

2010

# Adolescent Sexual Behavior and Sexual Education in the United States

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## Recommended Citation

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### Acknowledgements

I would first and foremost like to thank my academic advisor and thesis reader, Professor Daniel Krauss. My first *Introduction to Psychology* course at Claremont McKenna College was taken with Professor Krauss, and it was that class that sparked my interest in the field of psychology. Since then, my love for psychology has continued to grow. Professor Krauss has always pushed me to try harder and has been my motivation throughout this entire process. I could not have completed this work without his enthusiasm, helpful insight, and guidance. I would also like to thank my mother who has continued to support me in anything and everything I do. She is my best friend and the person I look up to most. Her passion for helping young, at-risk adolescents is the inspiration behind my own interest in this subject and the reason why I wrote my Senior Thesis on sexual education, adolescent sexual behavior, and the risks involved.

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## **Chapter 1: The History of Sexual Education**

Contrary to popular belief, the birth of sexual education was not the result of the infamous sexual revolution that took place in the 1960's, but rather an attempt to deal with the rising rate of divorce, venereal disease, and prostitution that was beginning to trouble physicians in the early 1900's. The progressive era, a time period that stretched from the 1890's to the 1920's, is most commonly remembered for its battle against political corruption and endorsement of quality education. It was also a time of scientific advancements in technologies and research. By 1905, both the gonorrhea and syphilis bacteria had been identified and in 1906 German bacteriologist, August von Wasserman, invented the first antibody test for syphilis, the Wasserman test. Finally, in 1910, an effective treatment for syphilis was discovered and the motivation for physicians to combat and control venereal diseases was at an all time high (Kuriansky & Schroeder, 2009). Many of these physicians began to band together to create a united front against the problems they were facing. During this time period, the American Federation for Sex Hygiene and the American Vigilance Association were two groups that emerged that shared a common goal of spreading awareness of venereal disease and moral guidance. These particular groups did not receive great support or popularity but in 1914, the two merged to create the American Social Hygiene Association (ASHA) (Clarke, 1955).

The ASHA garnered a much stronger following with more prominent physicians, businessmen, and even women joining in the cause. Generous financial contributions from men like John D. Rockefeller and the president of Sears, Julius Rosenwald, also added to the importance of the association. In addition, the ASHA gained support from groups such as the Young Men's Christian Association, the Young Men's Hebrew

Association, the Metropolitan Life Insurance Company, the Children's Bureau, the General Federation of Women's Clubs and many more (Luker, 2006). However, the two most important groups responsible for the ASHA's early successes are the United States Army and Navy. World War I soldiers were a primary at-risk group for sexually transmitted diseases. Prostitution sites were popular around army bases and camps and venereal disease was prevalent amongst military personnel; so prevalent, in fact, that it became the second most common cause of absence from duty (Kuriansky & Schroeder, 2009). The Security of War recognized this problem and turned to the ASHA for help. The association created a program with four main goals: (1) diagnosis and treatment to all armed force members, (2) elimination of prostitution in and around army vicinities, (3) education for soldiers on the existing venereal diseases and prevention, and (4) creation and support of "wholesome recreation" in and around army vicinities. Their efforts paid off, as the rate of venereal disease by the end of WWI declined to the lowest rate the United States had ever seen up to that point. (Clarke, 1955)

After WWI, the ASHA continued to campaign for more educational programs to spread awareness of venereal disease and its prevention. When the U.S entered into the Second World War, the association was ready with more resources and support to re-implement their programs in order to further combat the spread of disease. By the end of World War II, the rate of venereal disease was even lower than before. One contributing factor to this decline may have been that the ASHA also focused more on moral and character guidance within the troops. Among many things, they preached respect, ways to be a good husband, and the importance of being an honorable, healthy and wholesome man. Physicians and the American elite were desperate to return America to the

Victorian values of their childhood that were changing due to the rising prostitution and divorce rates. Part of the plan to control the spread of venereal disease and put an end to prostitution was to emphasize the importance of marriage and the sacredness of sex within marriage.

During this progressive era, sex and procreation were beginning to be viewed as two different activities. With the increased popularity of prostitution, men could partake in sexual activities without having to think about the consequences of childbirth. Even as early as the 1900's, sex was seen as a more casual activity, which concerned many groups including the American Social Hygiene Association. Working with the troops in both World Wars, the ASHA realized that it would take more than just venereal disease "scare" talks and education to change American's sexual habits. They needed to focus on family values and promote "wholesome" lifestyles such as only having sex within marriage, having children and properly caring for them, and being a good wife or husband. This style of "family life education" was one of the first types of sexual education taught in schools. By the late 1930's, and well into the 1940's and 1950's, colleges, universities, and even high schools added family life education into their normal curriculum (Kuriansky & Schroeder, 2009). These courses mainly stressed sexual repression and restrictions and when they did not specifically support repression of sexual thoughts, they at least emphasized that the only way to have proper and morally sound sex was to have it within the holy union of marriage. Although much of the values that were taught in these types of family life education are still an integral part of many of the sexual education courses taught today, the 1960's saw the beginnings of the sexual revolution and with it a new type of sexual education was born.

In 1960, the United States Food and Drug Administration (FDA) approved the birth control pill, changing sex and sexuality forever (PBS Online, 2002). Although the pill did not become popular or widely used for at least another decade or more, the new availability of oral contraceptives widened the already existing gap between sex and procreation. When it was first approved several states immediately made it illegal to sell or purchase the pill and others made it illegal for single women to obtain and use it. By the 1970's only a few states including Massachusetts and Connecticut had laws prohibiting the sale of oral contraceptives to unmarried women. Finally, in 1972, the U.S Supreme Court declared that no state could prohibit the sale of contraceptives to unmarried women deeming it unconstitutional, violating the Equal Protection Clause and an individual's right to privacy (*Eisenstadt v. Baird*, 1972). With such reliable birth control now available to couples, the outlook that Americans had on sex completely changed. Having sex with someone no longer equated to children, marriage and a family. It could be even more casual, with fewer strings attached and fewer consequences.

This shift in sexual thought prompted Mary S. Caldrone, the medical director of Planned Parenthood of America, to co-found the Sex Information and Education Council of the United States (SIECUS) in 1964. Through SIECUS, Caldrone wanted to begin an open dialog about sex, sexuality, pleasure and science. SIECUS' aim was to change discussions about sex. It focused on moving away from the Victorian "just say no" model of sexual education and moving towards a sexual education that would encompass all aspects of sexuality including gays, lesbians, and even masturbation. Members and supporters of SIECUS believed that the public should have access to medically accurate information about contraceptives and sexually transmitted diseases. Sexual educators

should be able to talk about sex with an open mind, portraying sex and sexuality as a natural part of human life (Irvine, 2002). This liberal approach to sex and sexuality that SIECUS initiated was one of the first attempts at a comprehensive sexual education program and would soon become the backbone of sexual education programs in nearly half of the states in the U.S.

In addition to the birth control pill, the availability of abortions was yet another reason for the great change in American's sex life during the sexual revolution. In 1973, in the case of *Roe v. Wade*, the Supreme Court came to a decision that changed almost every state's law. The Court held that during the first trimester of a pregnancy, woman should have the constitutional right to abort her child if she wanted to, and that states were limited in their ability to restrict this right (*Roe v. Wade*, 1973). The legalization of abortions not only further widened the gap between sex and family life, and heightened the public's interest for an open discussion about sex, but it also added to the already existing fury that certain religious and social groups were feeling with regards to sexual education.

Liberal groups like SIECUS and Planned Parenthood of America were not the only groups on the rise during this crucial time of sexual change. Many religious and social organizations fought against these new comprehensive approaches to sexual education because they believed they were corrupting America's youth. Members of groups like the *Christian Crusade* and the *John Birch Society* were outraged that schools were moving farther and farther away from the Christian morals that they themselves had grown up on. *Sanity on Sex* (SOS) and the *Mothers Organization for Moral Stability* (MOMS) were among the groups that supported a regression back to the Victorian model

of sexual education that preached abstinence from sex or supported an educational system where sex was never mentioned. Many people against sexual education believed that children and young adults were not able to handle such an inappropriate discussion about sex. They feared that it was harmful to expose such young people to sex and sexuality, and that such discussions would lead to increases in these behaviors (Irvine, 2002). For these followers, sex was a private act that school's educational programs had no business intervening in. These organizations had many followers and continued to gain support as the AIDS epidemic of the 1980's took the United States by storm.

The United States saw its first reported case of AIDS in 1981 and throughout the rest of that decade the number of people infected with the disease grew at an alarmingly fast rate. By 1990, over 10,000 people had been infected with AIDS, and most of them died from it (CDC, HIV/AIDS, 2001). This new and terrifying epidemic led to a contentious debate between comprehensive sexual education supporters and supporters of an abstinence-only education. Both types of advocates strongly stood by their beliefs, believing that their method of educating America's youth on sex and sexuality was the only way to remedy the AIDS problem. As the AIDS epidemic advanced well into the 1990's, mothers and fathers were overcome by fear and the "just say no" type of teaching against any sexual activity before marriage was then seen as a more comforting, appealing and seemingly easy answer to the issue at hand. The panic and anxiety soon reached the White House and by 1996, 50 million federally funded dollars were added to the annual budget in support for abstinence-only-until-marriage sexual education programs.

Today, groups like SIECUS are still fighting for comprehensive sexuality education programs and organizations such as the *Christian Crusaders* and the *American Family Association* continue to support and push for abstinence-only-until-marriage programs. Although many more federally funded dollars have been spent on abstinence only programs, recent legislation has added available federal funding for a more comprehensive approach to sexual education. Additional comprehensive programs have sprouted from this new funding and support for comprehensive sexual education. As a consequence, more schools around the nation are beginning to adopt these comprehensive approaches of teaching in their health classes. Currently, nearly half of the country's schools offer the newer and more liberal comprehensive approach to sexual education and half have continued to employ the abstinence-only-until-marriage programs. To find out what is working, what is not working, and where this country needs to move in the future, a better understanding of these two types of educational programs is needed.

In this review of sexual education in the United States, I will broadly define the two most common approaches in sexual education seen in this country today. I will then go over the status of certain sexual behaviors and risks amongst the teenage population in the U.S. and specifically cover reported sexual activity in high school students and overall data on teen pregnancies and sexually transmitted infections (STIs). Next I will look at Maine, California, Texas, Maryland, North Carolina, and New Mexico to highlight the variety of state policies concerning sexual education and the differences in teenage sexual behaviors that exist within each of those six states. After that I will describe how certain cultural influences can affect a young person's sexual behavior. In the final discussion section of this paper I will emphasize the need for more

comprehensive sexual education programs in the United States and the importance of providing culturally sensitive programs in order to continue the fight against teenage pregnancy and STI rates in adolescents.

## **Chapter 2: Sexual Education Today**

Currently, any curriculum involving sexual education depends on individual state policy. If a sexual education course is offered at any particular school, each state can decide what the courses will and will not cover, and if some type of sexual education is mandated the state can decide at what age certain curriculum is appropriate. More than half of the states require education about HIV/AIDS and other sexually transmitted infections, and the majority of public school districts offer policies on how to teach sexual education. Most state laws that do require some form of sexual education tend to be general, though, and leave much of the specific details of a sexual education curriculum up to each individual school at the local level. Other states allow schools and teachers to plan their own curriculum or they can decide to have no curriculum at all (Guttmacher Institute, 2010).

Although the content of a sexual education program in any given school has been, and still is, determined by the state, the United States government has become actively involved in sexual education and has attempted to provide funding for specific types of educational programs. In 1996, President Bill Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act, which included the first federal funding for states that would distribute to organizations or schools in order to run abstinence-only education programs. Programs could only receive the funding if, and only if, the money would go towards programs that would teach abstinence education as specified by the act (Fields, 2008). Today, under section 510 of Title V of the Social Security Act, the funding restrictions and the definition of an “abstinent education”

remain roughly similar to the bill passed in 1996. An “abstinent education” program that seeks federal funding under Title V of the Social Security Act must:

- (A) have as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- (B) teach abstinence from sexual activity outside marriage as the expected standard for all school age children;
- (C) teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- (D) teach that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
- (E) teach that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- (F) teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
- (G) teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- (H) teach the importance of attaining self-sufficiency before engaging in sexual activity.

(Section 510(b) of Title V of the Social Security Act, 2010).

In fiscal year 2009, not only was \$50 million of Title V funding distributed, but also \$13 million for the Adolescent Family Life Act (AFLA) and \$99 million for the Community-Based Abstinence Education (CBAE) were distributed by the federal

government. Similar to Title V, the AFLA and the CBAE are both specific programs that offer support and guidance to organizations that want to teach young people to abstain from sexual intercourse until marriage. With the additional funding designated towards these two programs as well as Title V funding, a total of nearly \$160 million was spent in the last year alone in support of programs that promote abstinence-only (SIECUS Overview, 2010). When funding for abstinence-only-until-marriage programs was first introduced in 1996, only two states including California opted out and chose not to accept (Levine, 2002). However, in 2009, nearly half of the states completely rejected federal funding for “abstinent education”. The increase in the number of states that are rejecting Title V funding could be due to the financial requirements of Title V; any state that accepts funding must match every 3\$ they receive from the government with 4\$ from their own state budget (SIECUS Overview, 2010). The change could also be due to the decline in popularity of abstinence-only education as more studies and research continue to show how ineffective these programs are at changing adolescent sexual behavior. The effectiveness or ineffectiveness of particular approaches to sexual education will be further evaluated later on in this discussion.

The government has recently noticed the increasing lack of support for abstinence-only educational programs and in December of 2010, Congress passed the Consolidated Appropriations Act, which eliminated the funding for abstinence education programs through the CBAE and the AFLA. Congress almost let Title V expire as well, but President Barack Obama has recently signed the Patient Protection and Affordable Care Act as part of the health care reform legislation, extending funding for abstinence education over the next five years. Although a majority of federal funding for

abstinence-only programs has been removed from the budget, this extension of Title V will amount to an additional \$250 million of the roughly \$1.5 billion the government has already spent on abstinence-only education (SIECUS Overview, 2010).

In signing the Consolidated Appropriations Act of 2010 and the Patient Protection and Affordable Care Act, President Obama was also supporting new funding for two of the first federal initiatives promoting comprehensive sexual education programs. One of these initiatives is called the President's Teen Pregnancy Prevention Initiative (TPPI). \$114.5 million has been delegated to the TPPI, and 29.5 million of those dollars are provided specifically for program testing, program evaluations and research on different approaches to teenage pregnancy prevention. The rest of the money is devoted to funding medically accurate and age-appropriate programs that will help reduce the rate of unintended teen pregnancies (SIECUS Overview, 2010). Although the TPPI is a step in the right direction towards increasing comprehensive sexual education programs in the United States, the act is not very specific, thus making it easier for organization like CBAE or AFLA to take advantage of the funding. The act, for example, does not require any discussion on contraceptives and fails to require programs to include STI and HIV/AIDS information and prevention. The act simply requires that the funding go towards evidence-based programming. Many groups could request funding and promise that some type of evidence-based programming is incorporated into their programs but then continue to employ their older, abstinence-only educational model once they are granted the funding. (SIECUS Overview, 2010).

Another comprehensive sexual education initiative that the government passed is the Personal Responsibility Education Program (PREP). This program was created as part

of the Patient Protection and Affordable Care Act and offers grants to individual states that want to provide a comprehensive sexual education program that emphasizes abstinence as well as condom use to prevent pregnancy and STIs including HIV/AIDS. The program also hopes to promote personal and responsible decision making amongst youth and encourages states to target specific groups that are at a higher risk for unintended pregnancy such as homeless youth or anyone living in an area where high teen pregnancy rates are common. The PREP has well defined terms and specifications such that any program that receives funding under this legislation will not be able to misuse or misrepresent the grant. Not only is there a two-step process to apply for the funding, states that apply must also present specific, realistic, and tangible goals that they want to achieve in their communities in the context of teen pregnancy, adolescent relationships, and STI prevention. Once states receive the funding, any program that wishes to utilize those resources must equally emphasize both abstinence and contraception for pregnancy and STI prevention in their curricula. The U.S allotted a little over \$55 million to fund state grants under PREP (Department of Health and Human Services, 2010).

Government grants, state's board of education, and separate school administrators are not the only influencing factor in sexual education curriculum. Committees, parents, and even students have a significant say in what can and cannot be taught in schools. Since laws regarding sexual education are generally broad, school administrations will often meet with concerned groups of parents and other community members to go over possible curriculum and options for their health courses. Many parents feel very strongly about what is appropriate material and what is inappropriate material for their children to

be learning in school (Irvine, 2002) (Fields, 2008). With such a controversial subject, an increase in parental involvement is inevitable and school districts feel the effects and pressure from these powerfully motivated groups.

Once states receive funding from initiatives such as the PREP, the TPPI or Title V, they will then distribute it across schools and other community programs and many schools will look to specific organizations that offer sexual education guidelines to help them implement their sexual education courses. *Sex Respect*, for example, has gained a considerable amount of interested followers since its foundation in 1983, and in 1997 more than 2,500 schools around the country were implementing a curriculum based upon the *Sex Respect* program. Schools that implement a curriculum planned by *Sex Respect* teach their students that abstaining from sex is the only way to stay safe from sexually transmitted infections and pregnancy as well as the only way to avoid psychological harm from sexual activity. *Sex Respect* suggests and promotes that premarital sex will lead to depression, poverty, and sometimes death. *Sex Respect* preaches, “sex is a privilege, not a right” and that if we “misuse it by treating it as our right, in premarital or even extramarital relationships, we then suffer terrible costs” (Kelly, 2010). Many Christian or conservative organizations such as *Sex Respect* continue to bombard school districts in attempts to discourage any curriculum that is not strictly abstinence-only-until-marriage.

Opposite these Christian and conservative attempts to promote abstinence-only educational programs, groups such as SIECUS and *Advocates for Youth* are currently advocating for schools to adapt a more comprehensive approach to their sexual education. The *Advocates for Youth* mission attempts to teach adolescents about responsible decision making by advocating accurate and complete information

surrounding sexual health and sexuality. They advertise three main core values; rights, respect, and responsibility (the 3R's). This organization argues that youth have the *right* to accurate information and confidential health services, they deserve the *respect* of being able to actively participate in the implementation and evaluation of any and all programs that affect their own lives, and society has the *responsibility* to its youth to provide the tools they need to practice safe sex and youth in turn have the responsibility to protect themselves (Advocates for Youth, 2008). *Advocates for Youth* target school districts all over the country, and even reach to developing countries around the world, to spread their knowledge on sexual and reproductive health and offer their comprehensive curriculum. Similar to *Sex Respect*, *Advocates for Youth* has created lesson plans and programs for schools to use or mirror in their own health courses and currently work with over 28,000 educators and health care providers.

The controversy within the United States over what type of sexual education is the “proper” or “right” way to teach America’s youth is far from a conclusion and schools continue to alter their programs in hopes of finding an effective curriculum. Some districts are persistent in maintaining at least the basic idea behind abstinence-only education, while others are making an attempt to add more scientific and factual information into their content including new information regarding contraceptives. Many school programs highlight the two concepts together while others continue to exclude themselves entirely and do not offer any type of education that covers sexual health or sexuality. Is the fight over sexual education worth it? Are the millions of dollars being spent towards creating useful and effective programs going to make a difference? In order to answer these questions we must examine our countries current status with

regards to STIs (including HIV/AIDS), teen pregnancy and birth rates, the types of relationships adolescents are currently involved in, and what they already know or do not know about sex. Without answers to those questions it is not clear that certain sex education programs are necessary or whether existing programs are having their intended effects on adolescents or, more broadly, the general population.

### **Chapter 3: The Status of Teen Sexual Behavior and Risk in the United States**

Starting in 1991, the Center for Disease Control and Prevention (CDC) began implementing a Youth Risk Behavior Surveillance System (YRBSS) to monitor health-risk behaviors among young adults, including sexual behaviors that lead to sexually transmitted infections and unintended pregnancies. For nearly two decades, the CDC has conducted national school based anonymous surveys to gather information about national and local trends in risky sexual behaviors among high school students. These surveys are conducted in an attempt to understand teenager's behaviors, what type of risk teenagers face, and how prevalent or serious these risks are. Survey results help the CDC to better evaluate the impact of any school or community based programs and interventions regarding these particular health risks. Although the surveys cover a variety of high-risk behaviors including alcohol consumption, driving safety, and drug and tobacco use, the survey also asks questions such as "have you ever had sexual intercourse?" or, "the last time you had sexual intercourse, did you or your partner use a condom?". The CDC is a crucial component of the Department of Health and Human Services and state governments and other federal agencies use the information gathered from the YRBSS to help set health program goals and curricula for their schools or organizations. (CDC, YRBS, 2010).

In 2009, the surveys conducted through the YRBSS targeted 47 states, four territories and 23 local districts. Since the CDC began collecting data, more states have participated. In 1991 only 26 states participated but in 2009, the most recent year data has been collected, 47 states participated; Washington, Oregon and Minnesota were the only three states that did not complete them. Although not as many states participated when

the CDC began collecting data as they do now, obvious trends can still be noticed from 1991 to present day.

In 1991, 54.1% of high school students surveyed said that they had sexual intercourse and 37.5% were currently sexually active, meaning that they had sexual intercourse during the 3 months prior to taking the survey. When asked about contraceptives, 46.2% reported that they had used a condom, or that their partner had used a condom, the last time they had sexual intercourse. To compare, in 2009, 46% of high school students surveyed said that they had sexual intercourse, 34.2% were currently sexually active at the time that they had taken the survey, and 61.1% has used a condom, or their partner had used a condom, the last time they had sexual intercourse. As seen in Figures 1 and 2, although the percent of high school students that have ever had sex or are currently sexually active has decreased slightly overall, the rates have mostly remained consistent over the past several years. Figure 3, however, illustrates the steady increase in condom use from 1991 to 2009.

The Guttmacher Institute, a well-known, non-for-profit corporation dedicated to advancing sexual and reproductive health through scientific research, policy analysis and public education, assembles and compares useful statistics to further their research. Among other statistics, the institute compiles data on birth and pregnancy rates and trends in the United States. The pregnancy rate of women between the ages of 15 and 19 in 1992 in the United States was 111 per 1,000 women and in 2006, that rate was 71.5. These statistics are shown in Figure 4 and show a significant decrease in the teen pregnancy rate amongst young adults over the last few decades. (The Guttmacher Institute, 2010).

Although the rate of teenagers that are sexually active has stayed constant, the rate of teen pregnancies has decreased considerably and the rate of condom use has increased. While a direct causal relationship between increase in condom use and decrease in unintended pregnancies is not possible, epidemiologic and laboratory studies have shown that condoms, when used correctly and consistently, are highly effective at preventing pregnancy and the spread of STI's including the HIV infection (CDC, HIV/AIDS and STDs, 2010). Therefore, the decrease in unintended teenage pregnancies could be the result of the increased condom use within the adolescent community.

In addition to unintended pregnancies, sexual behaviors can also result in sexually transmitted infections including the HIV infection which leads to AIDS. Some of the most common STIs apart from HIV include chlamydia, gonorrhea, syphilis, herpes, and the human papillomavirus (HPV). Chlamydia is an infection that usually manifests without noticeable symptoms but can seriously damage a woman's reproductive system and can cause infertility. In 2008, there were 596,437 cases of teenagers with chlamydia reported in the United States; making it the most frequently reported STI in the country. It is especially threatening to adolescent girls whose cervixes are not fully matured yet, which makes them more susceptible to the infection. Fortunately, if chlamydia is detected it is easily treatable. (CDC, HIV/AIDS and STDs, 2010)

Gonorrhea is another common STI in the United States; the CDC estimates that approximately 167,320 young people each year get newly infected. Similar to chlamydia, some people may have no apparent symptoms but others will show uncomfortable signs of infection. In men, for example, gonorrhea can cause a burning sensation when urinating or there can be a discharge from the penis. Men can also get swollen or tender

testicles. Symptoms for women are often milder, but can also include a burning sensation while urinating and a discharge from the vagina. Vaginal bleeding between periods is another sign that a woman may have gonorrhea. The infection is also a common cause for pelvic inflammatory disease, a disease that can lead to infertility. Gonorrhea is the most prevalent STI amongst adolescents in the U.S. (CDC, HIV/AIDS and STDs, 2010)

Syphilis is a less common STI but it can still cause irreparable damage to the body. In 2008, 6,333 cases of primary and secondary syphilis were reported in young adults. Syphilis is an infection that progresses in stages. If symptoms occur, the first stage will appear as a syphilis sore, or chancre. The infection will progress to a rash in the second stage and in the late stages syphilis can damage internal organs that can lead to paralysis, numbness, dementia or a number of other debilitating health problems. Unlike HPV or herpes, if syphilis is caught early it can be easily treated with antibiotics. (CDC, HIV/AIDS and STDs, 2010)

Genital herpes is an infection that is more commonly seen in women than in men. In the United States today, about 1 in every 6 persons has genital herpes. If, and when, people do show signs of the infection, it appears in outbreaks of sores or painful blisters around the genitals. The first outbreak will usually occur within the first two weeks after the infection was contracted. After the initial outbreak, several additional outbreaks reappear throughout that first year but overtime the amount of outbreaks and the severity of outbreaks will decrease. Currently, there is no treatment or cure for herpes. (CDC, HIV/AIDS and STDs, 2010)

Another STI that has no treatment is the human papillomavirus. HPV is the most common sexually transmitted infection; 20 million Americans are currently infected.

Among sexually active men and women, at least 50% will get HPV at some point in their lives. Fortunately, most people who become infected with HPV will never develop symptoms or suffer from any health problems and in 90% of cases the infection clears itself within two years. If the infection does not remit, it can lead to cervical cancer or, although less common, it can also lead to vulvar, vaginal, and penile cancer. There exist over 40 types of HPV and there are vaccines available on the market today that protect against the most common types of HPV and the strands that cause most cervical cancers. (CDC, HIV/AIDS and STDs, 2010)

The human immunodeficiency virus (HIV) is a virus that slowly destroys certain blood cells in the body that are key elements the body needs to fight off diseases. In its later stages, HIV becomes acquired immune deficiency syndrome (AIDS) at which point the person infected has a severely damaged immune system. Although medication does exist that can slow down the rate at which the HIV infection harms the immune system or can limit its effects, there is no cure. More than 1 million people in the United States are infected by HIV and more than 18,000 people die each year with AIDS. In 2007, there were 1,744 reported cases of HIV/AIDS in young adults between the ages of 13 and 19. The AIDS epidemic is still a prevalent and serious problem in this country. (CDC, HIV/AIDS and STDs, 2010)

One study that examined the prevalence of STI's in the United States sampled 853 females between the ages of 14 and 19 to learn more about specific sexual health concerns. Each subject participated in a nationally representative National Health and Nutrition Examination Survey and was then tested for five sexually transmitted infections including chlamydia, gonorrhea, herpes and HIV. The data showed that among women

who were tested in the same year or one year after they first had sexual intercourse, prevalence of any STI was 25.6%. Among those who reported only having sexual intercourse with one partner in their lifetime, prevalence of any of the five STIs was 19.7%. (Forhan et al., 2009). This study highlights that regardless of how many times a young woman has engaged in sexual intercourse or how many partners they have had, they are still extremely vulnerable to contracting a dangerous sexually transmitted infection.

American youth continue to be sexually active and confront the harsh, and at times deadly, consequences that accompany their actions. All over the country, young people appear to be having sex and not protecting themselves against pregnancies or STIs. Of all the countries in the western industrialized world, the United States has the highest rate of teen pregnancies and one of the highest rates of STIs. Although efforts have been made to educate the adolescent population on sexual health and risks, the U.S. is still divided on what students need to learn in order to decrease unintended pregnancies and the spread of STIs amongst teenagers. Very little is known about what programs are going to work the best to fight these epidemics but each state has their own policies and views on how to try.

#### **Chapter 4: Comparing State Policy and Data**

United States policy over sexual education varies considerably from state to state. Several states serve as exemplars based on the programs they have adopted and their rates of teen pregnancy and STI prevalence. When examining STI rates, sexual education programs, and rates of teen pregnancy at the state level, certain trends in the relationships between these issues emerge. Maine, California, Texas, Maryland, North Carolina, and New Mexico are six states that convey the broad spectrum of state policies that exist concerning sexual education. Yet, each state has a unique history and stance on sexual education programs that can elucidate the current battle over sexual education in the United States and the epidemic of teen pregnancy and STI's, including HIV and AIDS that has been affecting this country for decades.

For example, states such as Maine and Maryland offer a contrast to states like Texas and New Mexico. Maine has one of the lowest teen pregnancy rates in the U.S., and Maryland also has a pregnancy rate much lower than the countries average, while Texas and New Mexico both have close to the highest teen pregnancy rates reported. California is a useful example as well because its demographics are comparable to regions such as Texas or New Mexico. California's estimated population in 2009 was 36,961,664 with 76.4% Caucasians, 6.6% African Americans and 37% persons of Hispanic or Latino origin and Texas' estimated population was 24,782,302 with 82% Caucasian, 12% African American and 36.9% persons of Hispanic or Latino origin. New Mexico's population is 45.6% Hispanic. Maryland and North Carolina have a large African American population which also make them unique populations in that certain

cultural issues may impact their teen pregnancy and STI rates and the overall effectiveness of sexual education programs. (U.S. Census Bureau, 2010)

### **Maine**

Maine has maintained a comprehensive sexual education policy longer than most other states. Maine's current legislation demands that all schools implement "comprehensive family life education" programs that are medically accurate and age appropriate, and that teach about abstinence, contraceptives, and healthy relationships (Me. Rev. Stat. Ann. Tit. 22, § 1910). Schools must also provide STI education that is medically accurate as well as age appropriate. Maine's Department of Health and Human Services offers training for teachers, parents and community members to best help them develop an efficient comprehensive family life education curriculum in addition to providing resources for program staff to evaluate the classes they teach. The state also provides funding through legislation for forums in high-risk communities and for issue management and policy development training for school administrators, superintendents and principals (Me. Rev. Stat. Ann. Tit. 22, § 1910).

Maine's efforts appear to be successful as it has one of the lowest rates of students contracting STI's and rates of teen pregnancy in the country; Maine ranks 48<sup>th</sup> in the United States for teen pregnancy rates. The states average rate of pregnancies for women between the ages of 15 and 19 is 43 per 1,000. Furthermore, although Maine's teen pregnancy rate has always been relatively low, the state still experienced a very large decrease in teen pregnancies from 1988 to 2005 with a percent decrease of 47.6. (The Guttmacher Institute, 2010)

**California**

California stands out as a strong supporter for comprehensive, all encompassing sexual education programs, and has so for many years. In California, it is required that every school, at the very least, teaches STI/HIV education which must cover abstinence as well as contraceptives. Educational programs must provide information about the effectiveness and safety of all contraceptives that have been FDA-approved including emergency contraception, or the “morning-after pill”. Courses on STI/HIV education and any program that covers sexual education must be medically accurate and age appropriate. California legislation is specific when defining “age appropriate” and “medically accurate” (Cal. Ed. Code § 51931). A program that is age appropriate will investigate topics and use teaching methods that are suitable for particular age groups of children and adolescents “based on developing cognitive, emotional, and behavioral capacity typical for the age or age group” (Cal. Ed. Code § 51931). For a program to be medically accurate, the information covered must be “verified or supported by research conducted in compliance with scientific methods and published in peer-reviewed journals... and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field” (Cal. Ed. Code § 51931). Sexual education courses may be implemented in any class from kindergarten to grade 12 in high school and must be taught by a trained instructor who is up-to-date with the most recent medically accurate information and research on pregnancy and sexually transmitted infections.

California fully endorses a comprehensive approach to sexual education and is the only state that has never accepted funding for Abstinence-Only-Until-Marriage programs

under Title V of the social security act. California is also unique in that it has demonstrated the steepest decline in teen pregnancy rate since 1988. In 1988, California had the highest rate of teen pregnancy with an estimated 154 pregnancies per 1,000 women between the ages of 15 and 19. Currently, California has the 15<sup>th</sup> highest teen pregnancy rate with a rate roughly half that of its 1988 rate. Its 51.3% decrease is significantly higher than the overall 36.9% decrease that the country has experienced since 1988 (The Guttmacher Institute, 2010). Again, although it is impossible to determine a causal relationship between program implementation and state's teen pregnancy rates, California's extreme drop in teen pregnancy rate could be in part due to its continuous rejection of funding for abstinence-only educational programs.

California has also seen significant changes compared to other states in safe sex practices and risky behaviors. For example, in California's most populated county, Los Angeles, condom use has increased a considerable amount. In surveys conducted from 2001 to 2009, the percent of students reporting condom use the last time they had sex increased from 53.3% to 60.5%, an increase of 7.2%. In comparison, the rate of high school students in Texas who reported condom use in their last sexual experience only increased by 2.3% over the same time period (CDC, YRBS, 2001 & 2009).

### **Texas**

Texas has one of the least comprehensive sexual education policies in the country. Not only does Texas not mandate that any type of sexual education be taught in schools, but it is also one of the few states that do not require STI/HIV education. However, if a school does choose to offer a course in sexual education, Texas law has several requirements for what the material can and cannot cover (Tex. Ed. Code §§ 28.004). Any

sexual education course must stress abstinence until marriage and devote more attention to the importance of abstaining from sexual activity over any other behavior. The program must “emphasize that abstinence from sexual activity, if used consistently and correctly, is the only method that is 100 percent effective in preventing pregnancy, sexually transmitted diseases, infection with human immunodeficiency virus and acquired immune deficiency syndrome, and the emotional trauma associated with adolescent sexual activity” (Tex. Ed. Code §§ 28.004). If the instructor decides to teach about contraceptives including birth control and condoms, they must teach “in terms of human use reality rates instead of theoretical laboratory rates” (Tex. Ed. Code §§ 28.004). Texas also requires that no school may distribute condoms in connection with their sexual education programs. Moreover, each district’s instruction in human sexuality must be determined and specified by the board of trustees. After the course content has been selected, parents in the district must receive a summary of the materials being taught in their child’s health education class and parents then have the option to remove their son or daughter from any part of the course without subjecting the student to any disciplinary action or penalty (Tex. Ed. Code §§ 28.004).

The results from the YRBS distributed in 2009 show that Texas had one of the lowest percent of students who reported using a condom the last time they had sexual intercourse. Furthermore, the average amount of Texan students reporting using condoms is currently much lower than the countries average. Texas also has the 4th highest teen pregnancy rate with 88 pregnancies per 1,000 women between the ages of 15 and 19 and this rate is not expected to decrease dramatically anytime soon (The Guttmacher Institute, 2010). One study estimates that by 2015 the pregnancy rate amongst teenage women in

Texas will increase by 13% (Sayegh, et al., 2010). Although the rate of teen pregnancy today is much lower than it was several decades ago, as is true for every state, the percent decrease of Texas' rate is much lower than the average decrease that the United States.

### **Maryland**

Maryland is similar to Maine and California in that it has demonstrated positive outcomes and progress with regards to their teen pregnancy rates and adolescent safe sexual behavior while continuing to promote comprehensive sexual education programs. For the past several years Maryland has supported a more comprehensive approach to their health courses. As early as 2003, Maryland education code required that school boards work with county health departments to achieve certain goals, including that sexuality education programs taught about family planning and contraceptives. Since that time, Maryland's regulations have become more specific and comprehensive. In 2005, the education code required that in all middle and high schools an elective sexuality education course designed in part by a citizen advisory committee must be offered. This committee represents community views on the subject and the course must cover several topics, including contraception and sexually transmitted infections. Maryland education code also states that the teachers appointed to teach a sexuality education class may have additional preparation in order for him or her to feel more comfortable with the material. Today, Maryland has one of the most comprehensive sex education policies mandating that sexual education not only be taught, but also cover abstinence as well as contraceptives and there must be STI/HIV education. (SIECUS, State Profiles, 2010)

As for teen pregnancy rates, Maryland has seen an extreme decline. Between 2000 and 2005, Maryland exhibited the greatest decrease in teen pregnancy rate from 91

pregnancies per 1,000 women between the ages of 15 and 19, to 65 pregnancies per 1,000 women in the same age group. In 1988, Maryland ranked 4<sup>th</sup> in the United States for highest teen pregnancy rates. Since then, Maryland's rates have dropped considerably and as of 2005, Maryland is ranked 24<sup>th</sup> in the nation for teen pregnancy rates (The Guttmacher Institute, 2010).

### **North Carolina**

The state of North Carolina also requires that a more comprehensive sexual education course be taught and STI/HIV education be covered in their schools. Curricula must stress abstinence but also cover FDA-approved methods of reducing the risk of contracting sexually transmitted infections and reducing unintended pregnancies. Courses must inform students about local resources available for testing and medical care for STI's, and instructors should also inform students about where to obtain contraceptives and abortion services but only in accordance with the local school board's policy with regards to parental consent (SIECUS, State Profiles, 2010). Although students are required to learn about contraceptives, no school may distribute condoms on their property. Furthermore, any and all instruction must be medically accurate, based on the most up-to-date research, and it must be age appropriate. North Carolina also stresses the importance of parental involvement in their sexual education courses and with their students on the subject matters covered in class. (SIECUS, State Profiles, 2010)

Although North Carolina's teen pregnancy rate is not the lowest, it is ranked 14<sup>th</sup> in the country for rates of teen pregnancies with 76 pregnancies per 1,000 women between the ages of 15 and 19; from 1988 to 2005 that state has seen a 37.7% decrease in

their teen pregnancy rate. North Carolina's percent decrease in teen pregnancy rate is still much higher than many other states including Texas and New Mexico.

### **New Mexico**

Recently, New Mexico appears to have adopted a comprehensive policy on sexual education across their school districts (this is the first year that the state requires schools to teach some type of sexual education), but the state has advanced few requirements for their programs. As a result, it is easy for schools to not offer much in their instruction on sexual behavior, risks and pregnancy and STI prevention. Schools are obligated to teach about HIV in their required health education courses to all students in elementary, middle and high school. Abstinence must be stressed in every course but apart from those specifications, each school district determines what material they will cover in their programs, and the state does not limit what may or may not be included. In addition, the state does not require that the information relayed to students be medically accurate.

(SIECUS, State Profiles, 2010)

New Mexico is the state with the highest rate of teen pregnancies in the United States with an average 93 pregnancies per 1,000 women between the ages of 15 and 19. From 1988 to 2005, its decrease in teen pregnancies was less than the countries average percent decrease, decreasing by 25% compared to 36.9% for the United States (Guttmacher Institute, 2010). According to the YRBS in 2009, out of every student in New Mexico that was surveyed, only 77.3% of them reported having been taught about AIDS or HIV infection in school, one of the lowest rates of students in the country. Of those students who are sexually active, 57.5% reported using a condom the last time they

had engaged in sexual intercourse which, compared to other states, is also one of the lowest rates of reported condom use amongst young adults. (CDC, YRBS, 2009)

To summarize, after examining certain state policies and subsequent data on their teen pregnancy and STI rates, certain patterns become apparent. As seen in Figure 5, the rate of teen pregnancy in the United States has declined overall, however the decline is significantly more dramatic in some states compared to others. Collectively, it appears as if states with more comprehensive sexual education programs report healthier and safer sexual behaviors, have lower teen pregnancy rates, and have a higher and faster decrease in teen pregnancies from year to year. However, some states such as New Mexico, who have a comprehensive program and mandate that schools teach about STI's, still have extremely high teen pregnancy rates. This could be the result of the requirements of New Mexico's state policy on health education which makes it easy for schools to not offer much instruction and guidance and allows them to offer inaccurate information. It could also be due to how recent these laws have been enacted; although they now have a comprehensive sexual education policy, it has only been a year and it could take much longer to gain traction. However, the higher than average rate of teen pregnancy could also result from other factors such as cultural issues and racial makeup of the state.

New Mexico has one of the largest Hispanic populations in the country and research has shown that due to certain cultural differences surrounding the family, religion and relationship dynamics, they are more likely to engage in risky sexual behavior at a young age (Pérez-Jiménez & Serrano-García, 2009) (Flores et al., 2002). Research has also found that African Americans are the most at-risk population for

contracting certain STI's including the HIV infection in the United States. Although North Carolina and Maryland both produce generally comprehensive sexual education programs, they have surprisingly high rates of both adolescents and adults infected with STI's compared to the rest of the country. This could be due to their large African American populations. If culture and race are influential factors in teen pregnancy and STI rates, then it is important to not only look at state policy in general, but to also look at more specific programs targeting certain at-risk groups and to get a clearer understanding of why these particular groups are engaging in riskier sexual behavior and what can be done about it.

### **Chapter 5: Cultural Influences**

The percent of students reporting ever having had sexual intercourse or having their first sexual intercourse experience before the age of 13 has remained close to constant over the past several decades. Yet these numbers have consistently and considerably varied between races. In 2009, 65.2% of African American high school students reported ever having had sexual intercourse compared to only 42% of Caucasian students and 49.1% of Hispanic students. Also, more African American students report having had their first sexual intercourse experience before the age of 13. Compared to Caucasian students, a higher percent of Hispanic and African American students report having had sexual intercourse with four or more persons during their life time and show higher percentages of students who are currently sexually active. As for condom use, in 2009, the YRBS found that compared to Caucasian and African American populations, Hispanic teenagers reported the lowest rate of condom use. Of the Hispanic high school students that reported being sexually active, only 53.5% reported using a condom the last time they had sexual intercourse while 62.4% of African American students and 63.3% of Caucasian students reported using a condom. (CDC, YRBS, 2009)

Although the rate of teen pregnancies in the United States has decreased across all races over the past few decades, this rate amongst minority populations is still much higher. In 2005, the rate of teen pregnancy for both the Hispanic and African American population was approximately 126 per 1,000 women between the age of 15 and 19 compared to 61 for Caucasians. Although both Hispanics and African Americans have high teen pregnancy rates, the Hispanic population's rate has shown a smaller decrease than African American and Caucasian youth. The teen pregnancy rate in the Hispanic

population decreased by only 25.1% compared to the 36.7% decrease for Caucasians, and the 43.2% decrease for African Americans. From 1991 to 2006, the overall teen pregnancy rate in the United States decreased by 37% for this age group. (The Guttmacher Institute, 2010)

Along with the variations in pregnancy rate and condom use, race differences also exist in the prevalence of sexually transmitted infections. Minority groups have higher reported rates of almost every STI, including HIV, and African American youth have especially high rates of these infections. As seen in Figure 6, African American adolescents between the ages of 15 and 19 had the highest rate of reported HIV infections in the year 2008 with a rate of 55 per 100,000 adolescents; hispanic teenagers had a rate of 10.7, and Caucasians had the lowest rate at 2.2 per 100,000 (CDC, HIV/AIDS and STDs, 2010).

There are obvious differences between the major racial/ethnic groups, their sexual behaviors, and their rates of teen pregnancy and STI's. Cultural differences in behavior and perceptions may partially be the cause of these disparities. Some of these differences reflected in teen pregnancy rates and STI prevalence within African American and Hispanic populations are likely related to perceived risk, societal norms, poverty, drug use, familial ties, and language barriers.

For example, several studies have shown that in general, African Americans perceive themselves to be at a lower risk than they actually are for contracting the HIV infection with some theorizing that this skewed perception of risk can lead to unsafe sexual behaviors (St. Lawrence, 1993) (Younge et al., 2008). For example, St. Lawrence

hypothesized that this misconception is due to school programs inability to “personalize” the risk for African American populations since lessons are geared towards the dominant Caucasian population. On the other hand, Younge and her colleagues believe that the low risk of HIV perceived by African Americans stems from the prejudice and discrimination that the African American population has historically endured. The existence of prejudice leads their culture to use coping mechanisms such as an optimistic bias in which they perceive everything to be much better than it actually is. One study in which African American women in particular were observed found that this group had trouble defining their “realities” with regards to high-risk behaviors (Gentry et al., 2005).

According to Thompson-Robinson and colleagues (2007), the Hip-Hop culture in the African American community is another influential factor that can impact their sexual behaviors and perceptions. These researchers used guided, small focus discussion groups with sexually active, heterosexual African American men to assess these men’s responses when asked about their high-risk sexual behaviors and possible cultural influences. Most of the participants indicated that the media had a great impact on their sexual behaviors and perception of HIV risk. Participants, for example, alluded to Black Entertainment Television (BET), a popular cable network for African American youth, and stated that the sexual content viewed on BET shows affects the way they approach women and sex. One participant mentioned that if he is not having sex with many women like he sees men doing on television, than he feels, in a sense, “less of a man” (Thompson-Robinson et al., 2007).

The prevalence of drug use and poverty in certain minority communities have also been offered as possible reasons for higher rates of teen pregnancy in Hispanic and

African American populations. Both minority groups have been shown to engage in drug use at an early and critical stage in development that affects their behaviors. Specifically, Hispanic middle and high school age children report the highest rate of illicit drug use (Szapocznik et al., 2007). Early illicit drug use has been found to be associated with unsafe sexual behaviors such as having multiple sexual partners and inconsistent condom use (Brook et al., 2004). In their book, *High-Risk Sexual Behavior: Interventions with Vulnerable Populations*, Becker and her colleagues (1998) describe how;

Poverty too often denies young people living in inner cities opportunities, so that they may be easily lured into drug use, drug dealing, and the consequences of these activities. Delaying sexual activity for the uncertain goal of becoming educated and financially better off is rarely seen as a viable option for African American youth from economically depressed neighborhoods, whereas drug dealing may bring immediate financial gains.

It is interesting to note the complex and multifaceted relationships between poverty, drug use and unsafe sexual practices. Not only does poverty lead to drug use, which in turn has been shown to lead to high-risk sexual behavior, but it can also directly cause feelings of hopelessness for the future which lessen the threats of negative consequences associated with early sexual intercourse such as STIs or unintended pregnancies.

Hispanics or people of Latino origin report some of the lowest uses of contraceptives in the United States and the Hispanic population has one of the highest rates of teen pregnancies compared to any other major racial/ethnic group. Cultural norms seem to play a significant role in the perception and use of contraceptives and teen pregnancy for Hispanic youth. Some believe that the high rate of teen pregnancies in particular amongst Latinas can be attributed to *familism*, a concept used to describe the cultural importance of family which the Hispanic population identifies as a core value. For a person of Hispanic or Latino origin, family is thought to be the most important

thing in their lives and the family unit often supersedes the individual and their independence (Bermudez et al., 2010). One study in which 84 Mexican American and Central American adolescent girls between the ages of 14 and 19 were interviewed suggests that, in fact, the perceived desires of all family members have a major impact on young Hispanic women and their sexual behaviors and intentions (Flores et al., 2002).

Hispanics feel a deep rooted sense of family obligation and this stress on family values could result in Hispanic women believing in a much lower ideal age of motherhood when compared to other cultures or ethnic groups (Wilkinson-Lee et al., 2006). A young Latina girl in high school may not view teenage pregnancy as the negative consequence that African American or Caucasians perceive it to be. This cultural perspective could change the way in which young Latinas behave in the context of safe sexual practices. One of the main driving forces behind young people's use of condoms is their strong motivation to prevent pregnancy (Hoefnagels et al., 2006). However, if Hispanic women do not fear teen pregnancy then they will have fewer reasons to use condoms.

Along with familism, *machismo*, a concept that revolves around masculine pride and male dominance, is another defining aspect of Hispanic culture. The acceptance of machismo in the Hispanic community has made it common for women to be submissive and obedient towards men. Furthermore, boyfriends or male sexual partners have a significant influence on the decisions that young Latina women make and their sexual behaviors (Pérez-Jiménez & Serrano-García, 2009) (Flores et al., 2002). In many cases, men will attempt to dissuade their partner from using condoms because they believe sex feels better without a condom (Oncale & King, 2001). If Latino men decide they do not

want to use condoms because sex is more pleasurable without them, or for whatever other reason they come up with, their Latina partners may not try to persuade them otherwise.

In addition to family ties and relationship dynamics, religion plays a very important role in the lives of Hispanic men and women (Bermudez et al., 2010). It is estimated that over 70% of Hispanics living in the United States practice Catholicism (Perl et al., 2006). The Catholic Church has been historically known for its conservative principles regarding birth control and condom use, and amongst strict followers, it is forbidden to use either form of contraceptive. Hispanic men and woman are thus highly influenced by Catholic Church doctrine and may be avoiding contraceptives due to religious traditional views. (Becker et al., 1998) In 2009, only 10.8% of Hispanic high school students reported taking birth control pills before their last sexual intercourse experience compared to the 26.8% of Caucasian students who were using birth control pills (CDC, YRBS, 2010).

Language is another cultural factor that can affect the way young people learn and this may especially affect how they learn about sex and safe sexual behavior. For Hispanic students, health education courses or programs offered in their community or at their schools (if any are offered at all) are usually taught in English. For many Hispanic students English may not be their most proficient language. One study interviewed various experienced practitioners involved in teen pregnancy prevention programs and asked them specifically about cultural sensitivity and important qualities needed for an effective program targeting Hispanic adolescents (Wilkinson-Lee et al., 2006). A large portion of the participants in this study reported that for any program to be effective it is important that the practitioner involved in the program speak Spanish. If a student is

learning the material in the language they are most comfortable with, they will better understand and retain the information. More importantly, if practitioners can speak Spanish then they will likely be able to more effectively communicate with the student's family members. As mentioned previously, family is very important and influential in the life of a young Latino/a, thus, intervening with the entire family will be beneficial to the student.

Apart from ethnic cultural differences, another culture that seems to be greatly affected by unsafe sexual behaviors is the gay community. Gay men represent only about 2% of the population in the United States yet they account for over half of all newly reported HIV infections and are the only at-risk group in which cases of HIV has been steadily increasing since 1990 (CDC, HIV/AIDS, 2010). Several cultural factors influence the sexual behavior and safety of young gay men. Just like the African American population has trouble perceiving any risk of contracting HIV, gay youth may also have trouble internalizing the harsh realities of their at-risk status. This could be due to the way in which STI/HIV education and prevention has been taught in the United States. If course content is being geared towards the majority in the U.S. (heterosexual, white males) then it is possible that certain minority groups including African Americans, Hispanics, and homosexuals cannot relate to the material and therefore not digest or incorporate the information in the same manner. HIV interventions targeted at the gay population need to address this gay culture to work towards positive identity development during the critical stage of growth in gay adolescents. Proper instruction on HIV prevention and cultural sensitivity in the gay community will help shape the sexual

behavior of gay teens and boost their sense of self worth which will lead to safer sexual practices within this at-risk group (Harper, 2007) (Becker et al., 1998).

Although much of what adolescents learn about sexual behavior and risks come from schools and peers, their actual sexual behavior does not solely stem from what is taught in school's health and sexual education courses. Culture seems to greatly impact and influence their behavior and perceptions of risk. In her book, *Sexuality Education Across Cultures*, Janice M. Irvine argues that;

Cultures have different sexual logic or rules. And, as we have seen, these differences are not innate but are patterns resulting from a complicated social, political and economic history... Cultures determine our fundamental ideas about what is considered sexual or not sexual and how, when, and where such acts should be carried out (Irvine, 1995).

There appears to be many more factors involved in the development of sexual thought and behavior than what students learn from textbooks. If this is the case, the solution to the teen pregnancy and STI/HIV epidemic affecting the United States today must be a combination of educational policy change as well as implementation of programs that include culturally sensitive material. Teaching just facts about sex, regardless of whether or not the content is structured around abstinence-only or comprehensive approaches, is not sufficient to properly educate all young people, including minority youth. Cultural factors need to be taken into account to make a real difference in the alarming rates and statistics in the United States.

For a program to be culturally sensitive educators must be ready to handle the cultural differences between their students. They must be respectful and knowledgeable of these differences in order to better instruct their students on sexual behavior in a way that they can relate and understand. One session of a culturally

sensitive comprehensive sexual education program geared towards African American women made a difference and subjects that participated were far more likely to report HIV testing and greater self-efficacy for condom use at 3 and 6-month follow ups (Diallo et al., 2010).

Programs should recognize their target audience when planning out their sexual education course and tailor each class specifically to the needs of their students. For example, in states such as Maryland or North Carolina where the African American population is larger, sexual education programs should pay close attention to the cultural sensitivity needed to teach African American youth; courses should appropriately emphasize their high vulnerability for contracting HIV to promote more HIV testing and awareness. Educators must be sensitive to minority's unequal treatment in society and find ways to empower and encourage them to demand more for themselves including safer sexual practices (Diallo et al., 2010).

Empowering Latina women in particular is important to keep in mind when creating a culturally sensitive sexual education program geared towards a Hispanic population. Latinas are heavily influenced by both their families and their male partners and empowering them to feel worthy and independent could help them to take a stance and make the decision to be safe while sexually active. Educators must promote independence while also always being respectful and understanding of the gender roles, family hierarchy, and traditions engrained in Hispanic values.

To empower minorities and properly educate them on practicing safer sexual behaviors, the most important focus of a sexual education program should be to support and understand each student's differences in a non-judgmental environment where they

can feel comfortable. Sex is a subject that many find difficult to discuss, especially if teachers are talking about it in a context that minority students cannot relate to.

Therefore, educators must teach about sexual behavior, risk and prevention as it relates to many different groups of people: African American's and gay adolescent boys need to be taught about their particular vulnerability for contracting HIV and what has been the cause of these high rates in the past, and Hispanics must recognize their high at-risk status of teen pregnancy and the negative consequences of unintended pregnancy that they may not fully comprehend. Cultural sensitivity is a necessity for creating an effective sexual education program to reduce teen pregnancy and STI prevalence.

### Discussion

The rate of teen pregnancy and STI prevalence in the United States is unsettling and it is clear that something needs to change to make a real difference. The reality the U.S. must face in order to make a significant change is that young people in this country are going to engage in sexual intercourse and other sexual activity. Regardless of any change that has occurred in policy or program implementation thus far, the amount of high school students having sexual intercourse and being sexually active has always stayed the same. Educators need to understand that, despite everything, teenagers are going to have sex and it is therefore important to give them the resources and information they need to stay as safe as possible in their sexual encounters instead of trying to persuade them to “just say no”. Every state needs to require that comprehensive sexual education courses be taught in every school.

When comparing state policy with teen pregnancy and STI rates, it appears that there is some connection between what schools are teaching and the safe sex behaviors practiced by adolescents. Texas and many other southern states including Arkansas, Arizona, Mississippi and Tennessee mandate the least in sexual education and have some of the least comprehensive sexual education programs. These states happen to have some of the lower rates of reported condom or birth control pill use and the *highest* rates of teen pregnancies. In comparison, Maryland, North Carolina, California and other states that have some of the most comprehensive sexual education programs and require the most from schools with regards to their schools sexual education courses, have much lower rates of teen pregnancies. (The Guttmacher Institute, 2010)

The fact is that comprehensive sexual education programs have been shown effective and significantly associated with reduced risk of teen pregnancy (Kohler et al., 2007). On the other hand, programs that preach abstinence-only have been shown ineffective. One longitudinal study examined several abstinence-only educational programs implemented with Title V funding and found that these abstinence-only models of education did not reduce adolescent sexual activity or the rate at which they were involved in unprotected sex (Trenholm et al., 2008).

Although culture and race do play a significant role in the sexual behaviors of adolescents, it is wrong to *only* attribute the higher rates of teen pregnancy on the racial demographics of certain states such as Texas and New Mexico. While both Texas and New Mexico have some of the largest Hispanic populations, California also has an extremely large Hispanic population (larger than Texas, even) and their teen pregnancy rate is much lower and has seen the most decrease compared to any other state. California's liberal and comprehensive approach to sexual education could account for this difference.

California has been able to demonstrate that there are ways to tackle the cultural differences that influence sexual behavior amongst adolescents. Although California is still struggling with their teen pregnancy rate and must continue to work towards decreasing the rate even further, they have done an impressive job thus far. Other states should use California as an example when constructing and implementing their sexual education programs. Ideally, all educators involved in sexual education courses and programs should be trained on up-to-date research regarding contraceptives including birth control pills and condoms that have been shown to reduce pregnancy and the spread

of STIs. Sexual education programs should cover a wide variety of topics, including human sexuality and contraceptives, but they should also go beyond textbook material and incorporate cultural sensitivity to provide the most successful program to reduce teen pregnancy and STI rates. This crucial combination of providing both accurate and useful information with cultural background and sensitivity is the key to implementing an effective sexual education program in the United States.

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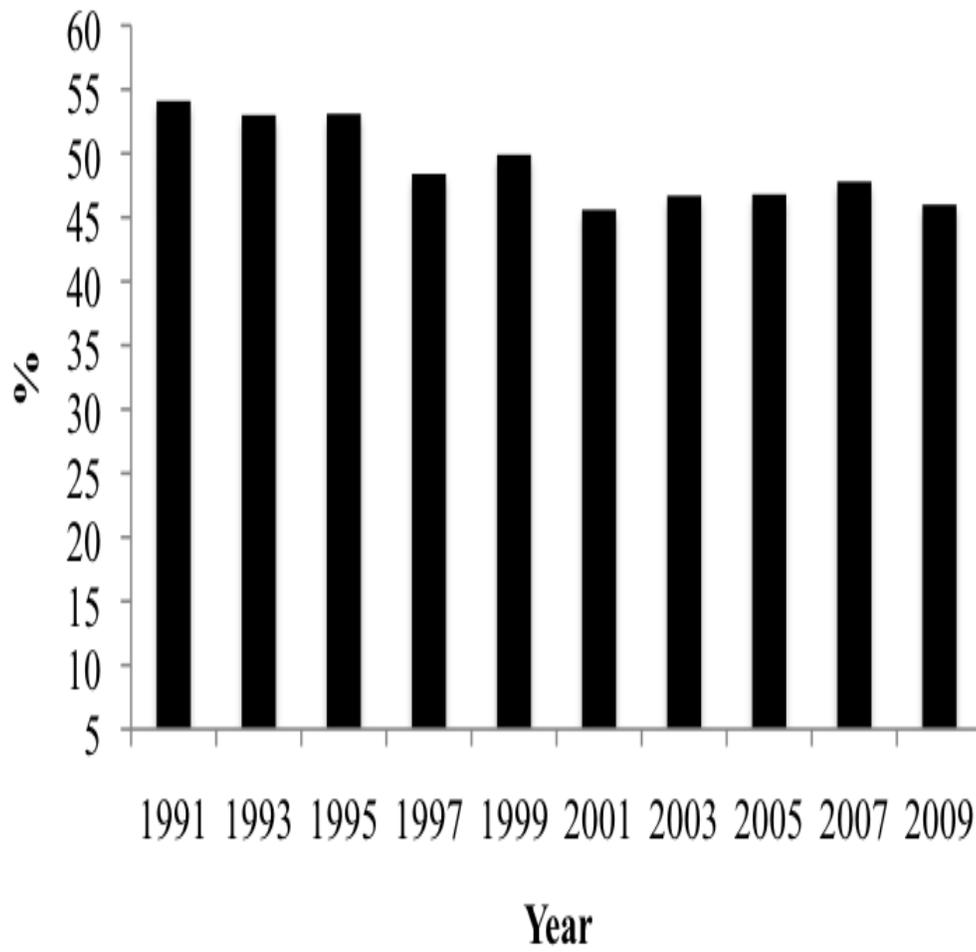
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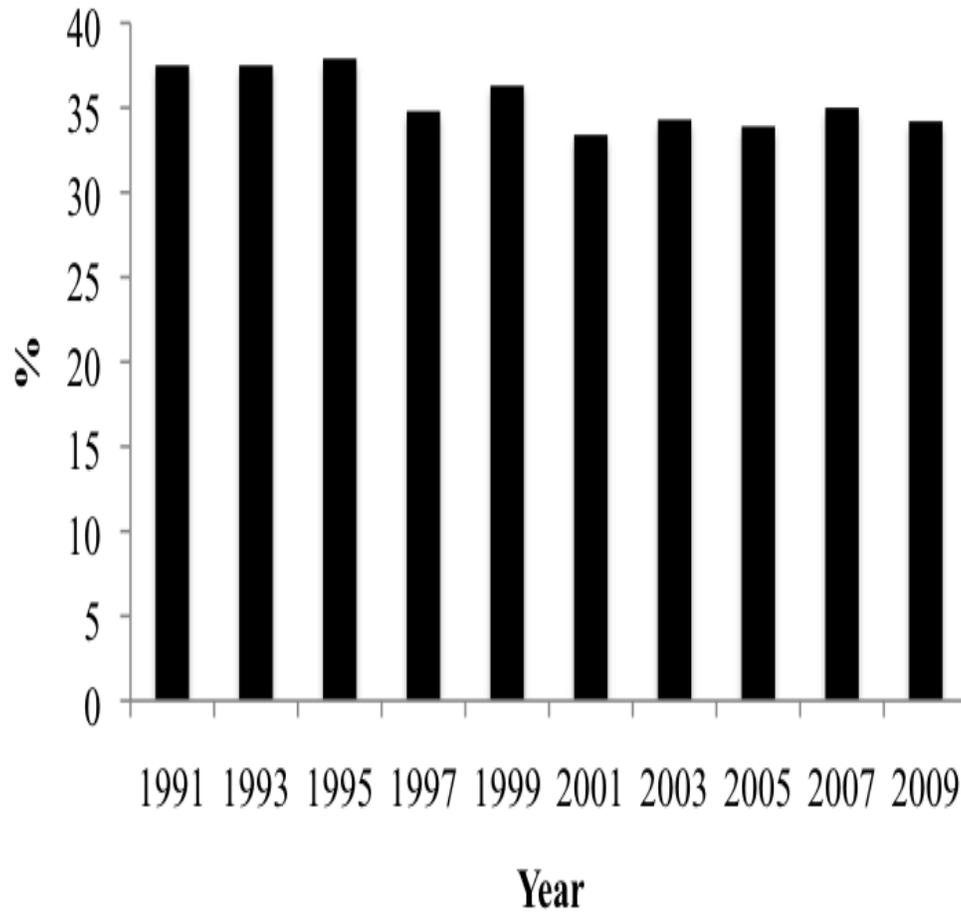
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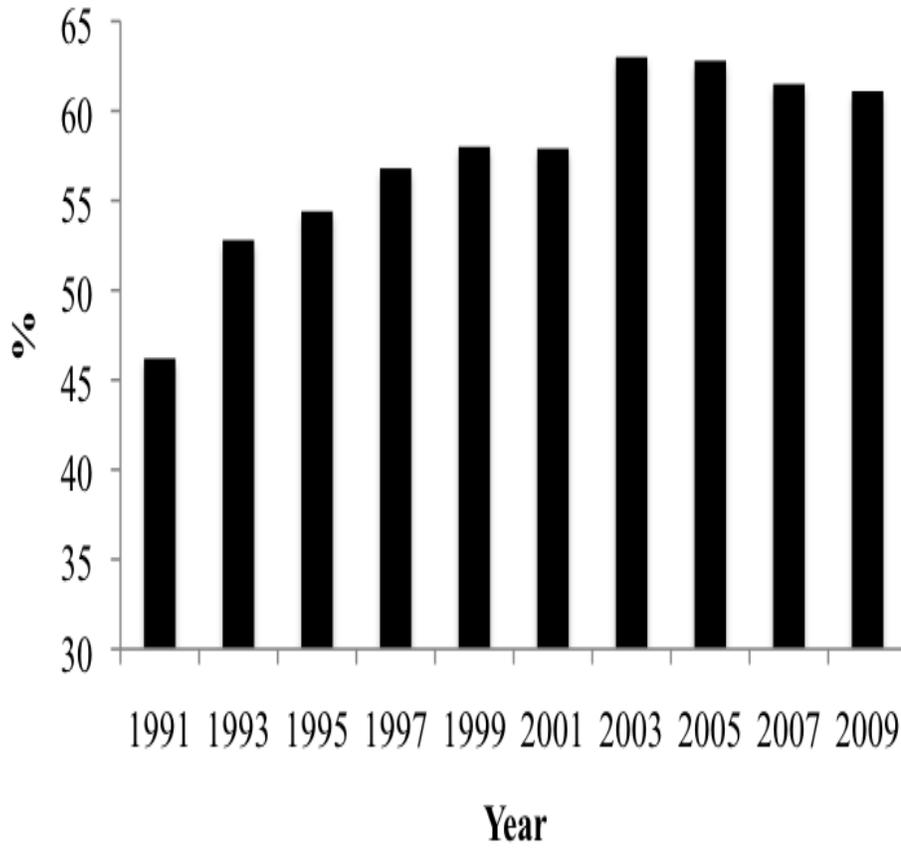
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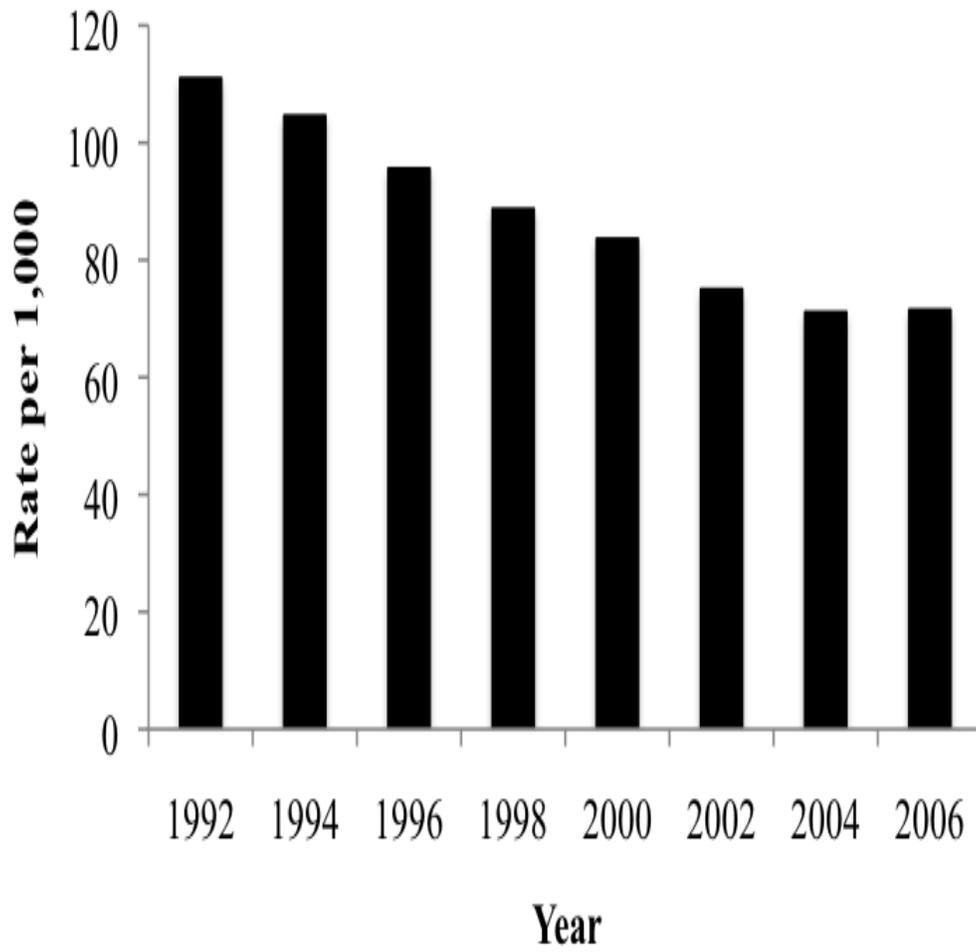
*Figure 1.* Percent of high school students per year who reported ever having sexual intercourse.



*Figure 2.* Percent of high school students per year who reported being currently sexually active.



*Figure 3.* Percent of high school students per year who reported using a condom the last time they had sexual intercourse.



*Figure 4.* The estimated teenage pregnancy rate of woman between the ages of 15 and 19 by year.

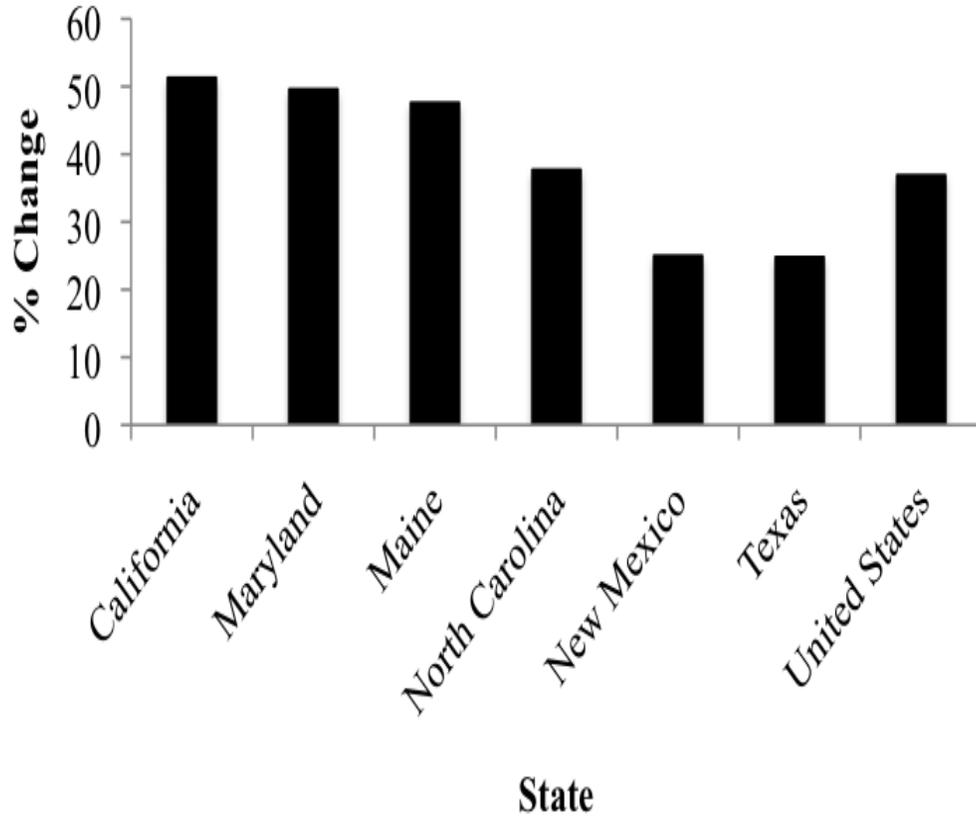
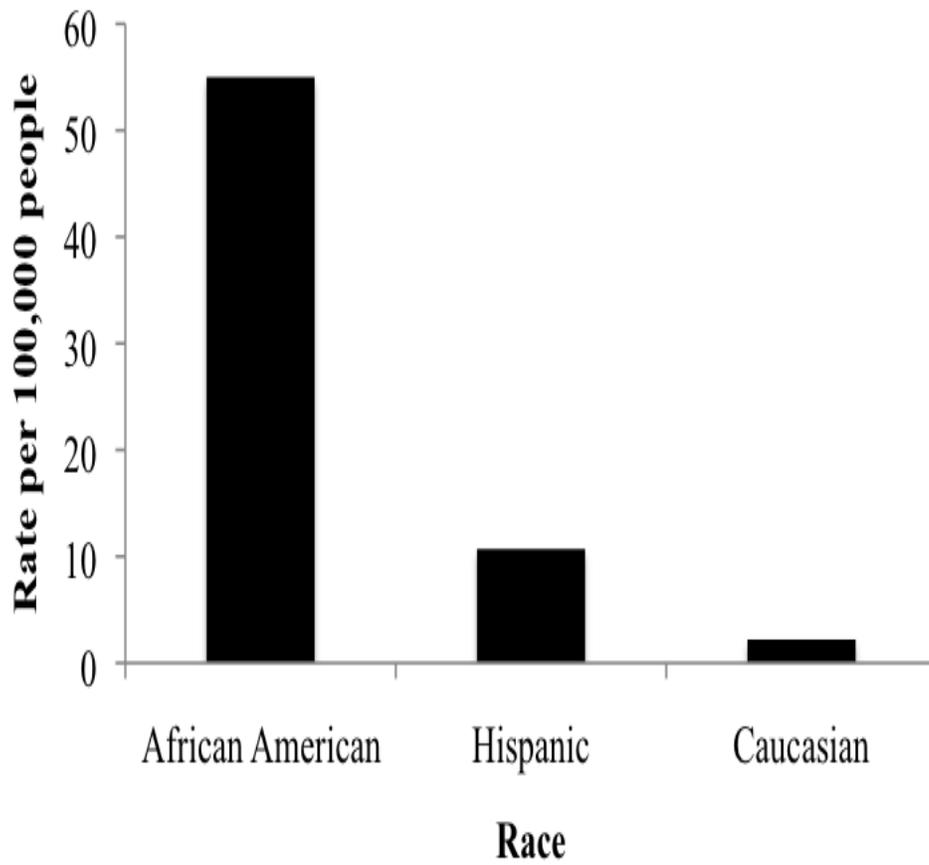


Figure 5. The percent decrease in teen pregnancy rate from 1988 to 2005 by state.



*Figure 6.* The estimated rate of new HIV infections in people between the ages of 15 and 19 in 2008 by race.