THE SURGEON GENERAL'S CALL TO ACTION TO PROMOTE SEXUAL HEALTH AND RESPONSIBLE SEXUAL BEHAVIOR

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A Letter from the Surgeon General
U.S. Department of Health and Human Services

I am introducing the *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* because we, as a nation, must address the significant public health challenges regarding the sexual health of our citizens. In recognition of these challenges, promoting responsible sexual behavior is included among the Surgeon General's Public Health Priorities and is also one of the *Healthy People 2010* Ten Leading Health Indicators for the Nation. While it is important to acknowledge the many positive aspects of sexuality, we also need to understand that there are undesirable consequences as well–alarmingly high levels of sexually transmitted disease (STD) and HIV/AIDS infection, unintended pregnancy, abortion, sexual dysfunction, and sexual violence. In the United States:

- STDs infect approximately 12 million persons each year;
- 774,467AIDS cases, nearly two-thirds of which were sexually transmitted, have been reported since 1981;
- an estimated 800,000 to 900,000 persons are living with HIV;
- an estimated one-third of those living with HIV are aware of their status and are in treatment, one-third are aware but not in treatment, and one-third have not been tested and are not aware;
- an estimated 40,000 new HIV infections occur each year;
- an estimated 1,366,000 induced abortions occurred in 1996;
- nearly one-half of pregnancies are unintended;
- an estimated 22 percent of women and two percent of men have been victims of a forced sexual act; and
- an estimated 104,000 children are victims of sexual abuse each year.

Each of these problems carries with it the potential for lifelong consequences–for individuals, families, communities, and the nation as a whole. As is the case with so many public health problems, there are serious disparities among the populations affected. The economically disadvantaged, racial and ethnic minorities, persons with different sexual identities, disabled persons, and adolescents often bear the heaviest burden. Yet it is important to recognize that persons of all ages and backgrounds are at risk and should have access to the knowledge and services necessary for optimal sexual health.

These challenges can be met but first we must find common ground and reach consensus on some important problems and their possible solutions. It is necessary to appreciate what sexual health is, that it is connected with both physical and mental health, and that it is important throughout the entire lifespan, not just the reproductive years. It is also important to recognize the responsibilities that individuals and communities have in protecting sexual health. The responsibility of well-informed adults as educators and role models for their children cannot be overstated. Issues around sexuality can be difficult to discuss–because they are personal and because there is great diversity in how they are perceived and approached. Yet, they greatly impact public health and, thus, it is time to begin that discussion and, to that end, this *Surgeon General's Call to Action* is offered as a framework.

It is, however, only a first step–a call to begin a mature and thoughtful discussion about sexuality. We must understand that sexuality encompasses more than sexual behavior, that the many aspects of sexuality include not only the physical, but the mental and spiritual as well, and that sexuality is a core component of personality. Sexuality is a fundamental part of human life. While the problems usually associated with sexual behavior are real and need to be addressed, human sexuality also has significant meaning and value in each individual's life. This call, and the discussion it is meant to generate, is not just intended for health care professionals or policy makers. It is intended for parents, teachers, clergy, social service professionals–all of us.

I would like to add a few words for the many thousands of persons living with HIV/AIDS in this country. We realize that you are not the enemy; that the enemy in this epidemic is the virus, not those who are infected with it. You need our support and encouragement. At the same time, it is also important that you realize you have an opportunity to partner with us in stemming the spread of this illness; to be responsible in your own behavior and to help others become aware of the need for responsible behavior in their sexual lives. Working together, we can make a difference.

This *Call to Action* has been developed through a collaborative process. It is based on a series of scientific review papers contributed by experts in relevant fields, on recommendations developed at two national conferences, and on extensive review and comment as the document was being prepared–all of which sought the broadest possible input and brought together a wide range of experience, expertise and perspective with representation from the academic, medical and religious communities, policy makers, advocates, teachers, parents and youth. The strategies presented here provide a point of reference for advancing a national dialogue on issues of sexuality, sexual health, and responsible sexual behavior. It can begin among individuals, but must also involve communities, the media, government and non-government agencies, institutions, and foundations.

In developing this *Call to Action,* we have received a wide range of input, and have identified several areas of common ground. A major responsibility of the Surgeon General is to provide the best available science based information to the American people to assist in protecting and advancing the health and safety of our Nation. This report represents another effort to meet that responsibility.

Finding common ground might not be easy, but it is possible. The process leading to this *Call to Action* has already shown that persons with very different views can come together and discuss difficult issues and find broad areas of agreement. Approaches and solutions might be complex, but we do have evidence of success. We need to appreciate the diversity of our culture, engage in mature, thoughtful and respectful discussion, be informed by the science that is available to us, and invest in continued research. This is a call to action. We cannot remain complacent. Doing nothing is unacceptable. Our efforts not only will have an impact on the current health status of our citizens, but will lay a foundation for a healthier society in the future.

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Surgeon General

THE SURGEON GENERAL'S CALL TO ACTION TO PROMOTE SEXUAL HEALTH AND RESPONSIBLE SEXUAL BEHAVIOR

I. Introduction

Sexuality is an integral part of human life. It carries the awesome potential to create new life. It can foster intimacy and bonding as well as shared pleasure in our relationships. It fulfills a number of personal and social needs, and we value the sexual part of our being for the pleasures and benefits it affords us. Yet when exercised irresponsibly it can also have negative aspects such as sexually transmitted diseases--including HIV/AIDS--unintended pregnancy, and coercive or violent behavior. To enjoy the important benefits of sexuality, while avoiding negative consequences, some of which may have long term or even life time implications, it is necessary for individuals to be sexually healthy, to behave responsibly, and to have a supportive environment--to protect their own sexual health, as well as that of others.

Sexual health is inextricably bound to both physical and mental health. Just as physical and mental health problems can contribute to sexual dysfunction and diseases, those dysfunctions and diseases can contribute to physical and mental health problems. Sexual health is not limited to the absence of disease or dysfunction, nor is its importance confined to just the reproductive years. It includes the ability to understand and weigh the risks, responsibilities, outcomes and impacts of sexual actions and to practice abstinence when appropriate. It includes freedom from sexual abuse and discrimination and the ability of individuals to integrate their sexuality into their lives, derive pleasure from it, and to reproduce if they so choose.

Sexual responsibility should be understood in its broadest sense. While personal responsibility is crucial to any individual's health status, communities also have important responsibilities. Individual responsibility includes: understanding and awareness of one's sexuality and sexual development; respect for oneself and one's partner; avoidance of physical or emotional harm to either oneself or one's partner; ensuring that pregnancy occurs only when welcomed; and recognition and tolerance of the diversity of sexual values within any community. Community responsibility includes assurance that its members have: access to developmentally and culturally appropriate sexuality education, as well as sexual and reproductive health care and counseling; the latitude to make appropriate sexual and reproductive choices; respect for diversity; and freedom from stigmatization and violence on the basis of gender, race, ethnicity, religion, or sexual orientation.

Sexual health and responsible sexual behavior are both linked to the Surgeon General's Public Health Priorities and the Department of Health and Human Services' *Healthy People 2010* initiative and the *Guide to Community Preventive Services*. These are, in turn, based on the scientific evidence and on principles of health promotion and disease prevention, and provide a basis for approaching these challenges.

The Surgeon General's Public Health Priorities include: (1) a balanced community health system, grounded at the community level and encompassing the promotion of healthy lifestyles, including responsible sexual behavior, and provision of equitable access to health care services; (2) the elimination of racial and ethnic disparities in health; and (3) a global approach to public health and the exchange of information and technology with other nations to improve world health.
Healthy People 2010 identifies national public health priorities and objectives to be achieved over the next decade. Its two overarching goals are to improve years and quality of healthy life and to eliminate disparities

in health including those related to HIV/AIDS, sexually transmitted diseases, domestic violence and unintended pregnancy. The document also includes a set of 10 Leading Health Indicators for the nation, one of which is responsible sexual behavior. Two other leading health indicators are also relevant to this *Call to Action*–reducing substance abuse and improving access to health care.

The *Guide to Community Preventive Services: Systematic Reviews and Evidence-Based Recommendations* represents a significant national effort in encouraging evidence-based public health practice. It is being developed to make recommendations regarding public health interventions in a variety of areas, including mental health, violence prevention and sexual behavior. It is intended to provide an independent and scientifically rigorous road map to help reach the goals of improved health envisioned in *Healthy People 2010*.

This *Call to Action* focuses on the need to promote sexual health and responsible sexual behavior throughout the lifespan. Its primary goal is to stimulate respectful, thoughtful, and mature discussion in our communities and in our homes. While sexuality may be difficult to discuss for some, and there are certainly many different views and beliefs regarding it, we cannot afford the consequences of continued or selective silence. It is necessary to find common ground--balancing diversity of opinion with the best available scientific evidence and best practice models--to improve the health of our nation. This *Call to Action* is also the first step toward the development of guidelines to assist parents, clergy, teachers, and others in their work of improving sexual health and responsible sexual behavior.

II. The Public Health Approach

Use of a public health approach is requisite to promoting sexual health and responsible sexual behavior. This approach has four central components: 1) identifying the problem; 2) identifying risk and protective factors; 3) developing and testing interventions; and 4) implementing, and further evaluating, those interventions that have demonstrated effectiveness. In the present case, public health responds to the problem–sexually transmitted diseases, unintended pregnancies, and sexual violence–by asking what is known about its distribution and rates, what factors can be modified, if those modifications are acceptable to the community, and if they are likely to address the problem. Such approaches can range from provision of information about responsible sexuality and interventions designed to promote healthy behavior--such as sexuality education that starts from within the family, where educated and informed adults can also serve as positive role models--to developing vaccines against sexually transmitted diseases (STDs) and AIDS, and to making sexual health care more available and accessible. Additionally, public health focuses on involving communities in their own health and tailoring health promotion programs to the needs and cultures of the communities involved. Because sexuality is one of the human attributes most endowed with meaning and symbolism, it is of particular importance that addressing sexual health issues involve community wide discussion, consultation, and implementation.

This *Call to Action* provides an evidence based foundation for developing a public health approach to sexual health and responsible sexual behavior. It identifies the problems and then discusses risk and protective factors. Numerous intervention models that have been evaluated and shown to be effective, as well as some that are promising but not yet adequately evaluated, are also presented. The last step, implementation of effective interventions, will depend heavily on individual communities and their members.

III. The Public Health Problem

The United States faces a significant challenge related to the sexual health of its citizens. Concerns include: STDs; infertility and cancer resulting from STDs; HIV/AIDS; sexual abuse, coercion and prejudice; unintended pregnancy; and abortion.

Five of the ten most commonly reported infectious diseases in the U.S. are STDs; and, in 1995, STDs accounted for 87 percent of cases reported among those ten (Institute of Medicine [IOM], 1997). Nevertheless, public awareness regarding STDs is not widespread, nor is their disproportionate impact on women, adolescents, and racial and ethnic minorities well known:

- Chlamydia infection is the most commonly reported STD. While reported rates of infection in women greatly exceed those in men, largely because screening programs have been primarily directed toward women, the rates for both women and men are probably similar. Chlamydia rates for women are highest among those aged 15-19 years and rates for Black and Hispanic women are also considerably higher than those for White women (IOM, 1997).

- Rates for gonorrhea are highest among women aged 15-19 years and Blacks (IOM, 1997).

- It is estimated that 45 million persons in the U.S. are infected with genital herpes and that one million new cases occur per year (Fleming et al, 1997).

- Sexually transmitted infections in both women and men contribute to infertility, which affects approximately 14 percent of all couples in the United States at some time (Sciarra, 1991). For example, chlamydia and gonorrhea infections account for 15 percent of cases of infertility in women (IOM, 1997).

- Human Papillomavirus (HPV) is a sexually transmissible virus that causes genital warts. An estimated 5.5 million persons become infected with HPV each year in the U.S. and an estimated 20 million are currently infected. There are many different types of HPV. While most women who have HPV do not develop cervical cancer, four HPV subtypes are responsible for an estimated 80 percent of cervical cancer cases, with approximately 14,000 new cervical cancer cases occurring per year (Centers for Disease Control and Prevention [CDC], 1999a).

Currently, there are an estimated 800,000 to 900,000 persons living with HIV in the United States, with approximately 40,000 new HIV infections occurring every year. Among those who are currently positive for HIV, an estimated one-third are aware of their status and in treatment, one-third are aware of their status but not in treatment, and one-third have not been tested and are unaware of their status (CDC, 2000a; CDC, 2001a).

Since 1981, a total of more than 774,467 AIDS cases had been reported to the U.S. Centers for Disease Control and Prevention (CDC). The disease has disproportionately affected men who have sex with men--47 percent of reported cases--and minority men who have sex with men have now emerged as the population most affected (CDC, 2001b). A recently released seven city survey indicates that new HIV infection was substantially higher for young Black gay and bisexual men than for their White or Hispanic counterparts (CDC, 2001c). During the 1990s, the epidemic also shifted toward women. While women account for 28 percent of HIV cases reported since 1981, they accounted for 32 percent of those reported between July 1999 and June 2000. Similarly, women account for 17 percent of AIDS cases reported since 1981, but 24 percent of those reported between July 1999 and June 2000 (CDC, 2000b).

Sexual abuse contributes to sexual dysfunction and other public health problems such as substance abuse and mental health problems. There are an estimated 104,000 child victims of sexual abuse per year (U.S. Department of Health and Human Services [USDHHS], 2000a), and the proportion of women in current relationships who are subject to sexual violence is estimated at eight percent (Coker et al, 2000). While it is estimated that only a relatively small proportion of rapes are reported (Koss et al, 1988), a major national study found that 22 percent of women and approximately two percent of men had been victims of a forced sexual act (Laumann et al, 1994).

Sexual orientation is usually determined by adolescence, if not earlier (Bell et al, 1981), and there is no valid scientific evidence that sexual orientation can be changed (Haldeman, 1994; APA, 2000). Nonetheless, our culture often stigmatizes homosexual behavior, identity and relationships (Herek, 1993). These anti-homosexual attitudes are associated with psychological distress for homosexual persons and may have a negative impact on mental health, including a greater incidence of depression and suicide, lower self-acceptance and a greater likelihood of hiding sexual orientation (Gonsiorek, 1982; Ross, 1985; Ross, 1990; Greene, 1997; Remafedi, 1998). Although the research is limited, transgendered persons are reported to experience similar problems. In their extreme form, these negative attitudes lead to antigay violence. Averaged over two dozen studies, 80 percent of gay men and lesbians had experienced verbal or physical harassment on the basis of their orientation, 45 percent had been threatened with violence, and 17 percent had experienced a physical attack (Berrill, 1992).

There are also persons who are challenged with developmental, physical or mental disabilities whose sexuality and sexual needs have often been ignored, or at worst, exploited and abused (Schover and Jensen, 1988; Hingsburger and Harber, 1998). Although appropriate assistance has been developed for these vulnerable populations, it is seriously underutilized (Acton, 1992; Sipski and Alexander, 1997). Additional materials and programs, as well as further research, are needed.

It is estimated that nearly one-half of all pregnancies in the U.S. are unintended (US.DHHS, 2000b). While women in all age, income, race and ethnicity categories experience unintended pregnancies, the highest rates occur among adolescents, lower-income women and Black women (IOM, 1995). Unintended pregnancy is medically costly in terms of the precluded opportunity for preconception care and counseling, as well as increased likelihood of late or no prenatal care, increased risk for low birthweight, and increased risk for infant mortality. It is also socially costly in terms of out-of-wedlock births, reduced educational attainment and employment opportunity, increased welfare dependency, and later child abuse and neglect--and economically in terms of health care costs (IOM, 1995).

An estimated 1,366,000 induced abortions occurred in the U.S. in 1996, a slight increase from the 1,364,000 in 1995, but a 15 percent decrease from the 1,609,000 in 1990. A similar pattern of decrease has been observed in abortion rates with 22.9 abortions per 1000 women aged 15-44 years in 1996 compared to 27.4 in 1990 (Ventura, 2000). Moreover, surveillance data indicate that for those States that report previous induced abortions, nearly 45 percent of abortions reported in 1996 were obtained by women who had already had at least one abortion (CDC, 1999b).

The belief that adolescents obtain the majority of abortions in the U.S. is inaccurate. Abortion rates are substantially higher for women in their twenties than for adolescents. Rates in 1996 were 50.7 abortions per 1000 for women aged 20-24 years and 33.6 per 1000 for women aged 25-29 years, compared with a rate of 29.2 abortions per 1000 women aged 15-19 years. Moreover, women over 20 years of age account for 80 percent of total induced abortions. Nonetheless, a higher proportion
of adolescent pregnancies end in abortion (29 percent) than do pregnancies for women over 20 years of age (21 percent) (Ventura, 2000).

Significant differences of opinion exist regarding the morality of abortion. In general, U.S. courts have ruled that the procedure is legal and health care technology has made abortion relatively safe. However, there is broad accord that abortion should be a rare procedure and that improvements in sexual health and an emphasis on a reduction in the number of unintended pregnancies will clearly move this objective forward. The underpinning of the public health approach to this issue is to apply a variety of interventions at key points to prevent unintended pregnancy from occurring, and thus, ensure that all pregnancies are welcomed.

IV. Risk and Protective Factors for Sexual Health

Human beings are sexual beings throughout their lives and human sexual development involves many other aspects of development– physical, behavioral, intellectual, emotional, and interpersonal. Human sexual development follows a progression that, within certain ranges, applies to most persons. The challenge of achieving sexual health begins early in life and continues throughout the lifespan. The actions communities and health care professionals must take to support healthy sexual development vary from one stage of development to the next. Children need stable environments, parenting that promotes healthy social and emotional development, and protection from abuse. Adolescents need education, skills training, self-esteem

promoting experiences, and appropriate services related to sexuality, along with positive expectations and sound preparation for their future roles as partners in committed relationships and as parents. Adults need continuing education as they achieve sexual
maturity--to learn to communicate effectively with their children and partners and to accept continued responsibility for their sexuality, as well as necessary sexual and reproductive health care services.

There are also a number of more variable risk and protective factors that shape human sexual behavior and can have an impact on sexual health and the practice of responsible sexual behavior. These include biological factors, parents and other family members, schools, friends, the community, the media, religion, health care professionals, the law, and the availability of reproductive and sexual health services.

Biological Factors

Although human sexuality has come to serve many functions in addition to reproduction, its biological basis remains fundamental to the sexual experience. Sexual response involves psychological processing of information, which is influenced by learning, physiological responses and brain mechanisms which link the information processing to the physiological response. Although there is much that is not well understood about this complex sequence, it is understood that individuals vary considerably in their capacity for physical sexual response. This variability can be explained only in part by cultural factors. The role of early learning or genetic factors, or an interaction between the two, remains to be determined by further research.

Reproductive hormones are clearly important. However, their role is best understood and most predictable for men–and much more complex for women. For example, apart from the fact that women may experience a variety of reproduction-related experiences--the menstrual cycle, pregnancy, lactation, the menopause, and hormonal contraception–all of which can influence their sexual lives, there does appear to be greater variability among women in the impact of reproductive hormones on their sexuality (Bancroft, 1987). In addition, variations in the onset of puberty and menstruation can represent special challenges for girls in some populations.

Parents and Other Family Members

A number of family factors are known to be associated with adolescent sexual behavior and the risk of pregnancy. Adolescents living with a single parent are more likely to have had sexual intercourse than those living with both biological parents (Miller, 1998). Having older siblings may also influence the risk of adolescent pregnancy, particularly if the older siblings have had sexual intercourse, and if an older sister has experienced an adolescent pregnancy or birth (East, 1996; Widmer, 1997). For girls, the experience of sexual abuse in the family as a child or adolescent is linked to increased risk of adolescent pregnancy (Browning, 1997; Roosa, 1997; Miller, 1998). In addition, adolescents whose parents have higher education and income are more likely both to postpone sexual intercourse and to use contraception if they do engage in sexual intercourse (Miller, 1998).

The quality of the parent-child relationship is also significant. Close, warm parent-child relationships are associated with both postponement of sexual intercourse and more consistent contraceptive use by sexually active adolescents (Jaccard, 1996; Resnick, 1997). Parental supervision and monitoring of children are also associated with adolescents postponing sexual activity or having fewer sexual partners if they are sexually active (Hogan and Kitagawa, 1985; Miller, 1998; Upchurch et al, 1999). However, parental control can be associated with negative effects if it is excessive or coercive (Miller, 1998).

Schools

Evidence suggests that school attendance reduces adolescent sexual risk-taking behavior. Around the world, as the percentage of girls completing elementary school has increased, adolescent birth rates have decreased. In the United States, youth who have dropped out of school are more likely to initiate sexual activity earlier, fail to use contraception, become pregnant, and give birth (Mauldon and Luker, 1996; Brewster et al, 1998, Manlove, 1998; Darroch et al, 1999). Among youth who are in school, greater involvement with school–including athletics for girls--is related to less sexual risk-taking, including later age of initiation of sex, and lower frequency of sex, pregnancy, and childbearing (Holden et al, 1993; Billy et al, 1994; Resnick et al, 1997).

Schools may have these effects on sexual risk-taking behavior for any of several reasons. Schools structure students' time; they create an environment which discourages unhealthy risk-taking--particularly by increasing interactions between youth and adults; and they affect selection of friends and larger peer groups. Schools can increase belief in the future and help youth plan for higher education and careers, and they can increase students' sense of competence, as well as their communication and refusal skills (Manlove, 1998; Moore et al, 1998).

Schools often have access to training and communications technology that is frequently not available to families or clergy. This is important because parents vary widely in their own knowledge about sexuality, as well as their emotional capacity to explain essential sexual health issues to their children. Schools also provide an opportunity for the kind of positive peer learning that can influence social norms.

The Community

Community can be defined in several ways: through its geographic boundaries; through the predominant racial or ethnic makeup of its members; or through the shared values and practices of its members. Most persons are part of several communities, including neighborhood, school or work, religious affiliation, social groups, or athletic teams. Whatever the definition, community influence on the sexual health of those who comprise it is considerable, as is its role in determining what responsible sexual behavior is, how it is practiced and how it is enforced.

The measurable physical characteristics of neighborhoods and communities, such as economic conditions, racial and ethnic composition, residential stability, level of social disorganization, and service availability have

demonstrated associations with the sexual behavior of their residents–initiation of sexual activity, contraceptive use, out-of-wedlock childbearing and risk of STD infection (Billy and Moore, 1992; Brewster et al, 1993; Grady, 1993; Billy et al, 1994; Grady et al, 1998; Tanfer et al, 1999). An understanding of these characteristics and their impact on individuals is important in planning and developing services and other interventions to improve the sexual health and promote the responsible sexual behavior of community residents.

A shared culture, based either on heritage or on beliefs and practices, is another form of community. Each of these communities possesses norms and values about sexuality and these norms and values can influence the sexual health and sexual behavior of community members. For example, strong prohibitions against sex outside of marriage can have protective effects with respect to STD/HIV infection and adolescent pregnancy (Comas-Diaz, 1987; Kulig, 1994; Savage and Tchombe, 1994; Sudarkasa, 1997; Tiongson, 1997; Abraham, 1999; Amaro, 2001). On the other hand, undue emphasis on sexual restraint and modesty can inhibit family discussion about sexuality and perhaps contribute to reluctance to seek sexual and reproductive health care (Hiatt et al, 1996; Schuster et al, 1996; He et al, 1998; Tang et al, 1999). Gender roles that accord higher status and more permissiveness for males and passivity for females can have a negative impact on the sexual health of women if they are unable to protect themselves against unintended pregnancy or STD/HIV infection (Amaro and Raj, 2000; Bowleg et al, 2000; Castaneda, 2000).

When a community--defined by its culture--also has minority status, its members are potential objects of economic or social bias which can have a negative impact on sexual health. Economic inequities, in the form of reduced educational and employment opportunities, and the poverty that often results, has obvious implications for accessing and receiving necessary health education and care. In addition, a history of exploitation has, in some cases, led to distrust and suspicion of public health efforts in some minority communities (Tafoya, 1989; Thomas and Quinn, 1991; Wyatt, 1997).

The Media

The media--whether television, movies, music videos, video games, print, or the Internet–are pervasive in today's world and sexual talk and behavior are frequent and increasingly explicit. More than one-half of the programming on television has sexual content (Cope and Kunkel, in press). Significant proportions of music videos and Hollywood movies also portray sexuality or eroticism (Greenberg et al, 1993; DuRant et al, 1997). Among young people, 10-17 years of age, who regularly use the Internet, one-quarter had encountered unwanted pornography in the past year, and one-fifth had been exposed to unwanted sexual solicitations or approaches through the Internet (Finkelhor et al, 2000).

Media programming rarely depicts sexual behavior in the context of a long-term relationship, use of contraceptives, or the potentially negative consequences of sexual behavior. The media do, however, have the potential for providing sexuality information and education to the public. For example, more than one-half of the high school boys and girls in a national survey said they had learned about birth control, contraception, or preventing pregnancy from television; almost two-thirds of the girls and 40 percent of the boys said they

had learned about these topics from magazines (Sutton et al, in press).
While the available research evidence shows a connection between media and information regarding sexuality, it is still inadequate to make the link between media and sexual behavior.

Religion

Simply being affiliated with a religion does not appear to have great effect on sexual behavior; however, the extent of an individual's commitment to a religion or affiliation with certain religious denominations does (Brewster et al, 1998). For example, an adolescent's frequent attendance at religious services is associated with less permissive attitudes about premarital sexual activity and a greater likelihood of abstinence (Ku et al, 1993; Billy et al, 1994; Werner-Wilson, 1998). On the other hand, for adolescents who are sexually active, frequency of attendance is also associated with decreased use of contraceptive methods among girls and increased use by boys (DuRant and Sanders, 1989; Ku et al, 1993).

Health Care Professionals

Physicians, nurses, pharmacists and other health care professionals, often the first point of contact for individuals with sexual health concerns or problems, can have great influence on the sexual health and behavior of their patients. Yet, both adolescents and adults frequently perceive that health care providers are uncomfortable when discussing sexuality and often lack adequate communication skills on this topic (Croft and Asmussen, 1993).

Health care providers typically do not receive adequate training in sexual aspects of health and disease and in taking sexual histories. Ideally, curriculum content should seek to decrease anxiety and personal difficulty with the sexual aspects of health care, increase knowledge, increase awareness of personal biases, and increase tolerance and understanding of the diversity of sexual expression. Although such training for physicians has increased–95 percent of North American medical schools offer curriculum material in sexuality–nearly one-third do not address important topics such as taking a sexual history (Dunn and Alarie, 1997).

The Law

In the United States, the law regulates sexual behavior in complicated ways through criminal, civil, and child welfare law and operates at local, state, and federal levels. Criminal law imposes penalties for certain kinds of sexual activities, considering factors such as age, consent of both parties, the actual act performed, and the location in which it takes place. Civil law complements criminal law and can extend the law's reach. Civil law, for example, provides individuals with protection from sexual harassment and allows legal redress for some victims of sexual violence (Levesque, 1998). It can also have an impact through regulation of relationships such as marriage, divorce, and child custody and support.

The law may also regulate some aspects of the community's influence on sexuality, including the family, schools, and media. While it generally protects parental rights (Levesque, 2000), the law also imposes limits. For example, it protects children from sexual victimization by a family member. The law also regulates access to sexual health services through mechanisms such as parental notification and waiting period requirements. With respect to schools, although states may set certain minimum standards, the law allows individual school systems to determine the content of curriculum, including sexuality education curriculum. In addition, the legal system provides schools with the power to
develop and implement programs to address the prevention of sexual harassment, relationship violence, and rape.

Under protection of the First Amendment to the U.S. Constitution, the media have great freedom in the choice of content they portray. At the same time, the law can impose certain restrictions on the media; for example, it may limit minors' access to sexually explicit materials.

Availability of Reproductive Health Services

In the United States, contraceptive and reproductive health services are provided to women and men by a wide range of health care professionals. These services are offered in a variety of settings–private practice offices, publicly funded family planning clinics, private clinics, military clinics, school-based health centers, college and university health centers, and private hospitals. Often, contraceptive services are integrated with other basic preventive health services such as pelvic examinations and pap tests, and screening for sexually transmitted infections (Frost and Bolzan, 1997). In addition to medical care, counseling or education related to sexual and reproductive health may be provided.

Barriers to obtaining these services can exist if providers are not conveniently located, are not available when needed, do not provide (or are thought not to provide) confidential, respectful, culturally sensitive care, or are not affordable (Forrest and Frost, 1996). Federally subsidized family planning services have been an important factor in helping many persons overcome these barriers and avoid an estimated 1.3 million unintended pregnancies per year (Forrest and Samara, 1996).

V. Evidence-based Intervention Models

Substantial work has been done in the areas of sexual health and responsible sexual behavior, through public-private partnerships at the national as well as community level, by many researchers and organizations throughout the country. Many of these approaches and programs to improve sexual health have been evaluated and shown to be effective. They include: community based programs, school based programs, clinic based programs, and religion based programs.

Community Based Programs

Youth development programs, although they typically do not specifically address sexuality, have been shown

to have a significant impact on sexual health and behavior. Programs that improve education and life options for adolescents have been demonstrated to reduce their pregnancy and birth rates (Olsen and Farkas, 1990; Allen et al, 1997; Melchior, 1998; Hawkins et al, 1999). These programs may increase attachment to school, improve opportunities for careers, increase belief in the future, increase interaction with adults, and structure young people's time.

The CDC has identified a number of effective STD and HIV prevention programs that are curriculum based and presented by peer and health educators in various community settings (CDC, 1999c). Other community interventions have involved changing community norms and the distribution of condoms to reduce unwanted pregnancies and STDs, including HIV. Such interventions have the advantages of reaching large numbers of people at a relatively low cost and engaging the active involvement of community members, including local opinion leaders. They have had considerable success in changing community norms about sexual behavior as evidenced by substantial increases in condom use (Arnold and Cogswell, 1971; Kelly et al, 1991; Grosskurth et al, 1995; Kegeles et al, 1996; Kelly et al, 1997). It is important to point out that although the correct and consistent use of condoms has been shown to be effective in reducing the risk of pregnancy, HIV infection, and some STDs, more research is needed on the level of effectiveness.

School Based Programs

A majority of Americans favor some form of sexuality education in the public schools and also believe that some sort of birth control information should be available to adolescents (Smith, 2000). School based sexuality education programs are generally of two types: abstinence-only programs that emphasize sexual abstinence as the most appropriate choice for young people; and sexuality and STD/HIV education programs that also cover abstinence but, in addition, include condoms and other methods of contraception to provide protection against STDs or pregnancy.

To date, there are only a few published evaluations of abstinence-only programs (Christopher and Roosa, 1990; St Pierre et al, 1995; Kirby et al, 1997; Kirby, 2001). Due to this limited number of studies it is too early to draw definite conclusions about this approach. Similarly, the value of these programs for adolescents who have initiated sexual activity is not yet understood. More research is clearly needed.

Programs that typically emphasize abstinence, but also cover condoms and other methods of contraception, have a larger body of evaluation evidence that indicates either no effect on initiation of sexual activity or, in some cases, a delay in the initiation of sexual activity (Kirby, 1999; Kirby, 2001). This evidence gives strong support to the conclusion that providing information about contraception does not increase adolescent sexual activity, either by hastening the onset of sexual intercourse, increasing the frequency of sexual intercourse, or increasing the number of sexual partners. In addition, some of these evaluated programs increased condom use or contraceptive use more generally for adolescents who were sexually active (Kirby et al, 1991; Rotheram-Borus et al, 1991; Jemmott et al, 1992; Walter and Vaughn, 1993; Magura et al, 1994; Main et al, 1994; St Lawrence et al, 1995; Hubbard et al, 1998; Jemmott et al, 1998; Coyle et al, 1999).

Despite the available evidence regarding the effectiveness of school-based sexuality education, it remains a controversial issue for many– in terms of whether schools are the most appropriate venue for such education, as well as curriculum content. Few would disagree that parents should be the primary sexuality educators of their children or that sexual abstinence until engaged in a committed and mutually monogamous relationship is an important component in any sexuality education program. It does seem clear, however, that providing sexuality education in the schools is a useful mechanism to ensure that this Nation's youth have a basic understanding of sexuality. Traditionally, schools have had a role in ensuring equity of access to information that is perhaps greater than most other institutions. In addition, given that one-half of adolescents in the United States are already sexually active–and at risk of unintended pregnancy and STD/HIV infection–it also seems clear that adolescents need accurate information about contraceptive methods so that they can reduce those risks.

Clinic Based Programs

Prevention programs based in health clinics that have an impact on sexual health and behavior are of three types: counseling and education; condom or contraceptive distribution; and STD/HIV screening. Successful counseling and education programs have several elements in common: they have a clear scientific basis for their design; they require a commitment of staff time and effort, as well as additional time from clients; they are tailored to the individual; and they include building clients' skills through, for example, exercises in negotiation. Even brief risk-reduction messages have been shown, in some studies, to lead to substantial increases in condom use (Cohen et al, 1991; Cohen et al, 1992; Mansfield et al, 1993; Kamb et al, 1998;) although other studies have shown little effect (Wenger et al, 1992; Clark et al, 1998). More extensive counseling, either individual or small group, can produce additional increases in consistent condom use (Boyer et al, 1997; Shain et al, 1999).

Most school clinic based condom and contraceptive availability programs include some form of abstinence or risk-reduction counseling to address the concern that increased condom availability could lead to increased sexual behavior (Kirby and Brown, 1996). The evidence indicates these programs, while still controversial in some communities, do not increase sexual behavior and that they are generally accepted by adolescents, parents, and school staff (Guttmacher et al, 1995; Wolk and Rosenbaum, 1995).

Because many STDs have no clear symptoms, STD/HIV screening promotes sexual health and responsible sexual behavior by detecting these diseases and preventing their unintentional spread. Routine screening in clinics has also been shown to reduce the incidence of some STDs, particularly chlamydia infection (Hillis et al, 1995; Scholes et al, 1996).

Religion Based Programs

Religion based sexuality education programs have been developed and cover a wide spectrum of different belief systems. Taken as a whole, they cover all age ranges, from early elementary school to adults, as well as youth with different sexual orientations and identities. Although it is reasonable to expect that religion

based programs would have an impact on sexual behavior, the absence of scientific evaluations precludes arriving at a definitive conclusion on the effectiveness of these programs. More research is needed.

VI. Vision for the Future

Strategies that cover three fundamental areas--increasing awareness, implementing and strengthening interventions, and expanding the research base–could help provide a foundation for promoting sexual health and responsible sexual behavior in a manner that is consistent with the best available science.

1. Increasing Public Awareness of Issues Relating to Sexual Health and Responsible Sexual Behavior

C Begin a national dialogue on sexual health and responsible sexual behavior that is honest, mature and respectful, and has the ultimate goal of developing a national strategy that recognizes the need for common ground.

C Encourage opinion leaders to address issues related to sexual health and responsible sexual behavior in ways that are informed by the best available science and that respect diversity.

C Provide access to education about sexual health and responsible sexual behavior that is thorough, wide-ranging, begins early, and continues throughout the lifespan. Such education should:

- recognize the special place that sexuality has in our lives;

- stress the value and benefits of remaining abstinent until involved in a committed, enduring, and mutually monogamous relationship; but

- assure awareness of optimal protection from sexually transmitted diseases and unintended pregnancy, for those who are sexually active, while also stressing that there are no infallible methods of protection, except abstinence, and that condoms cannot protect against some forms of STDs.

C Recognize that sexuality education can be provided in a number of venues–homes, schools, churches, other community settings–but must always be developmentally and culturally appropriate.

C Recognize that parents are the child's first educators and should help guide other sexuality education efforts so that they are consistent with their values and beliefs.

C Recognize, also, that families differ in their level of knowledge, as well as their emotional

capability to discuss sexuality issues. In moving toward equity of access to information for promoting sexual health and responsible sexual behavior, school sexuality education is a vital component of community responsibility.

2. Providing the Health and Social Interventions Necessary to Promote and Enhance Sexual Health and Responsible Sexual Behavior

- Eliminate disparities in sexual health status that arise from social and economic disadvantage, diminished access to information and health care services, and stereotyping and discrimination.

- Target interventions to the most socioeconomically vulnerable communities where community members have less access to health education and services and are, thus, likely to suffer most from sexual health problems.

- Improve access to sexual health and reproductive health care services for all persons in all communities.

- Provide adequate training in sexual health to all professionals who deal with sexual issues in their work, encourage them to use this training, and ensure that they are reflective of the populations they serve.

- Encourage the implementation of health and social interventions to improve sexual health that have been adequately evaluated and shown to be effective.

- Ensure the availability of programs that promote both awareness and prevention of sexual abuse and coercion.

- Strengthen families, whatever their structure, by encouraging stable, committed, and enduring adult relationships, particularly marriage. Recognize, though, that there are times when the health interests of adults and children can be hurt within relationships with sexual health problems, and that sexual health problems within a family can be a concern in and of themselves.

3. Investing in Research Related to Sexual Health and Disseminating Findings Widely

- Promote basic research in human sexual development, sexual health, and reproductive health, as well as social and behavioral research on risk and protective factors for sexual health.

- Expand the research base to cover the entire human life span–children, adolescents, young adults, middle age adults, and the elderly.

- Research, develop, disseminate, and evaluate educational materials and guidelines for sexuality education, covering the full continuum of human sexual development, for use by parents, clergy, teachers, and other community leaders.

- Expand evaluation efforts for community, school and clinic based interventions that address sexual health and responsibility.

VII. Advancing a National Dialogue

The primary purpose of this *Surgeon General's Call to Action* is to initiate a mature national dialogue on issues of sexuality, sexual health, and responsible sexual behavior. As stated so eloquently in the Institute of Medicine report, *No Time to Lose* (IOM, 2000):

> "Society's reluctance to openly confront issues regarding sexuality results in a number of untoward effects. This social inhibition impedes the development and implementation of effective sexual health and HIV/STD education programs, and it stands in the way of communication between parents and children and between sex partners. It perpetuates misperceptions about individual risk and ignorance about the consequences of sexual activities and may encourage high-risk sexual practices. It also impacts the level of counseling training given to health care providers to assess sexual histories, as well as providers' comfort levels in conducting risk-behavior discussions with clients. In addition, the "code of silence" has resulted in missed opportunities to use the mass media (e.g., television, radio, printed media, and the Internet) to encourage healthy sexual behaviors."

The strategies set out above provide a point of reference for a national dialogue. How it will be implemented will be determined by individuals and families, communities, the media, and by government and non-government agencies, institutions, and foundations. We must all share in the responsibility for initiating this dialogue, working at every level of society to promote sexual health and responsible sexual behavior.

Individuals can begin the dialogue – adult with adult, adult with child – by developing their own personal knowledge, attitudes, and skills with respect to sexual health and responsible sexual behavior. Adults can communicate with other adults about their views on responsible sexual behavior, what it is, and how to promote it. Parents can educate their children about sexuality and responsibility, most importantly by being healthy and positive role models.

Communities must necessarily approach a dialogue on sexual health and responsible sexual behavior in different ways, according to their diverse composition and norms. But *all* must participate so that *all* voices are heard. This dialogue can be sponsored by local governments, businesses, churches, schools, youth-serving organizations and other community based organizations and should, at a minimum, include: emphasis on respect for diversity of perspective, opinion and values; assessment of community resources available for educating community members and delivering necessary services; attention to policies and programs that

support and strengthen families; and assurance that systems are in place to promote equitable access and respect for all cultural, gender, age, and sexual orientation groups.

Media in all its forms can be engaged, by both public and private entities, in a national dialogue to promote sexual health and responsible sexual behavior. This dialogue should be a long-term effort and should treat sexuality issues responsibly, accurately, and positively. With respect to media programming, the portrayal of sexual relationships should be mature and honest, and responsible
sexual behavior should be stressed. Finally, it is also important that young people, as well as adults, be educated to critically examine media messages.

Government, in partnership with foundations and other private organizations, can target support for the research, education, and services necessary to sustain a meaningful campaign to promote sexual health and responsible sexual behavior. Government should continue to develop objective and measurable indicators to monitor progress over time. It can also review policies and laws to ensure that they facilitate--rather than impede--the promotion of sexual health and responsible sexual behavior.

Conclusion

Based on the scientific evidence, we face a serious public health challenge regarding the sexual health of our nation. Doing nothing is unacceptable. More than anyone, it is our children who will suffer the consequences of our failure to meet these responsibilities.

Solutions are complex but we do have evidence that we can promote sexual health and responsible sexual behavior. Given the diversity of attitudes, beliefs, values and opinions, finding common ground might not be easy but it is attainable. We are more likely to find this common ground through a national dialogue with honest and respectful communication. We need to appreciate and respect the diversity of our culture and be informed by the science that is available to us.

This is a call to all of society to respond to this challenge. These efforts will not only have an impact on the current health status of our nation, but lay the groundwork for a healthier society for future generations.

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Methodology

In June 1999, the Surgeon General formed a Departmental work group charged with finding ways to move forward on promoting responsible sexual behavior–one of his Public Health Priorities and one of the Healthy People 2010 Leading Health Indicators. After considerable deliberation, the work group concluded that promoting responsible sexual behavior necessarily included addressing sexual health.
To this end, in December 1999 a dialogue conference was held in Newport, Rhode Island, to discuss whether a national strategy to promote sexual health and responsible sexual behavior might be feasible and what such a strategy would look like. More than 100 persons, representing a broad range of disciplines and points of view, attended. Conference participants worked in small groups to discuss definition issues, action steps, barriers and facilitators, and strategies to bring together multi-partisan groups and develop common ground on these issues.

A summary of the Newport dialogue proceedings was subsequently presented to the Surgeon General and, at his direction, a steering committee of experts was convened to plan and carry out another conference specifically to develop recommendations for a *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*. In preparation for the conference, the steering committee also developed a draft outline for the *Call to Action* and commissioned a number of scientific review papers from experts in relevant fields to provide context for both the document and the conference.

The conference to develop recommendations for the *Call to Action* was held in July 2000, at the Airlie Center in Warrenton, Virginia. More than 130 persons representing 90 organizations--a diverse aggregation of expertise, perspective and experience--collaborated over three days to develop the conceptual framework for a national dialogue on sexual health and responsible sexual behavior that forms the core of this document. As in Rhode Island, conference participants worked in small groups to discuss issues concerning the value, function and purpose of sexuality in people's lives, policies and actions to promote sexual health and responsible sexual behavior, and their recommendations on the draft outline for the *Call to Action*, as well as those for advancing a national dialogue.

The final preparation of the *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* was then undertaken by a team of experts in the fields of public health, sexuality, and sexual health. The first five sections of this document, developed to frame and define the issues, were prepared in part from the scientific reviews written prior to the conference and the discussions of conference participants in their small groups. The last two sections, strategies and advancing a national dialogue, are a synthesis of the work of conference participants in their small groups and were held to standards of feasibility and support by the scientific literature.

Drafts of this *Call to Action* were subjected to a rigorous review by a committee representing the same diversity of expertise, perspective, and experience evidenced by the participants of both the Rhode Island and Virginia conferences. Review committee members included the discussion leaders from each small group and a cross-section of other conference participants to ensure that this document reflects the views expressed there. Several additional reviewers, who had attended neither conference, were also added to further maximize the breadth of participation and input.

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