



Sexuality Education for Children and Adolescents

Cora C. Breuner, MD, MPH, Gerri Mattson, MD, MSPH, COMMITTEE ON ADOLESCENCE,
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH

The purpose of this clinical report is to provide pediatricians updated research on evidence-based sexual and reproductive health education conducted since the original clinical report on the subject was published by the American Academy of Pediatrics in 2001. Sexuality education is defined as teaching about human sexuality, including intimate relationships, human sexual anatomy, sexual reproduction, sexually transmitted infections, sexual activity, sexual orientation, gender identity, abstinence, contraception, and reproductive rights and responsibilities. Developmentally appropriate and evidence-based education about human sexuality and sexual reproduction over time provided by pediatricians, schools, other professionals, and parents is important to help children and adolescents make informed, positive, and safe choices about healthy relationships, responsible sexual activity, and their reproductive health. Sexuality education has been shown to help to prevent and reduce the risks of adolescent pregnancy, HIV, and sexually transmitted infections for children and adolescents with and without chronic health conditions and disabilities in the United States.

INTRODUCTION

The purpose of this clinical report is to provide pediatricians with an update on the research regarding evidence-based sexual and reproductive health education that has been conducted since the original clinical report on the subject was published by the American Academy of Pediatrics (AAP) in 2001.¹ Education about sexuality that is provided by pediatricians can complement the education children obtain at school or at home,^{2,3} but many pediatricians do not address it. In a review of health maintenance visits, 1 of 3 adolescent patients did not receive any information on sexuality from their pediatrician, and if they did, the conversation lasted less than 40 seconds.⁴

abstract

FREE

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Clinical reports from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, clinical reports from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

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

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

DOI: 10.1542/peds.2016-1348

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2016 by the American Academy of Pediatrics

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

To cite: Breuner CC, Mattson G, AAP COMMITTEE ON ADOLESCENCE, AAP COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH. Sexuality Education for Children and Adolescents. *Pediatrics*. 2016;138(2):e20161348

BACKGROUND

Children and adolescents with and without chronic health conditions and disabilities will benefit when they are provided with accurate and developmentally appropriate information about the biological, sociocultural, psychological, relational, and spiritual dimensions of sexuality. Information about sexuality can be taught and shared in schools, communities, homes, and medical offices using evidence-based interventions. Children and adolescents should be shown how to develop a safe and positive view of sexuality through age-appropriate education about their sexual health. Sexuality education can be disseminated through the 3 learning domains: cognitive (information), affective (feelings, values, and attitudes), and behavioral (communication, decision-making, and other skills).⁵

Sexuality education is more than the instruction of children and adolescents on anatomy and the physiology of biological sex and reproduction. It covers healthy sexual development, gender identity, interpersonal relationships, affection, sexual development, intimacy, and body image for all adolescents, including adolescents with disabilities, chronic health conditions, and other special needs.⁶ Developing a healthy sexuality is a key developmental milestone for all children and adolescents that depends on acquiring information and forming attitudes, beliefs, and values about consent, sexual orientation, gender identity, relationships, and intimacy.⁷ Healthy sexuality is influenced by ethnic, racial, cultural, personal, religious, and moral concerns. Healthy sexuality includes the capacity to promote and preserve significant interpersonal relationships; value one's body and personal health; interact with both sexes in respectful and appropriate ways; and express

affection, love, and intimacy in ways consistent with one's own values, sexual preferences, and abilities. The various dimensions of healthy sexuality comprise the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles, and personality; and thoughts, feelings, and relationships.⁶ Ideally, children and adolescents receive accurate information on sexual health from multiple professional resources.^{8,9}

All children and adolescents need to receive accurate education about sexuality to understand ultimately how to practice healthy sexual behavior. Unhealthy, exploitive, or risky sexual activity may lead to health and social problems, such as unintended pregnancy and sexually transmitted infections (STIs), including gonorrhea, *Chlamydia*, syphilis, hepatitis, herpes, human papilloma virus (HPV); HIV infection; and AIDS.¹⁰ From a 2012 informative report by the National Campaign to Prevent Teen and Unplanned Pregnancy that surveyed 1200 high school seniors, many senior girls and boys reported having mixed feelings about the first time they had sex, with more than three-quarters responding that they would change the way their first sexual experience occurred. Interestingly, seniors in this study wanted their younger peers to know it was "fine to be a virgin" when they graduated from high school.¹¹

It has been demonstrated that sexuality education interventions can prevent or reduce the risk of adolescent pregnancy HIV, and STIs for children and adolescents with and without chronic health conditions and disabilities in the United States.¹² Adolescent sexual activity and teen births and pregnancies have been decreasing since 1991, with the exception of 2005 to 2007, when there was a 5% increase in birth rates. The decrease in adolescent birth rates in the United States reflects an

increased use of contraception at first intercourse and in the use of dual methods of condoms and hormonal contraception in already sexually active teenagers.¹³ Nevertheless, the United States continues to lead industrialized countries with the highest rates of adolescent pregnancy.¹⁴ Importantly, 88% of births to adolescents 15 to 17 years of age in the United States continued to be unintended (unwanted or mistimed).¹⁵

Sexual health information messages are received by children and adolescents multiple times throughout the day from the media, religious organizations, schools, and family peers, parents/caregivers, and partners, although the quality of the information varies.^{16,17} In an article published in 2013 on how sexually experienced adolescents in the United States receive sexual health information, parents and teachers were the source of information for 55% of girls and 43% of boys about birth control and for 59% of girls and 66% of boys about STIs/HIV.¹⁸ Only 10% of sexually experienced adolescents reported health care providers as a source of birth control/STI/HIV information. More than 80% of adolescents 15 to 19 years of age received formal instruction about STIs, HIV, or how to say "no" to sex between 2011-2013, yet only 55% of males and 60% of females received instruction about birth control.¹⁹ Strong support of multilevel expanded and integrative sex education is warranted now more than ever.²⁰

Delivery of Sexuality Education Pediatricians/Health Care Providers

Pediatricians are in an excellent position to provide and support longitudinal sexuality education to all children, adolescents, and young adults with and without chronic health conditions and disabilities as part of preventive health care. Over

the past decade, increasing numbers of adolescents contend with sexuality in the context of their own chronic physical or mental health condition and/or developmental disability.^{21,22} When sexuality is discussed routinely and openly during well-child visits for all children and adolescents in the pediatrician's office, conversations are easier to initiate, more comfortable to continue, and more effective and informative for all participants. Pediatricians and other primary care clinicians can explore the expectations of parents for their child's sexual development while providing general, factual information about sexuality and can monitor adolescent use of guidance and resources offered over time.

Pediatricians can introduce issues of physical, cognitive, and psychosexual development to parents and their children in early childhood and continue discussions at ongoing health maintenance visits throughout school age, adolescence, and young adulthood. Sharing this information can help overcome barriers to discussing the sexual development of all children and adolescents and to improve screening rates for STIs, pregnancy, and partner violence. It is also important to provide access to current accurate sexuality education and to provide access to confidential relevant information, services, and support over the course of a lifetime.^{18,21} These conversations can begin with questions the family might have about the child and his or her body as well as about self-stimulation and "safe touch." With insights into the typical stages of child and adolescent sexual development, parents can better understand their own child's behaviors. For example, by recognizing that masturbation is typical toddler behavior, parents can better understand and discuss self-stimulatory behaviors of their teenager. The problem is often the inability to distinguish between behaviors that are publicly and

privately appropriate as children grow older.²³

Often, the pediatrician can take the lead from the parent or caregiver and then ask a few gentle leading questions about how much information the family would like to receive with the child and parent together in the room. The dynamics of the sexuality education conversation can then change as the child becomes a young adolescent by asking the parent or caregiver to leave the room after the initial introductions and history taking has occurred with the parent in the room. Parents and adolescents benefit from being prepared for these changes in adolescent interactions when there will be time alone for the adolescent to engage with the pediatrician to discuss sexuality, as well as personal and mental health, drug and tobacco use, and other psychosocial issues. The importance of confidentiality and its role in adolescent health care autonomy should be discussed with both adolescents and their parents. Unlike school-based instruction, a conversation about sexuality with pediatricians can provide an opportunity for personalized information, for confidential screening of risks, and for addressing risks and enhancing existing strengths through 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 of early or unsafe sexual activity, which includes children with and without chronic health conditions and disabilities.

Use of a psychosocial behavior screening tool or the Bright Futures

Previsit Questionnaire (available at <https://brightfutures.aap.org/Bright%20Futures%20Documents/CoreTools11-14YearOCVisit.pdf>) is a good way to address all of these topics, in addition to physical activity, nutrition, school, and relationships. The AAP policy statement on providing care for lesbian, gay, bisexual, transgender, and questioning youth, as well as other resources, offer suggestions on how to incorporate important conversations about sexual and gender identity in the health supervision visit.²⁴⁻²⁶

In the office setting, children and adolescents have been shown to prefer a pediatrician who is open and nonjudgmental and comfortable with discussions to address knowledge, questions, worries, or misunderstandings among children, adolescents with and without chronic health conditions and disabilities, and their parents/caregivers related to a wide range of topics. These topics include, but are not limited to, anatomy, masturbation, menstruation, erections, nocturnal emissions ("wet dreams"), sexual fantasies, sexual orientation, and orgasms. Information regarding availability and access to confidential sexual and reproductive health services and emergency contraception is important to discuss with adolescents and with parents. During these discussions, pediatricians also can address homosexual or bisexual experiences or orientation, including topics related to gender identity. It is also important to acknowledge the influence of media imagery on sexuality as it is portrayed in music and music videos, movies, pornography, and television, print, and Internet content and to address the effects of social media and sexting. According to the US Preventive Services Task Force, intensive behavioral counseling is important for all sexually active

adolescents and for adults who are at increased risk of STIs.²⁷ Although there may not be time to address all of these topics in a brief office visit, the longitudinal relationship and annual well visit present several opportunities for discussion. In addition, more information and resources can be shared with adolescents, many of which are easily accessible and listed at the end of this report.

Most adolescents have the opportunity to explore intimacy and sexuality in a safe context, but some others experience coercion, abuse, and violence. In fact, unwanted first sexual encounters were reported in the National Survey of Family Growth among 11% of female and male subjects 18 to 24 years of age who had first intercourse before age 20 years.²⁸ Teenagers who report first sex at 14 years of age and younger are more likely to report that it was nonvoluntary, compared with those who were 17 to 19 years of age at sexual debut.²⁹ Unwanted encounters may include dating violence, stranger assaults, and intrafamilial sexual abuse/incest. Screening for sexual violence and nonconsensual sexual encounters is important when evaluating all sexually active adolescents, especially for adolescents with chronic health conditions and disabilities, because they may be more likely to be victims of sexual abuse.^{5,30}

In the Schools

Formal sexuality education in schools that includes instruction about healthy sexual decision-making and STI/HIV prevention can improve the health and well-being of adolescents and young adults.³¹ If comprehensive sexuality education programs are offered in the schools, positive outcomes can occur, including delay in the initiation and reduction in the frequency of sexual intercourse, a reduction in the number of sexual partners, and an

increase in condom use.^{12,32} Some studies also have shown less truancy and an improvement in academic performance in those who have taken sexuality education courses.³³

A student's experience in school with sexuality education can vary a great deal. The Sexuality Information and Education Council of the United States and the Future of Sex Education (FoSE) promote evidence-informed comprehensive school-based sexuality education appropriate to students' age, developmental abilities, and cultural background as an important part of the school curriculum at every grade.³⁴ A comprehensive sexuality program provides medically accurate information, recognizes the diversity of values and beliefs represented in the community, and complements and augments the sexuality education children receive from their families, religious and community groups, and health care professionals. Adolescents and most parents agree that school-based programs need to be an important source of formal education for adolescent sexual health.³⁵⁻³⁷

The protective influence of sexuality education is not limited to the questions about if or when to have sex, but extends to issues of partner selection, contraceptive use, and reproductive health outcomes.³⁸ Creating access to medically accurate comprehensive sexuality education by using an evidence-based curriculum and reducing sociodemographic disparities in its receipt remain a primary goal for improving the well-being of teenagers and young adults. Ideally, this education happens conjointly in the home and in the school.³⁹

Factors that shape the content and delivery of sexuality education include state and school district policies, state education standards, funding from state and federal sources, and individual teacher comfort, knowledge, and skills. Fewer

than half of states require public schools to teach sexuality education, and even fewer states require that, if offered, sexuality education must be medically, factually, or technically accurate. State definitions of "medically accurate" vary, from requiring that the department of health review curriculum for accuracy to mandating that curriculum be based on published medical information.⁴⁰

Two-thirds of states and the District of Columbia allow parents to remove their children from participation or opt out from sexuality education. Fewer than half of states and the District of Columbia require parents to be notified that sexuality education will be provided. Other states have specific content requirements, including "stressing abstinence" or precluding discussion of homosexuality or abortion.⁴¹ The status of sexuality education in private schools is less well known. There is little to no information available from parochial or private scholastic institutions on the provisions of sexuality education.

Although policies exist requiring sexuality education, it may not be occurring in an unbiased and systematic manner. From the 2012 School Health Policies and Practices Survey, only 71% of US high school districts have adopted a policy specifying that human sexuality is taught. In a separate study comparing high schools, middle schools, and elementary schools, sexuality education taught in middle schools across states was more likely to be focused on "how to say no to sex" rather than other topics, with approximately 1 in 5 teenagers reporting that they first received instruction on "how to say no to sex" while in the first through fifth grade. Adolescent boys were slightly more likely than girls to be instructed on how to say no to sex or were using birth control while in middle school (52% of male teenagers, compared

with 46% of female teenagers). Male teenagers were less likely than female teenagers to report first receiving instruction on methods of birth control while in high school (38% of male teenagers, compared with 47% of female teenagers).⁴²

Teacher training in the United States is quite variable from district to district and school to school especially in sexuality education. The FoSE Initiative has released the National Teacher Preparation Standards for Sexuality Education to provide guidance to institutions of higher education to better prepare future teachers.⁹ The FoSE teacher standards include professional disposition, diversity and equity, content knowledge, legal and professional ethics, planning, implementation, and assessment. According to these standards, teachers may benefit from receiving specialized training on human sexuality, which includes accurate and current knowledge about biological, social, and emotional stages of child and adolescent sexual development (including sexual orientation) and legal aspects of sexuality (ie, age of consent).

Professionals responsible for sexuality education may benefit from receiving training in several learning and behavior theories and how to provide age- and developmentally appropriate instruction as part of sexuality education lesson planning. Ideally, teachers would be familiar with relevant and current state and/or district laws, policies, and standards to help them choose and adapt an evidence-based and scientifically accurate curriculum that is appropriate and permissible within a school district. Ongoing professional development and participation in continuing education classes or intensive seminars is advised. Teachers can benefit from access to updated and current sexuality information, curricula, policies, laws, standards, and other

materials. The FoSE standards advise that teachers are aware of and take into account their own biases about sexuality, understand guidelines for discussion of sensitive subjects in the classroom and addressing confidentiality, and know how to address disclosure by students of sexual abuse, incest, dating violence, pregnancy, and other associated sexual health issues. The goal is for teachers to feel comfortable and committed to discussing human sexuality and to know how to conduct themselves appropriately with students as professionals both inside and outside of the classroom and school. It is important for teachers to have an appreciation for how students' diverse backgrounds and experience may affect students' personal beliefs, values, and knowledge about sexuality. In the United States, 35.5% of districts have adopted a policy stating that there is a requirement that those who teach health education must earn continuing education credits on strategies or on health-related topics. It is important for teachers to develop skills in creating a safe, respectful, and inclusive classroom.⁴¹

In the Home

Fundamentally, parents and caregivers can have an important role as their children's primary sexuality educators. However, a number of factors, including lack of knowledge, skills, or comfort, may impede a parent's or caregiver's successful fulfillment of that role. Health care providers, schools, faith-based institutions, the media, and professional sexuality educators are resources that guide and advise parents by providing training, resources, understanding, and encouragement. One program, "Talking Parents, Healthy Teens," aims to influence parents' skills, such as communication, monitoring, and involvement. These include intentions to talk about sex, to monitor and stay involved, and

to understand environmental barriers and facilitators that influence talking about sexuality (eg, community norms that discourage or encourage such communication).⁴³ By increasing parents' skills and facilitating opportunities for communication through take-home activities, the program also aims to affect the parent-adolescent relationship, further influencing adolescent behavior change (eg, the likelihood that adolescents will delay intercourse or use condoms).⁴⁴

In one study, adolescents were asked whether they received formal instruction on 4 topics of sexuality education at home, school, church, a community center, or some other place before they were 18 years old.⁴² They were specifically asked whether they spoke to their parents before the age of 18 about topics concerning sex, birth control, STIs, and HIV/AIDS prevention. Two-thirds of male and 80% of female adolescents reported having talked with a parent about at least 1 of 6 sexuality education topics ("how to say no to sex," methods of birth control, STIs, where to get birth control, how to prevent HIV/AIDS, and how to use a condom). Younger (15–17 years old) female teenagers were more likely (80%) than younger male teenagers (68%) to have talked to their parents about these topics.⁴²

The medical literature supports that family and parental characteristics can dictate patterns of sexual experience among teenagers, as shown in the National Survey of Family Growth data from 2006 to 2010.²⁸ For example, in both male and female teenagers, a significantly smaller percentage were sexually experienced if they lived with both parents when they were 14 years of age, if their mothers had their first birth at 20 years or older, if the teenager's mother was a college graduate, or if the teenager lived with both of his or her parents.²⁸ Further, the approaches parents take when talking with their adolescent

about sex may have a tremendous influence on the teenager.⁴⁵ Parents who dominate the conversation have teenagers who do not have as much knowledge. Conversely, parents who are engaged and comfortable talking about sexual health have teenagers who are more knowledgeable and may even be more proactive in seeking reproductive health medical services.⁴⁵

A review of 12 studies on parental communication about sex revealed that parents who received training on this topic had better communication with their adolescents about sexuality compared with those who did not.⁴⁶ Parental conversations with their adolescents about sexuality education is correlated with a delay in sexual debut and increased use of contraception and condoms.⁴⁷ Jaccard and Levitz⁴⁵ identified multiple effective components in parent-adolescent sexual health communication, including (1) the extent of communication as measured by frequency and depth of discussions, (2) informational style, (3) the content of data that is discussed, (4) when and how the communication occurs, and (5) the overall environment where the conversation takes place.

Discussions of sexuality do not occur equally among mothers and fathers. One review found that overall, the number of discussions parents have with teenagers about sex has decreased from 1995 to 2002.⁴⁸ From a separate review covering 1980 through July 2010, mothers were the primary discussant in all interventions.⁴⁹ In reviewing the role of fathers in sexual health discussions, Kirkman et al⁵⁰ found that fathers recognized, by self-report, that they need to share the role of communication about this topic with their teenagers but that they leave the conversation to the mothers more often than not. Although mothers can also effectively teach their sons about sexuality,⁵¹

the relationship boys have with their fathers or other male role models plays a crucial role in their sexual health, including reducing sexual risk taking and delaying initiation of sexual intercourse, especially in those boys with a connection to their fathers, whether they live in the same home or not.^{52,53}

It is clear that parents would benefit from support to improve communication with their adolescents about sex.

ABSTINENCE EDUCATION

We know that abstinence is 100% effective at preventing pregnancy and STIs; however, research has conclusively demonstrated that programs promoting abstinence-only until heterosexual marriage occurs are ineffective.^{54–57} A recent systematic review examined the evidence supporting both abstinence-only programs and comprehensive sexuality education programs designed to promote abstinence from sexual intercourse. In that review, most comprehensive sexuality education programs showed efficacy in delaying initiation of intercourse in addition to promoting other protective behaviors, such as condom use. There was no evidence that abstinence-only programs effectively delayed initiation of sexual intercourse.⁵⁷ In another review of sexuality education, Cavazos-Rehg et al³⁵ found that the literature examining the efficacy of current school-based sexuality education programs had insufficient evidence to support the intervention of abstinence on the basis of inconsistent results across studies.

The federal government has historically provided \$178 million for abstinence-only education through Title V, Section 510 of the Social Security Act in 1996, Community-Based Abstinence Education projects through the Patient Protection and Affordable Care Act, and the

Adolescent Family Life Act program. The Community-Based Abstinence Education program received the most federal funds and made direct grants to community-based organizations, including faith-based organizations. Federal guidance required all programs to adhere to an 8-point definition of abstinence-only education and prohibited programs from disseminating information on contraceptive services, sexual orientation and gender identity, and other aspects of human sexuality. Programs promoted exclusive abstinence outside of heterosexual marriage and required that contraceptive use, contraceptive methods, and specifically condoms must not be discussed except to demonstrate failure rates.⁵⁸

The Obama administration's proposed budget for fiscal year 2014 created funding for programs that have been proven effective in reducing teen pregnancy, delaying sexual activity, or increasing contraceptive use.^{32,59–61} There are still Title V-funded programs for abstinence-only programs in the schools and in other places in the community. However, most public funding now supports evidence-informed interventions that have been proven to delay onset of sexual activity, reduce numbers of partners, increase condom and contraceptive use, and decrease incidence of teen pregnancy and STIs, including HIV.^{32,59–61} Private and parochial schools also have their own standards/policies and limited funding stream for sexuality education.⁵⁷

In a 2005 study by Brückner and Bearman,⁶² a review of Add Health data suggested that many teenagers who take a "virginity pledge" and intend to be abstinent before marriage fail to do so and that when these teenagers do initiate intercourse, they fail to protect themselves by using contraception. In a review of the virginity pledge movement, these researchers found

that 88% of teenagers who took the pledge had initiated intercourse before marriage, compared with 99% of those who did not take the pledge. They also found that teenagers who took the pledge were less likely to use contraception after they did initiate sexual intercourse and not to seek STI screening. At 6-year follow-up, the prevalence of STIs (*Chlamydia*, gonorrhea, trichomoniasis, and HPV infection) was comparable among those who took the abstinence pledge and those who did not.⁶²

The American College of Obstetricians and Gynecologists, the Society for Adolescent Health and Medicine, the AAP, the American Medical Association, the American Public Health Association, National Education Association, and the National School Boards Association oppose abstinence-only education and endorse comprehensive sexuality education that includes both abstinence promotion and accurate information about contraception, human sexuality, and STIs.⁶²⁻⁶⁷

CLINICAL GUIDANCE FOR PEDIATRICIANS

1. The pediatrician should encourage early parental discussion with children at home about sexuality, contraception, and Internet and social media use that is consistent with the child's and family's attitudes, values, beliefs, and circumstances.
2. Diverse family circumstances, such as families with same-sex parents or children who identify as lesbian, gay, bisexual, transgender, or questioning, create unique guidance needs regarding sexuality education.
3. Modeling ways to initiate talks about sexuality with children at pertinent opportunities, such as the birth of a sibling can encourage parents to answer

children's questions fully and accurately.

4. Parents and adolescents are encouraged to receive information from multiple sources, including health care providers and sexuality educators, about circumstances that are associated with earlier sexual activity. Adolescents are encouraged to feel empowered through discussing strategies that allow for practicing social skills, assertiveness, control, and rejection of unwanted sexual advances and cessation of sexual activity when the partner does not consent.
5. Discussions regarding healthy relationships and intimate partner violence can be effectively included in health care visits.
6. Pediatricians are encouraged to acknowledge that sexual activity may be pleasurable but also must be engaged in responsibly.
7. Specific components of sexuality education offered in schools, religious institutions, parent organizations, and other community agencies vary based on many factors. The pediatrician can serve as a resource to each.
8. School-based comprehensive sexuality education that emphasizes prevention of unintended pregnancy and STIs should be encouraged.
9. The discussion of methods of contraception and STI and HPV cancer prevention with male and female adolescents is encouraged before the onset of sexual intercourse (see the AAP statement "Contraception and Adolescents"). It is also important to discuss consistent use of safer sex precautions with sexually active teens. Bright Futures recommendations can be used.

10. Abstinence is the most effective strategy for preventing HIV infection and other STIs, as well as for prevention of pregnancy.
11. Preparation for college entry is an excellent opportunity for pediatricians to address issues such as the effects of alcohol, marijuana, and other drug consumption on decisions about safe, consensual sexual practices.
12. Children and adolescents with special issues and disabilities may benefit from additional counseling, referrals, and sharing of online resources listed at the end of this report.

ONLINE SEXUALITY EDUCATION RESOURCES

School and Community

- United Nations Population Fund: <http://www.unfpa.org/public/home/adolescents/pid/6483>. *Advocates for and supports promotion of comprehensive sexuality education, provides programming guidance for both school and community settings, and advocates for wider educational opportunities for all young people and partners with civil society organizations.*
- The National Alliance to Advance Adolescent Health: <http://www.thenationalalliance.org/>. *Uses resources, advocacy, collaboration, and research to improve and increase access to integrated physical, behavioral, and sexual health care for adolescents.*
- The Future of Sexuality Education (FoSe): <http://www.futureofsexed.org/documents/josh-fose-standards-web.pdf>. *Developed the National Sexuality Education Standards for teachers to standardize and improve the quality of sexuality education provided in schools.*

- Sexuality Information and Education Council of the United States: <http://www.sexedlibrary.org/index.cfm>. A resource for educators, counselors, administrators, and health professionals about human sexuality research, lesson plans, and professional development. *The SexEd Library is a comprehensive online collection of lesson plans relate to sexuality education.*
- Sexual Education: Get Real: <http://www.getrealeducation.org>. *Get Real: Comprehensive Sex Education is a unique curriculum designed for implementation in both middle and high schools. Information provided is medically accurate and age-appropriate and can reinforce family communication and improve communication skills for healthy relationships.*
- Centers for Disease Control and Prevention Health Education Curriculum Analysis Tool: http://www.cdc.gov/healthyyouth/hecat/pdf/HECAT_Module_SH.pdf. *The Health Education Curriculum Analysis Tool can help school districts, schools, and others conduct a clear, complete, and consistent analysis of health education curricula based on the National Health Education Standards and the Centers for Disease Control and Prevention's Characteristics of an Effective Health Education Curriculum. The Health Education Curriculum Analysis Tool can help schools select or develop appropriate and effective health education curricula and can be customized to meet local community needs and conform to the curriculum requirements of the state or school district.*

Health Care Providers

- Bright Futures: http://brightfutures.aap.org/pdfs/Guidelines_PDF/9-Promoting-Healthy-Sexual-Development.pdf. *Preventive health information and*

recommendations about promoting healthy sexual development and sexuality to help health care providers during health supervision visits from early childhood through adolescence.

- The Community Preventive Services Task Force: <http://www.thecommunityguide.org/hiv/RRriskreduction.html>. *Recommendations about interventions to promote behaviors that prevent or reduce the risk of pregnancy, HIV, and other STIs in adolescents.*
- American Congress of Obstetricians and Gynecologists: <http://www.acog.org/About-ACOG/ACOG-Departments/Adolescent-Health-Care>. *Information and resources about adolescent sexuality and sex education.*

Youth

- Scarleteen: <http://www.scarleteen.com/>. *Scarleteen is an independent, grassroots sexuality education and support organization and Web site. Founded in 1998, Scarleteen.com is visited by approximately three-quarters of a million diverse people each month worldwide, most between the ages of 15 and 25. It is the highest-ranked Web site for sex education and sexuality advice online and has held that rank through most of its tenure.*
- Sex, etc: <http://sexetc.org/>. Sexetc.org has comprehensive sex education information, including the following:
 - Stories written by teen staff writers and national contributors.
 - Opportunities to get involved and make a difference on sexual health issues.
 - The Sex, etc. blog, which addresses timely and relevant news.

- Forums where teens can participate in moderated discussions with other teens.
- "Sex in the States," which is a state-by-state guide to teens' rights to sex education, birth control, and more.
- Videos about sexual health.
- A sex terms glossary of almost 400 terms.
- Love is Respect: <http://www.loveisrespect.org/>. *Loveisrespect is a project of the National Domestic Violence Hotline and Break the Cycle. By combining our resources and capacity, we are reaching more people, building more healthy relationships, and saving more lives.*

Youth With Disabilities

- Parent Advocacy Coalition for Educational Rights: www.pacer.org. *Parent training and information center for families of children and youth with all disabilities from birth through 21 years old. Parents can find publications, workshops, and other resources about a number of topics, including sexuality and disabilities.*
- Your Child Development and Behavioral Resources: www.med.umich.edu/1libr/yourchild/disabsex.htm. *A program at the University of Michigan that houses a resource list of materials and Web sites about sexuality education for youth with disabilities for families as well as for teachers, and providers.*
- Center for Parent Information and Resources: <http://www.parentcenterhub.org/repository/sexed/>. *Contains information about sexuality education for students with disabilities for use with parents and teachers. The site also contains information about specific disabilities and sexuality, such as autism spectrum disorders, cerebral palsy, and spina bifida.*

Advocacy

- United Nations Population Fund: <http://www.unfpa.org/public/home/adolescents/pid/6483>. *Advocates for and supports promotion of comprehensive sexuality education, provides programming guidance for both school and community settings, and advocates for wider educational opportunities for all young people and partners with civil society organizations.*
- National Alliance to Advance Adolescent Health: <http://www.thenationalalliance.org/>. *Uses resources, advocacy, collaboration, and research to improve and increase access to integrated physical, behavioral, and sexual health care for adolescents.*
- Futures Without Violence: <http://www.futureswithoutviolence.org/>. *Uses advocacy, collaboration, and training with policy makers; health care, legal, and educational professionals; and others to improve responses to violence and abuse against women and children.*
- Advocates for Youth: <http://www.advocatesforyouth.org/sex-education-home>. *Leads efforts that help young people make informed and responsible decisions about their reproductive and sexual health and focuses its work on young people ages 14 to 25 in the United States and around the globe. There are a number of resources for multiple audiences on the Sex Education home page.*
- The National Campaign to Prevent Teen and Unplanned Pregnancy: <http://thenationalcampaign.org/featured-topics/sex-education-and-effective-programs>. *A series of resources that relate to sex education and a database of those sex education programs and interventions that work as well as online curricula that can be used with various audiences, including teens, college students, and others.*

LEAD AUTHORS

Cora C. Breuner, MD, MPH
Gerri Mattson, MD, MSPH

COMMITTEE ON ADOLESCENCE, 2015–2016

Cora C. Breuner, MD, MPH, FAAP, Chairperson
William P. Adelman, MD, FAAP
Elizabeth M. Alderman, MD, FSAHM, FAAP
Robert Garofalo, MD, FAAP
Arik V. Marcell, MD, MPH, FAAP
Makia E. Powers, MD MPH, FAAP
Krishna Kumari Upadhy, MD, FAAP

LIAISONS

Laurie L. Hornberger, MD, MPH, FAAP – *Section on Adolescent Health*
Margo Lane, MD, FRCPC, FAAP – *Canadian Pediatric Society*
Benjamin Shain, MD, PhD – *American Academy of Child and Adolescent Psychiatry*
Julie Strickland, MD – *American College of Obstetricians and Gynecologists*
Lauren B. Zapata, PhD, MSPH – *Centers for Disease Control and Prevention*

STAFF

Karen S. Smith
James D. Baumberger, MPP

COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, 2015–2016

Michael W. Yogman, MD, FAAP, Chairperson
Nerissa S. Bauer, MD, MPH, FAAP
Thresia B. Gambon, MD, FAAP
Arthur Lavin, MD, FAAP
Keith M. Lemmon, MD, FAAP
Gerri Mattson, MD, FAAP
Jason R. Rafferty, MD, MPH, EdM
Lawrence S. Wissow, MD, MPH, FAAP

CONSULTANT

George J. Cohen, MD

LIAISONS

Sharon Berry, PhD, LP – *Society of Pediatric Psychology*
Terry Carmichael, MSW – *National Association of Social Workers*
Edward R. Christophersen, PhD, FAAP – *Society of Pediatric Psychology*
Norah L. Johnson, PhD, RN, CPNP-BC – *National Association of Pediatric Nurse Practitioners*
Leonard R. Sulik, MD – *American Academy of Child and Adolescent Psychiatry*

STAFF

Stephanie Domain, MS, CHES
Tamar M. Haro

ABBREVIATIONS

AAAP: American Academy of Pediatrics
FoSE: Future of Sex Education Initiative
HPV: human papillomavirus
STI: sexually transmitted infection

REFERENCES

1. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence. Sexuality education for children and adolescents. *Pediatrics*. 2001;108(2):498–502
2. Gruber EL, Wang PH, Christensen JS, Grube JW, Fisher DA. Private television viewing, parental supervision, and sexual and substance use risk behaviors in adolescents [abstract]. *J Adolesc Health*. 2005;36(2):107
3. Strasburger VC; Council on Communications and Media. American Academy of Pediatrics. Policy statement—sexuality, contraception, and the media. *Pediatrics*. 2010;126(3):576–582
4. Boekeloo BO. Will you ask? Will they tell you? Are you ready to hear and respond? Barriers to physician-adolescent discussion about sexuality. *JAMA Pediatr*. 2014;168(2):111–113
5. Duncan P, Hagan JF Jr, Shaw JS. Promoting healthy sexual development and sexuality. In: *American Academy of Pediatrics. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Elk Grove Village, IL: American Academy of Pediatrics; 2008:169–176. Available at: <https://brightfutures.aap.org/Bright%20Futures%20Documents/9-Sexuality.pdf>. Accessed September 28, 2015
6. Martino SC, Elliott MN, Corona R, Kanouse DE, Schuster MA. Beyond the “big talk”: the roles of breadth and repetition in parent-adolescent communication about sexual topics. *Pediatrics*. 2008;121(3). Available at: www.pediatrics.org/cgi/content/full/121/3/e612
7. Swartzendruber A, Zenilman JM. A national strategy to improve sexual health. *JAMA*. 2010;304(9):1005–1006

8. Sexuality Information and Education Council of the United States. Position Statement on Human Sexuality. Available at: www.siecus.org/index.cfm?fuseaction=page.viewPage&pageId=494&parentID=472. Accessed July 16, 2015
9. Future of Sex Education (FoSE). National Sexuality Education Standards Tools. Available at: <http://www.futureofsexed.org/documents/joshfose-standards-web.pdf>. Accessed July 16, 2015
10. Jackson CA, Henderson M, Frank JW, Haw SJ. An overview of prevention of multiple risk behaviour in adolescence and young adulthood. *J Public Health (Oxf)*. 2012;34(suppl 1):i31–i40
11. Kramer A. *Girl Talk: What High School Senior Girls Have to Say About Sex, Love, and Relationships*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy; 2012
12. Chin HB, Sipe TA, Elder R, et al; Community Preventive Services Task Force. The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: two systematic reviews for the Guide to Community Preventive Services. *Am J Prev Med*. 2012;42(3):272–294
13. Hamilton BE, Ventura SJ; Centers for Disease Control and Prevention, National Center for Health Statistics. Birth rates for U.S. teenagers reach historic lows for all age and ethnic groups. *NCHS Data Brief*. 2012;(89):1–8
14. United Nations. Statistics Division. Live births by age of mother and sex of child, general and age-specific fertility rates: latest available year, 2002–2011. In: *Demographic Yearbook*. New York, NY: United Nations, Statistics Division; 2012. Available at: <http://unstats.un.org/unsd/demographic/products/dyb/dyb2011/Table10.pdf>. Accessed July 16, 2015
15. Finer LB, Zolna MR. Unintended pregnancy in the United States: incidence and disparities, 2006. *Contraception*. 2011;84(5):478–485
16. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool (HECAT). Available at: www.cdc.gov/HealthyYouth/HECAT/. Accessed July 16, 2015
17. Wilson SF, Strohsnitter W, Baecher-Lind L. Practices and perceptions among pediatricians regarding adolescent contraception with emphasis on intrauterine contraception. *J Pediatr Adolesc Gynecol*. 2013;26(5):281–284
18. Donaldson AA, Lindberg LD, Ellen JM, Marcell AV. Receipt of sexual health information from parents, teachers, and healthcare providers by sexually experienced U.S. adolescents. *J Adolesc Health*. 2013;53(2):235–240
19. Lindberg LD, Maddow-Zimet I, Boonstra H. Changes in adolescents' receipt of sex education, 2006–2013. *J Adolesc Health*. 2016;58(6):621–627
20. Hall KS, McDermott Sales J, Komro KA, Santelli J. The state of sex education in the United States. *J Adolesc Health*. 2016;58(6):595–597
21. Cheng MM, Udry JR. Sexual behaviors of physically disabled adolescents in the United States. *J Adolesc Health*. 2002;31(1):48–58
22. Florida Developmental Disabilities Council Inc. Developmental disabilities: an instructional manual for parents of and individuals with developmental disabilities. Available at: www.fddc.org/sites/default/files/file/publications/Sexuality%20Guide-Parents-English.pdf. Accessed July 16, 2015
23. Murphy NA, Elias ER; American Academy of Pediatrics, Council on Children With Disabilities. Sexuality of children and adolescents with developmental disabilities. *Pediatrics*. 2006;118(1):398–403
24. Committee On Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*. 2013;132(1):198–203
25. Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011
26. Spigarelli MG. Adolescent sexual orientation. *Adolesc Med State Art Rev*. 2007;18(3):508–518, vii
27. US Preventive Services Task Force. Sexually transmitted infections: behavioral counseling. Released September 2014. Available at: www.uspreventiveservicestaskforce.org/uspstf/uspststds.htm. Accessed July 16, 2015
28. Martinez G, Copen CE, Abma JC; Centers for Disease Control and Prevention, National Center for Health Statistics. Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2006–2010 national survey of family growth. *Vital Health Stat*. 2011;23(31):1–35
29. Eaton DK, Kann L, Kinchen S, et al; Centers for Disease Control and Prevention (CDC). Youth risk behavior surveillance - United States, 2011. *MMWR Surveill Summ*. 2012;61(4):1–162
30. Caldas SJ, Bensy ML. The sexual maltreatment of students with disabilities in American school settings. *J Child Sex Abuse*. 2014;23(4):345–366
31. Lindberg LD, Santelli JS, Singh S. Changes in formal sex education: 1995–2002. *Perspect Sex Reprod Health*. 2006;38(4):182–189
32. Kohler PK, Manhart LE, Lafferty WE. Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *J Adolesc Health*. 2008;42(4):344–351
33. Advocates for Youth. *Science and Success*. 3rd ed. Programs that Work to Prevent Teen Pregnancy, HIV and STIs in the US. Washington, DC: Advocates for Youth; 2012
34. Sexuality Information and Education Council of the United States. Sexuality Education Q & A. Available at: www.siecus.org/index.cfm?fuseaction=page.viewpage&pageid=521&grandparentID=477&parentID=514. Accessed July 16, 2015
35. Cavazos-Rehg PA, Krauss MJ, Spitznagel EL, et al. Associations between sexuality education in schools and adolescent birthrates: a state-level longitudinal model. *Arch Pediatr Adolesc Med*. 2012;166(2):134–140
36. Frappier JY, Kaufman M, Baltzer F, et al. Sex and sexual health: a survey of Canadian youth and mothers. *Paediatr Child Health*. 2008;13(1):25–30

37. Merzel CR, VanDevanter NL, Middlestadt S, Bleakley A, Ledsky R, Messeri PA. Attitudinal and contextual factors associated with discussion of sexual issues during adolescent health visits. *J Adolesc Health*. 2004;35(2):108–115
38. Mueller TE, Gavin LE, Kulkarni A. The association between sex education and youth's engagement in sexual intercourse, age at first intercourse, and birth control use at first sex. *J Adolesc Health*. 2008;42(1):89–96
39. Grossman JM, Tracy AJ, Charmaraman L, Ceder I, Erkut S. Protective effects of middle school comprehensive sex education with family involvement. *J Sch Health*. 2014;84(11):739–747
40. Guttmacher Institute. State policies in brief: sex and HIV education. Available at: www.guttmacher.org/statecenter/spibs/spib_SE.pdf. Accessed July 16, 2015
41. Kann L, Telljohan S, Hunt H, Hunt P, Haller R. Health education. In: *Centers for Disease Control and Prevention. Results from the School Health Policies and Practices Study*. Atlanta, GA: Centers for Disease Control and Prevention; 2013. Available at: www.cdc.gov/healthyyouth/shpps/2012/pdf/shpps-results_2012.pdf#page=27. Accessed July 16, 2015
42. Martinez G, Abma J, Copen C. Educating teenagers about sex in the United States. *NCHS Data Brief*. 2010;(44):1–8
43. Eastman KL, Corona R, Schuster MA. Talking parents, healthy teens: a worksite-based program for parents to promote adolescent sexual health. *Prev Chronic Dis*. 2006;3(4):A126
44. Strasburger VC, Brown SS. Sex education in the 21st century. *JAMA*. 2014;312(2):125–126
45. Jaccard J, Levitz N. Counseling adolescents about contraception: towards the development of an evidence-based protocol for contraceptive counselors. *J Adolesc Health*. 2013;52(suppl 4):S6–S13
46. Wight D, Fullerton D. A review of interventions with parents to promote the sexual health of their children. *J Adolesc Health*. 2013;52(1):4–27
47. Klein JD, Sabaratnam P, Pazos B, Auerbach MM, Havens CG, Brach MJ. Evaluation of the parents as primary sexuality educators program. *J Adolesc Health*. 2005;37(suppl 3):S94–S99
48. Robert AC, Sonenstein FL. Adolescents' reports of communication with their parents about sexually transmitted diseases and birth control: 1988, 1995, and 2002. *J Adolesc Health*. 2010;46(6):532–537
49. Akers AY, Holland CL, Bost J. Interventions to improve parental communication about sex: a systematic review. *Pediatrics*. 2011;127(3):494–510
50. Kirkman M, Rosenthal DA, Feldman SS. Talking to a tiger: fathers reveal their difficulties in communicating about sexuality with adolescents. *New Dir Child Adolesc Dev*. 2002;(97):57–74
51. Jemmott LS, Outlaw FH, Jemmott JB, Brown EJ, Howard M, Hopkins B. Strengthening the bond: the Mother and Son Health Promotion Project. In: Pequegnat W, Szapocznik J, eds. *Inside Families: The Role of Families in Preventing and Adapting to HIV/AIDS*. Bethesda, MD: Sage Publications; 2000:133–151
52. King V, Sobolewski JM. Nonresident fathers' contributions to adolescent well-being. *J Marriage Fam*. 2006;68(3):537–557
53. Carlson MJ. Family structure, father involvement, and adolescent behavioral outcomes. *J Marriage Fam*. 2006;68(1):137–154
54. Ball H. Theory-based abstinence-only intervention may delay sexual initiation among black urban youth. *Perspect Sex Reprod Health*. 2010;42(2):135–136
55. Jemmott JB III, Jemmott LS, Fong GT. Efficacy of a theory-based abstinence-only intervention over 24 months: a randomized controlled trial with young adolescents. *Arch Pediatr Adolesc Med*. 2010;164(2):152–159
56. Kirby D. The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior. *Sexuality Research and Social Policy*. 2008;5(3):18–27
57. Trenholm C, Devaney B, Fortson K, Quay L, Wheeler J, Clark M; Mathematica Policy Research Inc. Impacts of Four Title V, Section 510 Abstinence Education Programs. Final Report. Submitted to US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Princeton, NJ: Mathematica Policy Research Inc; 2007. Available at: www.mathematica-mpr.com/~media/publications/PDFs/impactabstinence.pdf. Accessed July 16, 2015
58. Catalog of Federal Domestic Assistance. Community-based abstinence education. Available at: <https://www.cfda.gov/index?s=program&mode=form&tab=core&id=7a526272ffcfea290497a3548fb92654>. Accessed July 16, 2015
59. Ott MA, Santelli JS. Abstinence and abstinence-only education. *Curr Opin Obstet Gynecol*. 2007;19(5):446–452
60. Santelli J, Ott MA, Lyon M, Rogers J, Summers D. Abstinence-only education policies and programs: a position paper of the Society for Adolescent Medicine. *J Adolesc Health*. 2006;38(1):83–87
61. Advocates for Youth. Comprehensive sex education: research and results. Available at: www.advocatesforyouth.org/storage/advfy/documents/fscse.pdf. Accessed July 16, 2015
62. Brückner H, Bearman P. After the promise: the STD consequences of adolescent virginity pledges. *J Adolesc Health*. 2005;36(4):271–278
63. Kirby DB, Laris BA, Rolleri LA. Sex and HIV education programs: their impact on sexual behaviors of young people throughout the world. *J Adolesc Health*. 2007;40(3):206–217
64. Kirby D. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy; 2001
65. Manlove J, Romano-Papillo A, Ikramullah E. *Not Yet: Programs to Delay First Sex Among Teens*. Washington, DC: National Campaign to Prevent Teen Pregnancy; 2004
66. Bearman PS, Brueckner H. Promising the future: virginity pledges and first intercourse. *American Journal of Sociology*. 2001;106(4):859–912
67. Kraft JM, Kulkarni A, Hsia J, Jamieson DJ, Warner L. Sex education and adolescent sexual behavior: do community characteristics matter? *Contraception*. 2012;86(3):276–280

Sexuality Education for Children and Adolescents

Cora C. Breuner, Gerri Mattson, COMMITTEE ON ADOLESCENCE and
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY
HEALTH

Pediatrics; originally published online July 18, 2016;
DOI: 10.1542/peds.2016-1348

Updated Information & Services	including high resolution figures, can be found at: /content/early/2016/07/14/peds.2016-1348.full.html
References	This article cites 48 articles, 6 of which can be accessed free at: /content/early/2016/07/14/peds.2016-1348.full.html#ref-list-1
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): Adolescent Health/Medicine /cgi/collection/adolescent_health:medicine_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: /site/misc/Permissions.xhtml
Reprints	Information about ordering reprints can be found online: /site/misc/reprints.xhtml

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2016 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Sexuality Education for Children and Adolescents

Cora C. Breuner, Gerri Mattson, COMMITTEE ON ADOLESCENCE and
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY
HEALTH

Pediatrics; originally published online July 18, 2016;
DOI: 10.1542/peds.2016-1348

The online version of this article, along with updated information and services, is
located on the World Wide Web at:
</content/early/2016/07/14/peds.2016-1348.full.html>

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2016 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

