagery on sexuality as it is portrayed in music and music videos, movies, television, print, and Internet content.
 - Obtain a comprehensive sexual history from all adolescents, including knowledge about sexuality, sexual practices, partners and relationships, sexual feelings and identity, and contraceptive practices and plans.
 - In discussing reasons to delay sexual activity or use contraception, frame the suggestions in terms of the individual's development, language, motivation, and history. Be sensitive to cultural and family norms, values, beliefs, and attitudes, and integrate these factors into health promotion or behavior change counseling. Also be aware of the potential for, and ask about,

abuse or coercion in relationships or sexual activity.

- Counsel parents about sexuality. Suggest opportunities for them to provide guidance about abstinence and responsible sexual behavior to their children. Encourage reciprocal and honest dialogue between parents and children. Counsel parents and adolescents about circumstances that are associated with earlier sexual activity, including early dating, excessive unsupervised time, truancy, and alcohol use.^{7,8} Ensure that adolescents have opportunities to practice social skills, assertiveness, control, and rejection of unwanted sexual advances.¹⁷
4. Provide specific, confidential, culturally sensitive, and nonjudgmental counseling about key issues of sexuality.
- **General counseling.** Counsel children and parents about normal sexual development before the onset of sexual activity, and encourage parent-child communication about sexuality. Parents should be encouraged to discuss explicit expectations for abstinence, for delaying sexual activity, and for responsible expression of one's sexuality. Advise children and adolescents to discontinue high-risk sexual behavior and avoid or discontinue coercive relationships.²⁶ Discourage alcohol and other drug use and abuse not only for the direct benefits to the adolescent's health but also to prevent unwanted sexual activity or adverse consequences of sexual activity. Some pediatricians may want to consider the use of established curricula to ensure that all major points are covered.²⁷ Additionally, handouts to reinforce safe sex practices and responsible decision-making should be available in the office or clinic. Pediatricians may directly provide this counseling, and other members of the office staff, such as nurses, social workers, or health educators, may also provide counseling and health education.
 - **Preventing unintended pregnancy.** Discuss methods of birth control with male and female adolescents ideally before the onset of sexual intercourse (see the AAP statement "Contraception and Adolescents"²²). Barrier methods should always be used during intercourse in combination with spermicide or with hormonal contraceptives. Providing access to contraception for adolescents who are sexually active is an important method of reducing pregnancy rates.²⁶
 - **Strategies to avoid STDs, including HIV infection and AIDS.** Abstinence should be promoted as the most effective strategy for preventing HIV infection and other STDs as well as for prevention of pregnancy. Adolescents who become sexually active need additional advice and health care services. Adolescents should be counseled regarding the importance of consistent use of safer sex precautions. Pediatricians should assist adolescents in practicing communication and negotiation skills regarding use of condoms in every sexual encounter²⁸ and should consider providing adolescents with information and demonstrations about how condoms should be used. Comprehensive recommendations for HIV counseling, testing, and partner notification are addressed in detail in the AAP statement "Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention."²⁹
5. Provide appropriate counseling or referrals for children and adolescents with special issues and concerns.
- **Gay, lesbian, and bisexual youth.** Maintain nonjudgmental attitudes and avoid a heterosexual bias in history taking to encourage adolescents to be open about their behaviors and feelings (see the AAP statement "Homosexuality and Adolescence"⁹).^{30,31} If adolescents are certain of homosexual or bisexual orientation, discuss advantages and potential risks of disclosure to family and peers, and support families in accepting children who identify themselves as gay, lesbian, or bisexual. Adolescents who are homosexual should be screened carefully for depression, risk of suicide, and adjustment-related mental health problems. Similar issues are important to children unsure of their sexual orientation.
 - **Children and adolescents with disabilities.** Rates of sexual activity for adolescents with disabilities are the same as those for adolescents without disabilities.³² However, children in special education may not receive sexuality education in school. Children and youth with disabilities should be provided developmentally appropriate sexuality education. Parents may need reassurance and support in getting sexuality education for children and adolescents with disabilities. Discussions should be initiated with parents or guardians of children with disabilities at a young age to encourage self-protection and acceptable forms of sexual behavior. Community resources and support groups may also be of assistance.
 - **Other children at risk.** Identify children at risk for early or coercive and unintended sexual behaviors at an early age. Children who have been victims of physical or sexual abuse or have witnessed sexual violence or physical abuse; children with precocious puberty; and children with social risk factors, such as learning problems, drug or alcohol use, and antisocial behavior, may be at increased risk. Provide or arrange for counseling about sexuality for these children or adolescents. Refer to mental health services if appropriate.
6. Routine gynecologic services should be provided to female adolescents who have become sexually active. Screening for cervical cancer and STDs should be performed for sexually active females, and screening for STDs should be performed for sexually active males, as recommended in *Guidelines for Health Supervision III*.¹²

7. Become knowledgeable about sexuality education offered in schools, religious institutions, and other community agencies. Encourage schools to begin sexuality education in the fifth or sixth grade as a component of comprehensive school health education and to use curricula that provide effective and balanced approaches to puberty, abstinence, decision-making, contraception, and STD and HIV prevention strategies and information about access to services. Because nearly one third of school districts do not provide any information about contraception regardless of whether students are sexually active or at risk,²¹ pediatricians should consider presenting material at the school. The American College of Obstetricians and Gynecologists publishes the *Adolescent Sexuality Kit: Guides for Professional Involvement*.³³ This series addresses AIDS, date rape, contraceptive options, and other topics that may be useful to pediatricians who plan to provide sexuality education. Participate in community activities to monitor the effectiveness of prevention strategies and revise approaches to decrease the rate of untoward outcomes. Consider serving as a referral source for students who need comprehensive reproductive health services.
8. Work with local public planners to develop a comprehensive strategy to decrease the rates of unsafe adolescent sexual behavior and adverse outcomes.

RECOMMENDATIONS

1. Every pediatrician should integrate sexuality education into clinical practice with children from early childhood through adolescence. This education should respect the family's individual and cultural values.
2. Educational materials, such as handouts, pamphlets, or videos, should be available to reinforce office-based educational efforts.
3. Pediatricians should be knowledgeable about community services that provide appropriate high-quality sexuality education and additional services that children, adolescents, or families need.
4. Pediatricians should consider participating in the development and implementation of sexuality education curricula for schools or in public efforts to decrease the rates of unsafe adolescent sexual behavior and adverse outcomes.
5. Linguistically appropriate materials could be provided in the office or the pediatrician should have a way of helping children, adolescents, and their families get information in their language of choice.

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REFERENCES

1. Abma JC, Chandra A, Mosher WE, Peterson LS, Piccinino LJ. Fertility, family planning and women's health: new data from the 1995 National Survey on Family Growth. National Center for Health Statistics. *Vital Health Stat.* 1997;23:1–114
2. Amini SB, Catalano PM, Dierker LJ, Mann LI. Births to teenagers: trends and obstetric outcomes. *Obstet Gynecol.* 1996;87:668–674
3. Ventura SJ, Mathews TJ, Curtin SC. Declines in teenage birth rates, 1991–97: national and state patterns. *Natl Vital Stat Rep.* 1998;47:1–17
4. Spitz AM, Ventura SJ, Koonin LM, et al. Surveillance for pregnancy and birth rates among teenagers, by state—United States, 1980 and 1990. *MMWR CDC Surveill Summ.* 1993;42:1–27
5. Cooper LG, Leland NL, Alexander G. Effect of maternal age on birth outcomes among young adolescents. *Soc Biol.* 1995;42:22–35
6. Kann L, Kinchen SA, Williams BI, et al. Youth Risk Surveillance—United States, 1997. *MMWR CDC Surveill Summ.* 1998;47:1–89
7. Donovan P. *The Politics of Blame: Family Planning, Abortion, and the Poor.* New York, NY: Alan Guttmacher Institute; 1995
8. Alan Guttmacher Institute. *Sex and America's Teenagers.* New York, NY: Alan Guttmacher Institute; 1994
9. American Academy of Pediatrics, Committee on Adolescence. Homosexuality and adolescence. *Pediatrics.* 1993;92:631–634
10. Kapphahn CJ, Wilson KM, Klein JD. Adolescent girls' and boys' preferences for provider gender and confidentiality in their health care. *J Adolesc Health.* 1999;25:131–142
11. Millstein SG, Igra V, Gans J. Deliver of STD/HIV preventive services to adolescents by primary care physicians. *J Adolesc Health.* 1996;19:249–257
12. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. *Guidelines for Health Supervision III.* Elk Grove Village, IL: American Academy of Pediatrics; 1997

13. Green M, ed. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, VA: National Center for Education in Maternal and Child Health; 1994
14. Elster AB, Kuznets NJ, eds. *AMA Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale*. Baltimore, MD: Williams & Wilkins; 1994
15. Klein JD, Wilson KM, McNulty M, Kapphahn C, Collins KS. Access to medical care for adolescents: results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls. *J Adolesc Health*. 1999; 25:120–130
16. Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. *JAMA*. 1999;282:2227–2234
17. Frost JJ, Forrest JD. Understanding the impact of effective teenage pregnancy prevention programs. *Fam Plann Perspect*. 1995;27:188–195
18. Zabin LS, Hirsch MB, Streett R, et al. The Baltimore pregnancy prevention program for urban teenagers. I. How did it work? *Fam Plann Perspect*. 1988;20:182–187
19. Zabin LS, Hirsch MB, Smith EA, et al. The Baltimore pregnancy prevention program for urban teenagers. II. What did it cost? *Fam Plann Perspect*. 1988;20:188–192
20. Vincent ML, Clearie AF, Schluchter MD. Reducing adolescent pregnancy through school and community-based education. *JAMA*. 1987; 257:3382–3386
21. Landry DJ, Kaeser L, Richards CL. Abstinence promotion and the provision of information about contraception in public school district sexuality education policies. *Fam Plann Perspect*. 1999;31:280–286
22. American Academy of Pediatrics, Committee on Adolescence. Contraception and adolescents. *Pediatrics*. 1999;104:1161–1166
23. American Academy of Pediatrics, Committee on Adolescence. Adolescent pregnancy: current trends and issues: 1998. *Pediatrics*. 1999;103: 516–520
24. American Academy of Pediatrics, Committee on Adolescence. Counseling, the adolescent about pregnancy options. *Pediatrics*. 1998;101: 938–940
25. Ruusuvaara L. Adolescent sexuality: an educational and counseling challenge. *Ann N Y Acad Sci*. 1997;816:411–413
26. Peckham S. Preventing unintended teenage pregnancies. *Public Health*. 1993;107:125–133
27. Card JJ, Niego S, Mallari A, Farrell WS. The program archive on sexuality, health & adolescence: promising “prevention programs in a box.” *Fam Plann Perspect*. 1996;28:210–220
28. Darrow WW. Condom use and use-effectiveness in high-risk populations. *Sex Transm Dis*. 1989;16:157–168
29. American Academy of Pediatrics, Committee on Pediatric AIDS and Committee on Adolescence. Adolescents and human immunodeficiency virus infection: the role of the pediatrician in prevention and intervention. *Pediatrics*. 2001;107:188–190
30. Harrison AE. Primary care of lesbian and gay patients: educating ourselves and our students. *Fam Med*. 1996;28:10–23
31. Ryan C, Futterman D. *Lesbian and Gay Youth: Care and Counseling*. New York, NY: Columbia University Press; 2000
32. Suris JC, Resnick MD, Cassuto N, Blum RW. Sexual behavior of adolescents with chronic disease and disability. *J Adolesc Health*. 1996;19: 124–131
33. American College of Obstetricians and Gynecologists, Committee on Adolescent Health Care. *Adolescent Sexuality Kit: Guides for Professional Involvement*. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; 1992

ERRATUM

In “Tobacco’s Toll: Implications for the Pediatrician” by the AAP Committee on Substance Abuse, Catherine A. McDonald, MD, was omitted from the list of consultants due to an oversight. The statement was published in the April 2001 issue of *Pediatrics*. (*Pediatrics*. 2001;107(4):794–798.)

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