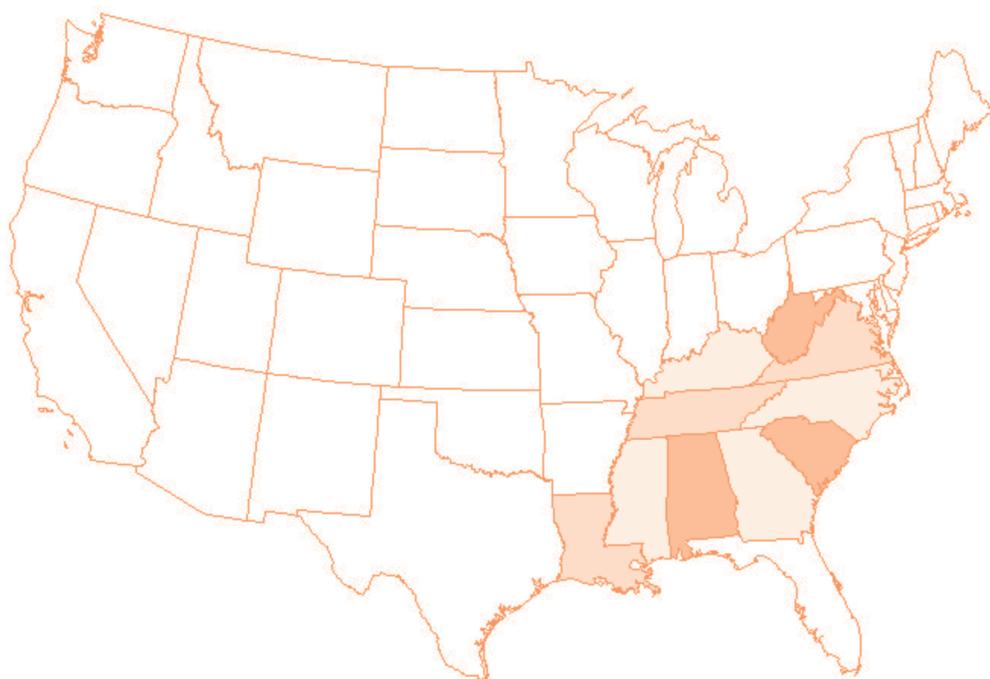


SEXUAL HEALTH OF YOUNG PEOPLE IN THE U.S. SOUTH: *Challenges and Opportunities*

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Sexual Health of Young People in the U.S. South: Challenges and Opportunities

EXECUTIVE SUMMARY

The United States has the highest rates of teenage pregnancy and sexually transmitted diseases among all developed nations.¹ This is even more severe in the southern region of the U.S. which has: higher teenage pregnancy rates; higher teenage births; a higher percentage of babies of low birth weight; and higher rates of sexually transmitted infections, including HIV, than other regions of the country.

This report, *Sexual Health of Young People in the U.S. South: Challenges and Opportunities*, examines the current challenges and opportunities related to the sexual health of young people in 10 Southern states: Alabama, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. The report will use the terms Southern states and U.S. South to refer to only these 10 states; the analysis does not include several other states that are sometimes included in definitions of the southern region such as Florida, Texas, Arkansas, and Oklahoma. It includes a profile of key sociodemographic factors in the South relevant to sexual health, including: population growth, race, poverty, and women's educational attainment. The report then looks at the sexual health profile of young people including indicators such as: sexually transmitted infections, HIV, teenage pregnancy, teenage birth, and low birth weight. Finally, the report explores sexual health education practices in the Southern states and the challenges and opportunities they offer to improve the sexual health of young people in the U.S. South.

The U.S. South is characterized by high population growth and high poverty

During the last ten years, the population of the 10 Southern states in this report grew by 11.9 percent: from 50,626,423 in 2000 to 56,668,395 in 2010.^{2,3} In fact, the U.S. South is the second fastest growing region in the nation, just behind the Western region. During the same time period, the national growth rate was 9.7 percent.⁴ These 10 Southern states were home to 18 percent of the U.S. population in 2010.

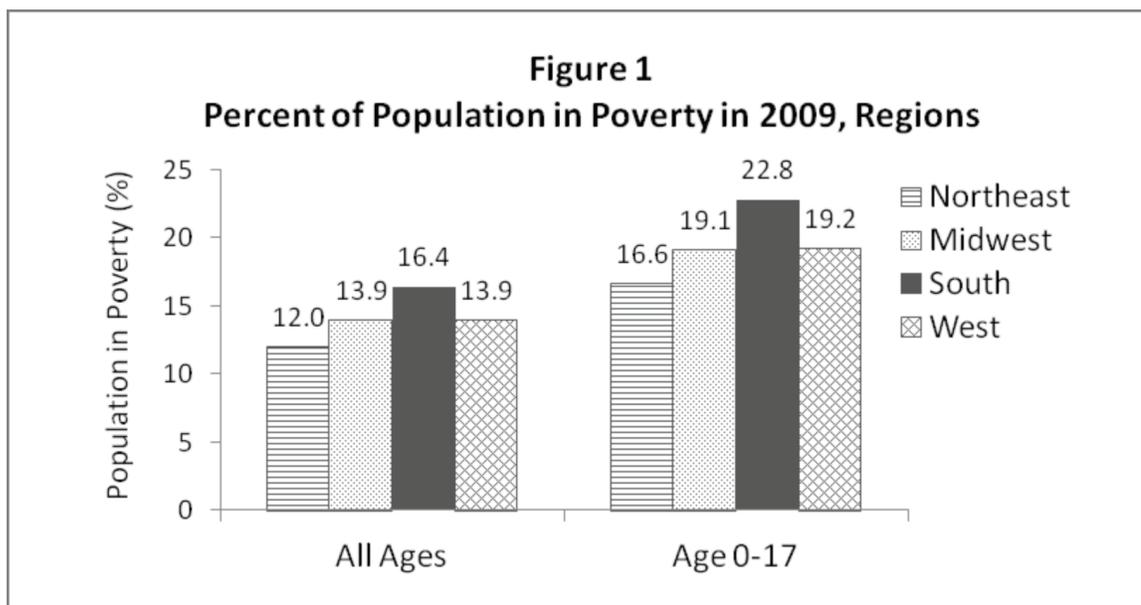
1 Stanger-Hall, K.F. and Hall, D.W. (2011). Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S. *PLoS ONE* 6 (10), e24658. <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0024658>, accessed December 17, 2011.

2 U.S. Census Bureau's American Fact Finder website, DP-1: Profile of General Demographic Characteristics: 2000. <http://factfinder2.census.gov/>, accessed December 18, 2011.

3 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saipo/national.cgi?year=2009&ascii>, accessed December 17, 2011.

4 According to the Census Bureau, the U.S population grew by 9.7 percent between 2000 and 2010. <http://2010.census.gov/2010census/data/apportionment-pop-text.php>, accessed December 20, 2011.

The percentage of people in poverty was higher in the Southern region than elsewhere in the nation.⁵ Data from the U.S. Labor Department indicate that, in 2010, the South had an 8.5 percent unemployment rate, compared to 8.5, 9.2, and 9.7 respectively for the Northeast, Midwest, and West regions.⁶



Source: The 2009 American Community Survey (see footnote 5 for details)

The South is characterized by a lower level of educational attainment for women. In 2010, only 25.4 percent of women age 25 years and older living in the 10 Southern states had a bachelor’s degree or higher.⁷ The corresponding figures for other regions were: Midwest, 26.7 percent; West, 28.9 percent; and Northeast, 32.3. In contrast, the U.S. South region has the highest percent of females age 18–24 with a high school diploma or equivalent, according to estimates from the 2010 American Community Survey.⁸

5 Calculated using state poverty data from the 2009 American Community Survey 1-Year Estimates (Table S1701), http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_1YR_S1701&prodType=table, accessed February 25, 2012.

6 Calculated using state unemployment data from U.S. Department of Labor, Bureau of Labor Statistics. “Unemployment Rates for States.” <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

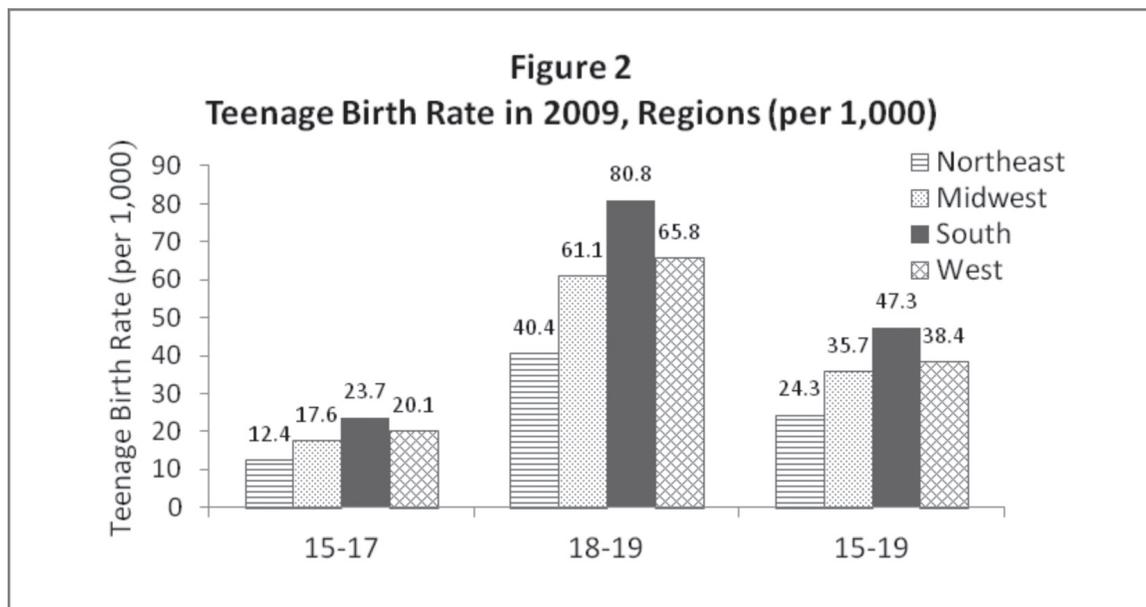
7 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

8 *Ibid.*

Teenage birth rate higher in the U.S. South than elsewhere in the country

A correlation has been found between poor sexual health, high poverty, and low educational attainment by women.⁹ Supporting this theory, the South's sexual health profile is ranked below that of other regions, as measured by rates of teenage pregnancy, teenage birth, babies of low birth weight, and sexually transmitted infections, including HIV.

Teenagers who lived in the South were more likely to get pregnant than their counterparts in other regions.¹⁰ Southern teenagers were also more likely to have babies than teenagers in all other three regions.¹¹



Source: Centers for Disease Control and Prevention (see footnote 11 for details)

9 Kirby, D., Coyle, K., and Gould, J.B. (2001). Manifestations of Poverty and Birthrates among Young Teenagers in California Zip Code Areas. *Family Planning Perspectives* 33(2), 63-69.

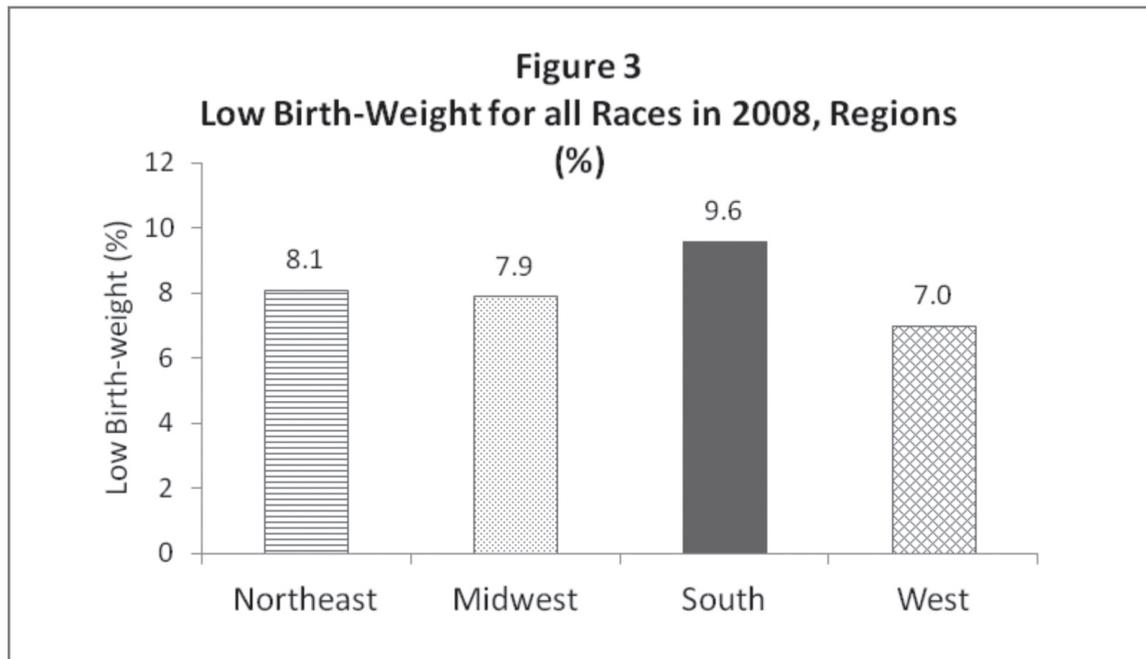
10 Regional data calculated using information from: Guttmacher Institute (2010). *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

11 Calculated using state data from the Centers for Disease Control and Prevention, http://www.cdc.gov/nchs/data/databriefs/db58_tables.pdf#5, accessed February 25, 2012.

Unintended births, an economic burden to tax payers in the U.S. South

Nearly half of all births (48.5%) in the Southern region are unintended; compared with 42.8 percent nationally, 36.5 percent in the Northeast, 41.5 percent in the West, and 41.8 percent in the Midwest.¹² More than half (53.1%) of births in the South were paid for by public funds, compared to 39.7 percent in the Northeast, 43.2 percent in the Midwest, and 47.3 in the West. Seventy percent of public money spent on births in the South went to pay for unintended births.¹³

Furthermore, nearly 1 in 10 babies (9.6%) born in the 10 Southern states in 2008 were of low birth weight (defined as 5 pounds, 8 ounces).¹⁴ The South's low birth weight rate is higher than that of any region in the nation. The national rate of low birth weight is 8.2 percent, with low birth-weight rates in the Northeast at 8.1 percent, in the Midwest at 7.9 percent and in the West at 7.0 percent. Low birth weight is often associated with infant mortality, and 7 of the 10 Southern states have some of the highest infant mortality rates in the nation.¹⁵



Source: Centers for Disease Control and Prevention (see footnote 14 for details)

12 Calculated using state data published in Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates." *Perspectives on Sexual and Reproductive Health* 43(2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

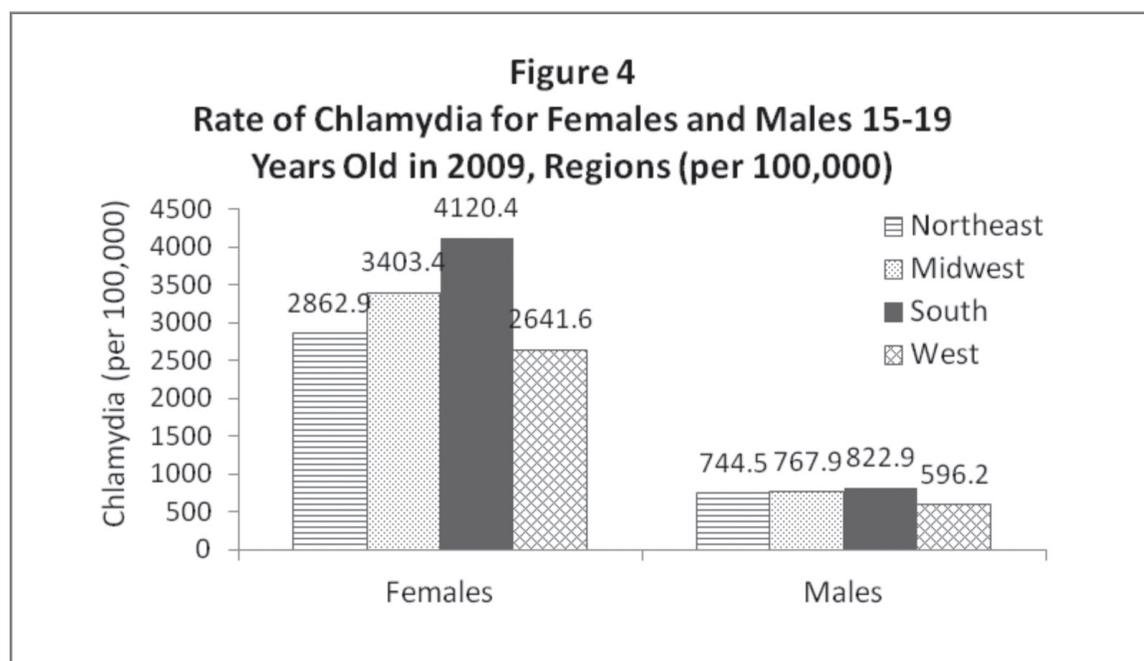
13 *Ibid.*

14 State data used to calculate regional indicators of low birth weight came from Centers for Disease Control and Prevention. Births: Final Data for 2008. National Vital Statistics Reports, 59 (1). Table I-9. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01_tables.pdf, accessed December 17, 2011.

15 Regional statistics calculated using state data from: Mathews, T.J. and MacDorman, M.F. (2011). *Infant Mortality Statistics from the 2007 Period Linked Birth/Infant Death Data Set*. National Vital Statistics Reports, 59 (6). Table 3. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_06.pdf, accessed December 18, 2011.

Sexually transmitted infections and HIV higher in the U.S. South than elsewhere in the nation

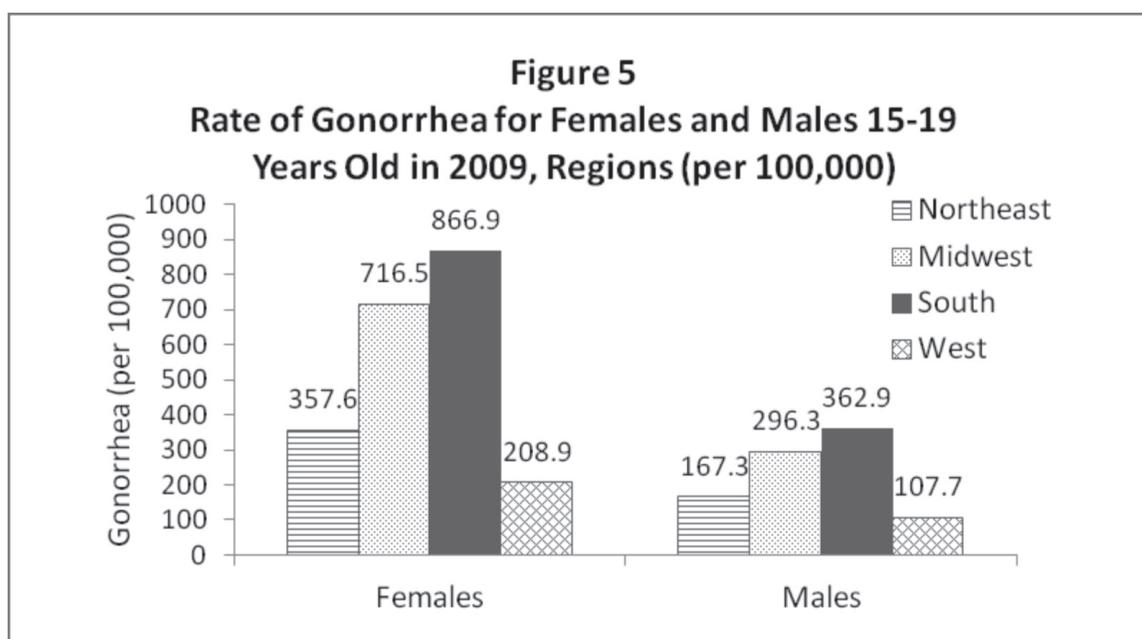
The Southern region also ranked high in terms of sexually transmitted infections and HIV. Chlamydia rates in the U.S. South were the highest nationally for both females and males, with a rate of 4,120.4 per 100,000 among females age 15–19, compared to 3,333.8 per 100,000 in the nation.¹⁶ A similar pattern was found for gonorrhea: the Southern region's rates were higher than those of any other region, at 866.9 for females and 362.9 per 100,000 for males age 15–19, compared with 566.0 for females and 248.3 per 100,000 for males age 15–19 nationally.¹⁷



Source: Centers for Disease Control and Prevention (see footnote 16 for details)

¹⁶ Regional statistics were calculated using state data from the Centers for Disease Control and Prevention's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57.jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

¹⁷ *Ibid.*



Source: Centers for Disease Control and Prevention (see footnote 16 for details)

The South ranked second in terms of HIV infections nationally, with 20.7 new cases of HIV diagnosed per 100,000 residents in 2009; the corresponding figures for other regions were 21.8, 10.1, and 2.9 per 100,000, respectively for the Northeast, Midwest, and West regions.¹⁸

These sexual health statistics have real costs in terms of public money. For example, in 2008 alone, an estimated \$2.3 billion from federal, state, and local governments was spent on teenage childbearing related expenses in the 10 Southern states.¹⁹ In 2008, \$10.9 billion from federal, state, and local governments was used to pay for teenage childbearing across the United States.²⁰

These numbers reflect most of the public-sector costs of teenage childbearing: public health care (Medicaid and CHIP), child welfare, and, for children who have reached adolescence or young adulthood, increased rates of incarceration and lost tax revenue due to decreased earnings and spending. Most of these are a result of significant challenges faced by young parents and the subsequent impact of those challenges on their children.

When adding in the estimated \$8 billion per year spent nationwide on treatment and diagnoses of sexually transmitted infections,²¹ with overall costs to the healthcare system reaching more than

18 Regional HIV incidences were calculated using state data from the Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

19 Based on data from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/#AL>, accessed December 17, 2011.

20 *Ibid.*

21 Guttmacher Institute. (2009). Facts on sexually transmitted infections in the United States. In Brief. http://www.guttmacher.org/pubs/FIB_STI_US.html, accessed December 18, 2011.

\$16 billion per year,²² the burden on public funds tremendously increases. Providing sexual health education intended to prevent unintended births, low birth-weight babies, sexually transmitted infections, including HIV, is necessary to reduce the public costs associated with poor sexual health. Also, prevention measures give young people more control over their own health and lives.

Medically Accurate, Age-Appropriate Sexual Health Education Programs Improve Sexual Health

In the United States, sex education is broadly divided into abstinence-only until-marriage, abstinence-only and abstinence-based or medically accurate, age-appropriate, evidence-based and evidence-informed sexual health education. Until 2009, the federal government had almost exclusively funded abstinence-only-until-marriage programs.²³

Over a billion dollars has been spent on abstinence-only-until-marriage programs, yet federally funded research has clearly shown that such programs are ineffective and do not lead to significant behavioral changes,²⁴ and contain inaccurate or erroneous information that may even cause harm.^{25, 26} These programs have been unsuccessful in lowering rates of teenage pregnancy and sexually transmitted infection.

The emphasis on teaching only about abstinence dates back to the 1960s,²⁷ and is based on the belief that this is in line with public opinion. The fact is that the vast majority of Americans have for decades supported the teaching of sex education in public schools that covers a broad set of topics. In the U.S., 89.6 percent of adults support medically accurate, age-appropriate sexual health education in public schools, an increase from 81.7 percent in 1974.²⁸

This increase is even more dramatic in the Southern region of the United States; the percentage of people in the U.S. South who favor the teaching of sex education in public schools increased

22 Centers for Disease Control and Prevention. (November 2010). Trends in Sexually Transmitted Diseases in the United States: 2009 National Data for Gonorrhea, Chlamydia and Syphilis. <http://www.cdc.gov/nchhstp/newsroom/docs/2009STDSurvReportMediaFactSheet.pdf>, accessed December 17, 2011.

23 Audelo, S. (2010). *End Funding for Abstinence-Only-Until-Marriage Programs*. Advocates for Youth. www.advocatesforyouth.org.

24 U.S. House of Representatives, Special Investigations Division. (2004). *The Content of Federally Funded Abstinence-Only Education Programs*. Washington, DC: U.S. House of Representatives. http://www.apha.org/apha/PDFs/HIV/The_Waxman_Report.pdf, accessed January 2, 2012.

25 Collins, C., Alagiri, P., and Summers, T. (2002). *Abstinence Only vs. Comprehensive Sex Education*. Policy Monograph Series. San Francisco, CA: AIDS Research Institute. <http://ari.ucsf.edu/science/reports/abstinence.pdf>, accessed January 2, 2012.

26 Kay, J.F. and Jackson, A. (2009). *Sex, Lies & Stereotypes: How Abstinence-Only Programs Harm Women and Girls*. New York, NY: Legal Momentum Advancing Women's Rights.

27 Pardini, P. (2011). "The History of Sexuality Education." Rethinking Schools. <http://www.rethinkingschools.org/sex/sexhisto.html>, December 12, 2011. accessed December 17, 2011.

28 Based on our analysis of data from the General Social Survey, a nationally representative survey of adult Americans conducted since 1972 by the National Opinion Research Center at the University of Chicago. Details available at <http://www3.norc.org/GSS+Website/>.

from 73.8 in 1974 to 89.3 in 2010. During the same period, the percentage of Southern residents who oppose the teaching of sex education decreased from 25.5 to 10.7.²⁹

In 2010, the federal government established new grant programs for adolescent sexual health and teen pregnancy prevention. These programs provide funding for the implementation of evidence-based and evidence-informed programs that teach young people how to delay sexual activity and avoid risky sexual behaviors. Among other topics, they include information about abstinence but also teach information on healthy relationships, contraception and sexually transmitted infections, including HIV/AIDS.^{30, 31} Programs that are grounded in scientific theory, evidence-based, medically accurate, age-appropriate and comprehensive in scope are endorsed by leading medical professional associations, including the American Medical Association.³²

The establishment of these new grant programs resulted in a significant increase in the total amount of federal funding spent on adolescent sexual health, from \$124.4 million in 2009 to \$188.7 million in 2010.³³ All 10 Southern states applied for and received federal funding for both abstinence-only and medically accurate, age-appropriate, evidence-based and evidence informed teen pregnancy prevention programs. In addition, the federal government established more flexible guidelines for the Title V State Abstinence Education Grant program, allowing the funds to support a broader range of intervention models that promote abstinence.

Based on high need (informed by poverty levels), the 10 Southern states together received more funding than each of the other three regions for both abstinence-only and medically accurate, age-appropriate, evidence-based sex education.³⁴ In 2010, the total amount the 10 Southern states received from the federal government for use in implementing medically accurate, age-appropriate, evidence-based sex education was three times higher than that for abstinence-only programs (\$34 million versus \$10 million).³⁵

29 Based on our analysis of data from the General Social Survey, a nationally representative survey of adult Americans conducted since 1972 by the National Opinion Research Center at the University of Chicago. Details available at <http://www3.norc.org/GSS+Website/>.

30 SIECUS – The Sexuality Information and Education Council of the United States. <http://siecus.org/document/docWindow.cfm?fuseaction=document.viewDocument&documentid=70&documentFormatId=70>, accessed February 27, 2012.

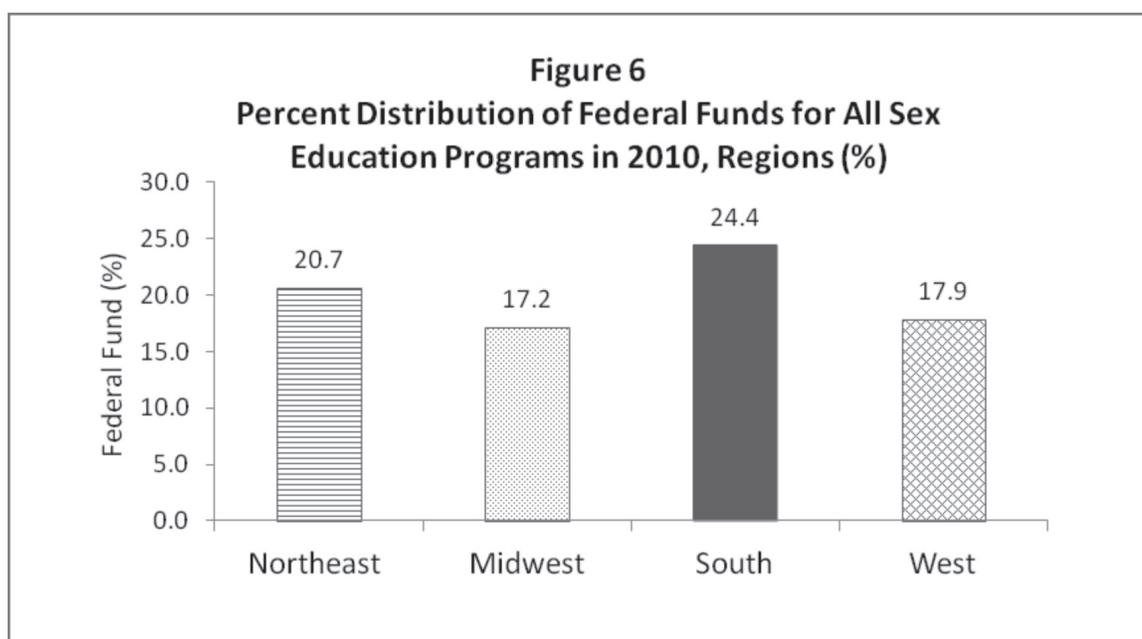
31 U.S. Department of Health and Human Services, Office of Adolescent Health. "Frequently Asked Questions and Answers about PREP and TPPI." http://www.hhs.gov/ash/oah/oah-initiatives/webinars/faqs_tpp_tier2.pdf; and U.S. Department of Health and Human Services website. http://www.hhs.gov/news/press/2010pres/09/teenpregnancy_abstinencegrants.html, accessed December 18, 2011.

32 American Medical Association. (2009). *An Updated Review of Sex Education Programs in the United States*. Substitute Resolution 409, A-08. Report 7 of the Council on Science and Public Health (A-09). <http://www.ama-assn.org/resources/doc/csaph/csaph-rep7-a09.pdf>, accessed January 2, 2012.

33 SIECUS – The Sexuality Information and Education Council of the United States. <http://siecus.org/index.cfm?fuseaction=Page.viewPage&pagelD=472>, accessed December 17, 2011.

34 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS). <http://siecus.org/index.cfm?fuseaction=Page.viewPage&pagelD=472>, accessed August 12, 2011.

35 *Ibid.*



Source: Sonfield, Adam et al. 2011 (see footnote 12 for details)

This report highlights the specific challenges facing young people in the Southern region related to sexual health, and the long-term negative impact poor sexual health can have on both the individual and the community as a whole. At this moment in time, decision-makers have an opportunity to improve the sexual health of young people in the South. There are no legal barriers to providing teenagers with medically accurate, age-appropriate, sexual health education in the 10 Southern states. New, more flexible federal funding programs, strong majorities of public support, and proven tools and curricula for teaching sexual health education can, if prioritized, change lives and improve the overall sexual health of young people in the South.

The data contained in this report, *Sexual Health of Young People in the U.S. South: Challenges and Opportunities*, is drawn from peer-reviewed literature about the sexual health of U.S. teenagers; analysis of data from the Census Bureau, the Centers for Diseases Control and Prevention, General Social Survey; selected data from the public health departments of some states; and various national policy resources. A full description of methodology can be found in Appendix B.

INTRODUCTION

According to the Centers for Disease Control and Prevention's (CDC) website,³⁶ sexual health is not simply about physical health; sexual health is:

...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

The *Sexual Health of Young People in the U.S. South: Challenges and Opportunities* report examines the current challenges faced by young people in the South related to their sexual health and the opportunities to address such challenges. The 10 Southern states covered in the report are: Alabama, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. As such, for the purposes of this report, the terms "Southern states" and "U.S. South" will refer only to these 10 states; the analysis does not include other states sometimes included in definitions of the U.S. South such as Florida, Texas, Arkansas and Oklahoma.

The Challenges

The data in the 10 Southern states the report covers show a strong correlation between sociodemographic factors and sexual health. These states generally rank high in terms of poverty; they represent 9 of the 15 states with the highest poverty rates in the nation. Similarly, they represent 9 of the 15 states with the highest poverty rates among children (from birth to age 17) in the nation.³⁷

These 10 Southern states also do not rank well in terms of sexual health. All 10 states are found among the 15 states with the highest numbers of low birth-weight babies (those born weighing less than 5 pounds, 8 ounces) nationally.³⁸ Nine of these states rank among the 15 states with the highest infant mortality rates in the country.³⁹ Seven of these 10 Southern states rank among the top 20 states with the highest rates of teen pregnancies nationwide.⁴⁰

36 Centers for Disease Control and Prevention (CDC). (2011). Sexual Health. <http://www.cdc.gov/sexualhealth/>, accessed October 26, 2011. This definition derived from the World Health Organization (WHO). (2010). "Measuring Sexual Health: Conceptual and Practical Considerations and Related Indicators."

37 Census Bureau website. <http://quickfacts.census.gov/qfd/states/01000.html>, accessed January 19, 2012.

38 State data used to calculate regional indicators of low birth weight came from Centers for Disease Control and Prevention. Births: Final Data for 2008. National Vital Statistics Reports, 59 (1). Table 1-9. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01_tables.pdf, accessed December 17, 2011.

39 Mathews, T.J. and MacDorman, M.F. (2011). *Infant Mortality Statistics from the 2007 Period Linked Birth/Infant Death Data Set*. National Vital Statistics Reports, 59 (6). Table 3. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_06.pdf, accessed December 18, 2011.

40 Guttmacher Institute. (2010). *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, Table 3.1, accessed December 17, 2011.

Statistics for sexually transmitted infections and HIV in this region of the country are disproportionately high. Six of the states rank in the top 15 nationally for rates of Chlamydia among 15–19 year-old women.⁴¹ Seven of these states rank in the top 15 nationally for rates of gonorrhea among 15–19 year-old women.⁴² Also in rates of new diagnoses of HIV/AIDS in the overall population, eight of these 10 states ranked among the top 15 states nationally.⁴³ More information about the specific statistics of each state is included in the state reports (see Appendix A).

The Opportunities

There is no doubt that the indicators outlined in this report suggest a need for serious solutions. Fortunately, new federal funding made available in the last two years that supports evidence-based and evidence-informed programs, provides these 10 Southern states a real opportunity to address their sexual health challenges.

In the United States, sex education is broadly divided into abstinence-only, abstinence-only-until-marriage, and abstinence-based or medically accurate, age-appropriate, evidence-based, and evidence-informed sexual health education. Until 2010, the federal government had almost exclusively funded abstinence-only-until-marriage programs.⁴⁴ Over one-billion dollars has been spent on abstinence-only-until-marriage programs, yet federally funded research has clearly shown that such programs are ineffective and do not lead to significant behavioral changes,⁴⁵ and contain inaccurate or erroneous information that may even cause harm.^{46,47} These programs have been unsuccessful in lowering rates of teenage pregnancy, sexually transmitted infections, and HIV/AIDS.

In 2010, the federal government established new grant programs for sexual health and teen pregnancy prevention. These programs provide funding for the implementation of evidence-based and evidence-informed programs that teach young people how to delay sexual activity and avoid risky sexual behaviors. Among other topics, they include information about

41 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

42 *Ibid.*

43 Centers for Disease Control and Prevention. (2009). HIV Surveillance Report. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

44 Audelo, S. (2010). *End Funding for Abstinence-Only-Until-Marriage Programs*. Advocates for Youth. www.advocatesforyouth.org.

45 U.S. House of Representatives, Special Investigations Division. (2004). *The Content of Federally Funded Abstinence-Only Education Programs*. Washington, DC: U.S. House of Representatives. http://www.apha.org/apha/PDFs/HIV/The_Waxman_Report.pdf, accessed January 2, 2012.

46 Collins, C., Alagiri, P., and Summers, T. (2002). *Abstinence Only vs. Comprehensive Sex Education*. Policy Monograph Series. San Francisco, CA: AIDS Research Institute. <http://ari.ucsf.edu/science/reports/abstinence.pdf>, accessed January 2, 2012.

47 Kay, J.F. and Jackson, A. (2009). *Sex, Lies & Stereotypes: How Abstinence-Only Programs Harm Women and Girls*. New York, NY: Legal Momentum Advancing Women's Rights.

abstinence, healthy relationships, contraception, and sexually transmitted infections, including HIV/AIDS.^{48, 49, 50} The programs support evidence-based models and innovative approaches to teenage pregnancy prevention efforts: the Teenage Pregnancy Prevention (TPP) program and the Personal Responsibility Education Program (PREP). These grant programs extend the sexual health efforts funded by the federal government to include evidence-based and evidence-informed, medically accurate, age-appropriate, sex education programs.⁵¹

TPP is administered by the Office of Adolescent Health (OAH) within the Office of Public Health and Science at the U.S. Department of Health and Human Services. The TPP program addresses rising teenage pregnancy rates by supporting grantees in replicating evidence-based models and implementing demonstration programs to develop and test additional models and innovative strategies.

PREP is administered by the Administration on Children, Youth, and Families which is within the Administration for Children and Families at the U.S. Department of Health and Human Services. Through PREP, the Family and Youth Services Bureau awards grants to state agencies to educate young people on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS. The program targets youth ages 10–19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen-birth rates, or come from racial or ethnic minority groups. The program also supports pregnant youth and mothers under the age of 21.

Funding for these two programs totaled \$155 million in 2010. In addition, the Title V State Abstinence Education Grant Program, which was first created in 1996, was funded at \$33 million in 2010.⁵²

TPP offers competitive grants open to states and local communities, and each of the 10 Southern states applied for and received funding from this new grant program. Under the TPP program, the grantee must choose from either Tier 1 (evidence-based) or Tier 2 (evidence-informed/innovative approaches) programs. Each state in this report chose to spend a significant amount of the federal funds on medically accurate, age-appropriate, evidence-based models or innovative

48 McKeon, B. (2006). "Effective Sex Education." Advocates for Youth. <http://www.advocatesforyouth.org/publications/450?task=view>, accessed December 15, 2011.

49 Healthy Teen Network. *Comprehensive Sexuality Education. Fast Facts*. Washington, DC: Health Teen Network. <http://htn.nonprofitoffice.com/vertical/Sites/%7BB4D0CC76-CF78-4784-BA7C-5D0436F6040C%7D/uploads/%7B4C5F842E-E67A-4AC2-921B-287950431BD7%7D.PDF>, accessed January 2, 2012.

50 Collins, C., Alagiri, P., and Summers, T. (2002). *Abstinence Only vs. Comprehensive Sex Education*. Policy Monograph Series. San Francisco, CA: AIDS Research Institute. <http://ari.ucsf.edu/science/reports/abstinence.pdf>, accessed January 2, 2012.

51 U.S. Department of Health and Human Services, Office of Adolescent Health. "Frequently Asked Questions and Answers about PREP and TPPI." http://www.hhs.gov/ash/oah/oah-initiatives/webinars/faqs_tpp_tier2.pdf, accessed December 18, 2011. U.S. Department of Health and Human Services website.

52 U.S. Department of Health and Human Services website. http://www.hhs.gov/news/press/2010pres/09/teenpregnancy_abstinencegrants.html, accessed December 18, 2011.

curricula. In fact, eight of these states spent more than 70 percent of the federal funds on evidence-based or evidence-informed programs, while only 2 states spent over 40 percent of the funds on abstinence-only programs (Alabama, 41.6%; and Virginia, 48.8%).⁵³ Research notes that more funding is needed to implement medically accurate, age-appropriate, evidence-based models or innovative approaches to sex education programs in order to reduce unintended pregnancy and sexually transmitted infections, including HIV/AIDS in the South.^{54, 55, 56}

Terms used consistently in this report are evidence-based and evidence-informed sexual health education. We use these terms in an attempt to allow for the inclusion of best practices and to make the transitional process to more effective sexual health education less daunting to educators, school administrators, and school district officials.

- The definition of an **evidence-based program** is one that has been proven effective on **the basis of rigorous scientific research and evaluation** to change behavior associated with the risk factors for unintended pregnancy and/or STD/HIV infection, including delaying sexual activity, reducing the frequency of sex, reducing the number of sexual partners, and/or increasing condom or contraceptive use.
- The definition of an **evidence-informed program** is one that is **informed by sound scientific research and effective practice**. Such a program replicates evidence-based programs or substantially incorporates elements of effective programs. The program shows some evidence of effectiveness, although it has not undergone enough rigorous evaluation to be proven effective.

The report begins with a profile of key sociodemographic factors in the South relevant to sexual health including population growth, race, poverty, and women's educational attainment. The report then looks at the sexual health profile of young people including indicators such as sexually transmitted infections, HIV, teenage pregnancy, teenage birth, and low birth weight for babies. Finally, the report explores sexual health education practices in the South and the challenges and opportunities they offer toward improving the sexual health of young people in 10 Southern states. The report also includes individual profiles of each of the 10 states (see Appendix A).

53 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), August 12, 2011.

54 Swartzendruber, A. and Zenilman, J.M. (2010). A National Strategy to Improve Sexual Health." *Journal of American Medical Association* 304 (9). <http://jama.ama-assn.org/content/304/9/1005.extract>, accessed December 17, 2011.

55 Pardini, P. (2011). "The History of Sexuality Education." <http://www.rethinkingschools.org/sex/sexhisto.html>, December 12, 2011.

56 Law Students for Reproductive Justice. (2011). *Abstinence-Only Education*. http://lsrj.org/documents/11_Abstinence%20Only.pdf, accessed January 4, 2012.

THE CHALLENGES: Poor Sexual Health Correlates with Sociodemographic Factors

Correlations have been clearly established between sociodemographic factors (including age, level of education, poverty, occupational status, race and ethnicity, and population size) and specific measures of sexual health (teenage pregnancy, teenage birth, sexually transmitted infections, HIV/AIDS, low birth weight, and infant mortality).

The South is a relatively fast-growing region, but the South's growing population is also associated with high poverty, a high teenage pregnancy rate, a high teenage birth rate, a high percentage of low birth-weight babies, high rates of sexually transmitted infections and HIV, and a heavy economic burden caused by unintended pregnancies.

During the last ten years, the population of the 10 Southern states in this report grew by 11.9 percent; during the same time period, the national growth rate was 9.7 percent.⁵⁷ The South is the second fastest growing region in the nation, just behind the Western region.

The percentage of people in poverty was higher in the Southern region than elsewhere in the nation, and particularly among those ages 0–17. In 2009, 16.4 percent of people in the South were defined as poor, compared with 12 percent in the Northeast, and 13.9 percent in the Midwest and West.⁵⁸ Among those ages 0–17, the poverty rate was 22.8 percent in the South, compared with 16.6 percent in the Northeast, 19.1 percent in the Midwest, and 19.2 percent in the West.⁵⁹

There are more African Americans in the South, per capita, than any other region of the United States. Nearly 23 percent of people living in the South are African American, compared to 4.5 percent in the West and 10.9 percent in the Northeast regions.⁶⁰ In contrast, the South has the lowest percent of Latinos in the nation (6.0%), whereas the West has the highest (29.0%).⁶¹

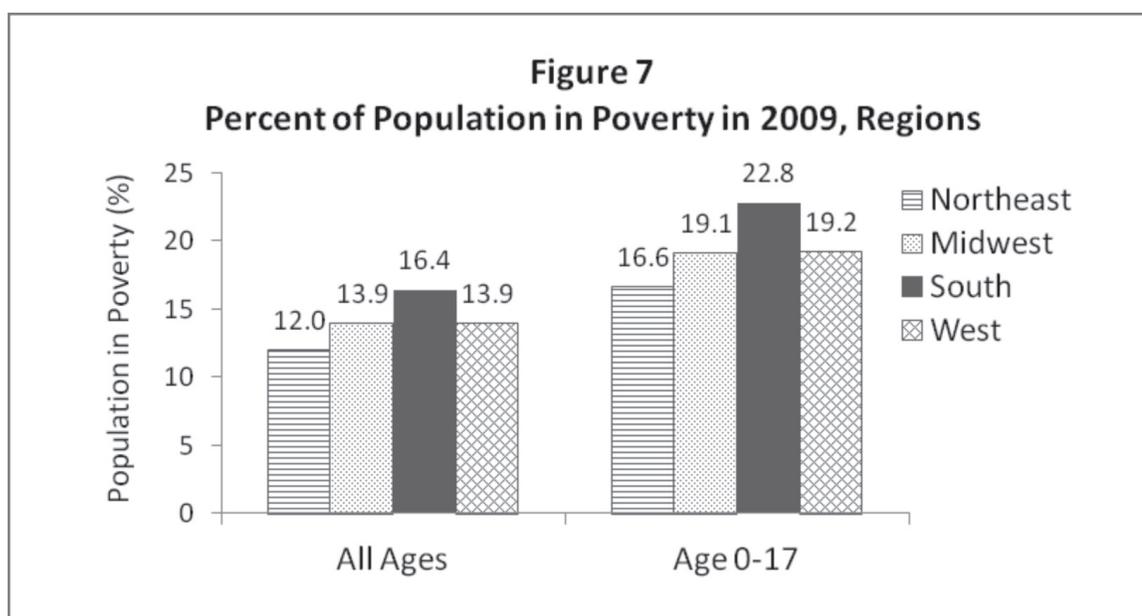
57 According to the Census Bureau, the U.S population grew by 9.7 percent between 2000 and 2010. Regional values were calculated from state data obtained from the Census Bureau website <http://2010.census.gov/2010census/data/apportionment-pop-text.php>, accessed December 20, 2011.

58 Calculated using state poverty data from the 2009 American Community Survey 1-Year Estimates (Table S1701), http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_1YR_S1701&prodType=table, accessed February 25, 2012.

59 *Ibid.*

60 Racial/ethnic composition data are from the Census Bureau's Fact Finder2 website. <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?ft=table>, accessed on December 28, 2011.

61 *Ibid.*



Source: The 2009 American Community Survey (see footnote 59 for details)

The South is also characterized by a lower level of educational attainment for women. In 2010, only 25.4 percent of women age 25 years and older living in the 10 Southern states had a bachelor's degree or higher.⁶² The corresponding figures for other regions were: Midwest, 26.7 percent; West, 28.9 percent; and Northeast, 32.3 percent.

Correlations with Sexual Health

Teenage Childbearing: In the United States, most recent studies show that variations in teenage childbearing rates reflect differences in sociodemographic and economic factors such as education, income, and availability of sexual health information and services to young people.^{63, 64} Analyzing data from five developed countries (Canada, France, Great Britain, Sweden and the United States), Singh et al. concluded that adolescent childbearing was more likely among women with low levels of income and education than among their better-off peers.⁶⁵ These authors also

62 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012

63 Abma, J.C., Martinez, G., and Copen, C.E. (2010). Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, National Survey of Family Growth, 2006–2008. National Center for Health Statistics. Vital Health Statistics, Volume 23, Number 30. http://www.cdc.gov/nchs/data/series/sr_23/sr23_030.pdf, accessed December 18, 2011.

64 Matthews, T.J., Sutton, P.D., Hamilton, B.E., and Ventura, S.J. (2010). *State Disparities in Teenage Birth Rates in the United States*. National Center for Health Statistics. Data Brief, Number 46. <http://www.cdc.gov/nchs/data/databriefs/db46.pdf>, accessed December 18, 2011.

65 Singh, S., Darroch, J.E., Frost, J.J., and the Study Team. (2001). Socioeconomic Disadvantage and Adolescent Women's Sexual and Reproductive Behavior: The Case of Five Developed Countries. *Family Planning Perspectives* 33 (6): 251-258.

noted that “comparatively widespread disadvantage in the United States helps explain why U.S. teenagers have higher birth rates and pregnancy rates than those in other developed countries.”⁶⁶

The relationship between early childbearing, poverty and education can go in both directions: teenagers who drop out of school are more likely to become pregnant, and children of teenage mothers are less likely to graduate from high school. Similarly, teenagers who live in poverty are more likely to become pregnant, and teenage mothers are more likely to live in poverty.⁶⁷

In his 30-year study of the relationship between teenage pregnancy and poverty, Professor Frank F. Furstenberg of the University of Pennsylvania states that teenage pregnancies are better understood as effects of poverty, showing that teenage childbearing is not the reason why so many Americans are trapped in poverty.⁶⁸ Instead, he says that lack of appropriate sex education and limited access to sexual health services are key contributing factors of unintended pregnancy, and sexually transmitted infections, including HIV/AIDS.

Teenagers who lived in the South were more likely to get pregnant than their counterparts in other regions.⁶⁹ Southern teenagers were also more likely to give birth than teenagers in all other three regions.⁷⁰ The one exception was 15–17 year-olds, with a pregnancy rate of 38.9 per 1,000 for Southern teenagers, compared to 40.3 per 1,000 for Western 15–17 year-old teenagers.⁷¹

Nearly half (48.5%) of all births in the Southern region are unintended; compared with 36.5 percent in the Northeast, 41.5 percent in the West, and 41.8 percent in the Midwest.⁷² More than half (53.1%) of births in the South were paid for by public funds, compared to 39.7 percent in the Northeast, 43.2 percent in the Midwest, and 47.3 in the West. Seventy percent of public money spent on births in the South went to pay for unintended births.⁷³

66 The National Campaign to Prevent Teen Pregnancy. (2010). *Why It Matters: Teen Pregnancy, Poverty, and Income Disparity*. <http://www.thenationalcampaign.org/why-it-matters/pdf/poverty.pdf>, accessed December 18, 2011.

67 The National Campaign to Prevent Teen Pregnancy. 2010. *Why It Matters: Teen Pregnancy, Poverty, and Income Disparity*. <http://www.thenationalcampaign.org/why-it-matters/pdf/poverty.pdf>, accessed December 18, 2011.

68 Furstenberg, Frank. F. 2007. *Destinies of the Disadvantaged: The Politics of Teen Childbearing*. Russell Sage Foundation .

69 According to our analysis of regional data calculated using information from: Guttmacher Institute. 2010. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

70 Based on statistics calculated using state data from the Centers for Disease Control and Prevention, http://www.cdc.gov/nchs/data/databriefs/db58_tables.pdf#5, accessed February 25, 2012.

71 According to our analysis of regional data calculated using information from: Guttmacher Institute. 2010. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

72 Calculated using state data published in Sonfield A, Kost K, Gold RB, and Finer LB. 2011. “The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates.” *Perspectives on Sexual and Reproductive Health* 43 (2): 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

73 *Ibid.*

Low birth weight has many root causes, including poverty, maternal age, educational attainment, and availability of sexual health information and services to young people.⁷⁴ Poverty has been cited as one of the most significant determinants of low birth weight in the United States. Women with household income below the poverty line are significantly more likely to give birth to a low birth-weight baby than their counterparts with higher income.⁷⁵

Women with higher educational attainment are less likely to have low birth-weight babies than those with lower education,⁷⁶ and women who start childbearing between ages 20 and 35 have a lower risk of having low birth-weight babies than those who start at younger or older ages.⁷⁷

Nearly 1 in 10 babies (9.6%) born in the 10 Southern states in 2008 were of low birth weight (defined as 5 pounds, 8 ounces or less.) The South's low birth-weight rate is higher than that of any region in the nation. The national low birth-weight rate is 8.2 percent, with low birth-weight rates in the Northeast at 8.1 percent, in the Midwest at 7.9 percent, and in the West at only 7.0 percent.⁷⁸ Low birth weight is often associated with infant mortality, and 7 of the 10 Southern states are found in the list of the top ten infant mortality states.⁷⁹

Sexually transmitted infections rates are higher in the United States than in other developed countries⁸⁰ and are even higher in the South. The economic cost of sexually transmitted infections (STIs) is very high; treatment and diagnoses cost more than \$8 billion annually, nationwide,⁸¹ with overall costs to the healthcare system reaching more than \$16 billion per year.⁸²

74 Conley, D. and Bennett, N.G. (2001). Birth Weight and Income: Interactions across Generations. *Journal of Health and Social Behavior* 42: 450-465.

75 Parker, J.D., Schoendorf, K.C., and Kiely, J.L. (1994). Associations between Measures of Socioeconomic Status and Low Birth Weight, Small for Gestational Age, and Premature Delivery in the United States. *Annals of Epidemiology* (4):271-8.

76 Duncan, G.J. and Laren, D. (1990). "Neighborhood and Family Correlates of Low Birthweight: Preliminary Results on Births to Black Women from the PSID Geocode File." Ann Arbor, MI: Mimeo, Survey Research Center.

77 Centers for Disease Control and Prevention. (2005). QuickStats: Rate of Very Low Birthweight, by Age of Mother and Multiple-Birth Status- United States, 2003. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5447a9.htm>, accessed February 27, 2012.

78 State data used to calculate regional indicators of low birth weight came from Centers for Disease Control and Prevention. Births: Final Data for 2008. National Vital Statistics Reports, 59 (1). Table I-9. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01_tables.pdf, accessed December 17, 2011.

79 McCormick, M.C. (1985). "The contribution of low birth weight to infant mortality and childhood morbidity." *The New England Journal of Medicine* 312 (2), 82-90.

80 Darroch, J.E., Singh, S., Frost, J.J., and the Study Team. (2001). Differences in Teenage Pregnancy Rates among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use. *Family Planning Perspectives* 33(6), 244-250 & 281. <http://www.guttmacher.org/pubs/journals/3324401.html>, accessed December 18, 2011.

81 Guttmacher Institute. 2009. "Facts on Sexually Transmitted Infections in the United States". *In Brief*. http://www.guttmacher.org/pubs/FIB_STI_US.html, accessed December 18, 2011.

82 Centers for Disease Control and Prevention. November 2010. "Trends in Sexually Transmitted Diseases in the United States: 2009 National Data for Gonorrhea, Chlamydia and Syphilis." Fact Sheet. <http://www.cdc.gov/nchhstp/newsroom/docs/2009STDsSurvReportMediaFactSheet.pdf>, accessed December 17, 2011.

Chlamydia rates in the South were the highest in the nation for both females and males ages 15–19, with a rate of 4,120.4 per 100,000 among females age 15–19.⁸³ This compares to 2862.9 per 100,000 in the Northeast, 3403.4 per 100,000 in the Midwest, and 2641.6 per 100,000 in the West. Among males, ages 15–19, the rate in the South is 822.9 per 100,000, compared with 744.5 per 100,000 in the Northeast, 767.9 per 100,000 in the Midwest, and 596.2 per 100,000 in the West.

A similar pattern was found for gonorrhea: the Southern region's rate is higher than those of any other region at 866.9 for females and 362.9 per 100,000 for males age 15–19. Among females, ages 15–19, this compares to 357.6 per 100,000 in the Northeast, 716.5 per 100,000 in the Midwest, and 208.9 per 100,000 in the West.⁸⁴ Among males, ages 15–19, the rate in the South is 362.9 per 100,000, compared with 167.3 per 100,000 in the Northeast, 296.3 per 100,000 in the Midwest, and 107.7 per 100,000 in the West.

Human Immunodeficiency Virus (HIV) has infected more than 1.6 million Americans since AIDS (Acquired Immune Deficiency Syndrome) was identified in 1981, and more than 540,000 have already died from the virus.⁸⁵ Recent estimates show that the infection rate has been around 50,000 new infections annually.⁸⁶ Moreover, among the more than one million people living with HIV, one in five is unaware that they are infected.⁸⁷

A recent report by the Duke Center for Health Policy and Inequalities Research confirms that the South has disproportionately high rates of HIV/AIDS compared to other regions of the country.⁸⁸ The South ranked second in HIV infections, with 20.7 new cases of HIV diagnoses per 100,000 residents in the South in 2009; the corresponding figures for other regions were 10.1, 2.9, and 21.8 per 100,000 respectively for the Midwest, West, and Northeast regions.⁸⁹

83 Regional Chlamydia and Gonorrhea rates were calculated using state data from the Center for Disease Control's WONDER database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2> accessed February 23, 2012.

84 Regional Chlamydia and Gonorrhea rates were calculated using state data from the Center for Disease Control's WONDER database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2> accessed February 23, 2012.

85 Guttmacher Institute. (2009). "Facts on Sexually Transmitted Infections in the United States". *In Brief*. http://www.guttmacher.org/pubs/FIB_STI_US.html, accessed December 18, 2011.

86 Centers for Disease Control and Prevention (CDC). (2011). "Estimates of New HIV Infections in the United States, 2006–2009". Fact Sheet. <http://www.cdc.gov/nchhstp/newsroom/docs/HIV-Infections-2006-2009.pdf>, accessed December 17, 2011.

87 <http://www.cdc.gov/hiv/resources/factsheets/us.htm>, accessed December 17, 2011.

88 Reif, S., Whetten, K., and Wilson, E. (2012). *HIV/AIDS Epidemic in the South Reaches Crisis Proportions in Last Decade*. Duke Center for Health Policy and Inequalities Research. <http://southernaids.files.wordpress.com/2012/01/research-report-final.pdf>, accessed January 26, 2012.

89 Regional HIV incidences were calculated using state data from the Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

Public Costs of Poor Sexual Health

These sexual health statistics have real costs in terms of public money. For example, in 2008 alone, an estimated \$2.3 billion from federal, state, and local governments was spent on expenses related to teenage childbearing in the 10 Southern states.⁹⁰ The same year, \$10.9 billion from federal, state, and local governments was used to pay for expenses related to teenage childbearing across the United States.⁹¹

These numbers reflect most of the public-sector costs of teenage childbearing: public health care (Medicaid and CHIP), child welfare, and, for children who have reached adolescence or young adulthood, increased rates of incarceration and lost tax revenue due to decreased earnings and spending. Most of these economic burdens are a result of significant challenges faced by young parents and the subsequent impact of those challenges on their children.

When adding in the estimated \$8 billion per year spent nationwide on treatment and diagnoses of sexually transmitted infections,⁹² with overall costs to the healthcare system reaching more than \$16 billion per year,⁹³ the burden on public funds tremendously increases. Providing sexual health education intended to prevent unintended births, low birth-weight babies, sexually transmitted infections, including HIV, is necessary to reduce the public costs associated with poor sexual health. Also, prevention measures give young people more control over their own health and lives.

90 Based on data from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/#AL>, accessed December 17, 2011.

91 *Ibid.*

92 Guttmacher Institute. 2009. "Facts on Sexually Transmitted Infections in the United States." *In Brief*. http://www.guttmacher.org/pubs/FIB_STI_US.html, accessed December 18, 2011.

93 Centers for Disease Control and Prevention. November 2010. "Trends in Sexually Transmitted Diseases in the United States: 2009 National Data for Gonorrhea, Chlamydia and Syphilis." Fact Sheet. <http://www.cdc.gov/nchhstp/newsroom/docs/2009STDSurvReportMediaFactSheet.pdf>, accessed December 17, 2011.

THE OPPORTUNITIES: Medically Accurate, Age-Appropriate, Evidence-Based and Evidence-Informed Sexual Health Education

Individuals living in the Southern region of the United States face disproportionately high rates of poor sexual health. The key contributing factors to this are limited access to health care, poverty, low educational attainment, unemployment, state geography and culture, and the region's focus on abstinence-only sex education. Three of the 10 Southern states do not require teaching sexual health education: Alabama, Louisiana, and Virginia. Even in states where sexual health education and/or education about sexually transmitted infections and HIV instructions are mandatory, the emphasis mostly is on teaching abstinence to the exclusion of other sexual health topics.⁹⁴

Sexual health education is critical to help young people lead healthy lives and make informed decisions that will significantly impact their future, including the opportunity to obtain an education, choose a career, and plan a family. More generally, sexual health education is a broad term used to describe a lifelong process through which people acquire information and form attitudes, beliefs, and values about sexual development, sexual and reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles.⁹⁵

As noted earlier, in the United States, sexual health education is broadly divided into abstinence-only, abstinence-only-until-marriage, and abstinence-based programs and programs that provide medically accurate, age-appropriate, evidence-based and evidence-informed sex education. As shown later in this report, there are different degrees of effectiveness among evidence-based practices.

Abstinence-only sex education programs began in 1981 with the passage of the *Adolescent Family Life Act* (AFLA),⁹⁶ and promote abstinence from all sexual activity until marriage.⁹⁷ In contrast, evidence-based and evidence-informed sex education promotes abstinence but also teaches information on healthy relationships, contraception, and sexually transmitted infections, including HIV/AIDS.^{98,99}

94 Guttmacher Institute. (2011). Sex and HIV Education. *State Policies in Brief*. January 1, 2012. http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf, accessed January 6, 2012.

95 Sexuality Education Q & A. SIECUS website. <http://www.siecus.org/index.cfm?fuseaction=page.viewpage&pageid=521&grandparentID=477&parentID=514#Q1>, accessed January 2, 2012.

96 Brewer, G., Brown, M.B., and Migdal, M.J. (2007). *The Importance of Appropriate Sexuality Education*. Washington, DC: The Center for Inquiry.

97 U.S. House of Representatives, Special Investigations Division. (2004). *The Content of Federally Funded Abstinence-Only Education Programs*. Washington, DC: U.S. House of Representatives. http://www.apha.org/apha/PDFs/HIV/The_Waxman_Report.pdf, accessed January 2, 2012.

98 McKeon B. 2006. "Effective Sex Education." *Advocates for Youth*. <http://www.advocatesforyouth.org/publications/450?task=view>, accessed December 15, 2011.

99 Healthy Teen Network. *Comprehensive Sexuality Education. Fast Facts*. Washington, DC: Health Teen Network. <http://htn.nonprofitoffice.com/vertical/Sites/%7BB4D0CC76-CF78-4784-BA7C-5D0436F6040C%7D/uploads/%7B4C5F842E-E67A-4AC2-921B-287950431BD7%7D.PDF>, accessed January 2, 2012.

The emphasis on teaching only about abstinence dates back to the 1960s,¹⁰⁰ and is based on the belief that this is in line with public opinion. The fact is that the vast majority of Americans have for decades supported the teaching of sex education in public schools that covers a broad set of topics. In the U.S., 89.6 percent of adults support medically accurate, age-appropriate sexual health education in public schools, an increase from 81.7 percent in 1974.¹⁰¹

This increase is even more dramatic in the Southern region of the United States; the percentage of people in the U.S. South who favor the teaching of sex education in public schools increased from 73.8 in 1974 to 89.3 in 2010. During the same period, the percentage of Southern residents who oppose the teaching of sex education decreased from 25.5 to 10.7.¹⁰²

In 2010, the federal government established new grant programs for adolescent sexual health and teen pregnancy prevention. These programs provide funding for the implementation of evidence-based and evidence-informed programs that teach young people how to delay sexual activity and avoid risky sexual behaviors. Among other topics, they include information about abstinence but also teach information on healthy relationships, contraception and sexually transmitted infections, including HIV/AIDS.^{103,104} Programs that are grounded in scientific theory, evidence-based, medically accurate, age-appropriate and comprehensive in scope that are endorsed by leading medical professional associations, including the American Medical Association.¹⁰⁵

The establishment of these new grant programs resulted in a significant increase in the total amount of federal funding spent on adolescent sexual health in the 50 states and Washington, DC, from \$124.4 million in 2009 to \$188.7 million in 2010.¹⁰⁶ All 10 Southern states applied for and received federal funding for both abstinence-only and medically accurate, age-appropriate, evidence-based and evidence informed teen pregnancy prevention programs. In addition, the federal government established more flexible guidelines for the Title V State Abstinence Education Grant program, allowing the funds to support a broader range of intervention models that promote abstinence.

100 Pardini, P. (2011). "The History of Sexuality Education." Rethinking Schools. <http://www.rethinkingschools.org/sex/sexhisto.html>, December 12, 2011. accessed December 17, 2011.

101 Based on our analysis of data from the General Social Survey, a nationally representative survey of adult Americans conducted since 1972 by the National Opinion Research Center at the University of Chicago. Details available at <http://www3.norc.uchicago.edu/GSS+Website/>.

102 *Ibid.*

103 SIECUS – The Sexuality Information and Education Council of the United States. <http://siecus.org/document/docWindow.cfm?fuseaction=document.viewDocument&documentid=70&documentFormatId=70>, accessed February 27, 2012.

104 U.S. Department of Health and Human Services, Office of Adolescent Health. "Frequently Asked Questions and Answers about PREP and TPPI." http://www.hhs.gov/ash/oah/oah-initiatives/webinars/faqs_tpp_tier2.pdf; and U.S. Department of Health and Human Services website. http://www.hhs.gov/news/press/2010pres/09/teenpregnancy_abstinencegrants.html, accessed December 18, 2011.

105 American Medical Association. 2009. *An Updated Review of Sex Education Programs in the United States*. Substitute Resolution 409, A-08. Report 7 of the Council on Science and Public Health (A-09). <http://www.ama-assn.org/resources/doc/csaph/csaph-rep7-a09.pdf>, accessed January 2, 2012.

106 SIECUS – The Sexuality Information and Education Council of the United States. <http://siecus.org/index.cfm?fuseaction=Page.viewPage&pageId=472>, accessed December 17, 2011.

Based on high need (informed by poverty levels), the 10 Southern states together received more funding than each of the other three regions for both abstinence-only and medically accurate, age-appropriate, evidence-based sex education.¹⁰⁷ In 2010, the total amount the 10 Southern states received from the federal government for use in implementing medically accurate, age-appropriate, evidence-based sex education was three times higher than that for abstinence-only programs (\$34 versus \$10 million).¹⁰⁸

Abstinence-Only Sexual Health Education Programs Do Not Work

The federal government has spent over a billion dollars on abstinence-only-until-marriage programs. According to data from SIECUS,¹⁰⁹ between 2001 and 2009 alone, the U.S. government spent \$1.123 billion on abstinence-only-until-marriage programming through the Title V State Abstinence Education Grant Program (Title V abstinence-only), the Community Based Abstinence Education (CBAE) program, and the Adolescent Family Life Act (AFLA) grant program. Yet, research has clearly shown that abstinence-only-until-marriage programs are ineffective, inaccurate, and may even cause harm.¹¹⁰

Federally funded studies show that abstinence-only-until-marriage programs do not lead to significant behavioral changes.¹¹¹ In a 2007 study, Trenholm and colleagues evaluated four school-based abstinence-only sex education programs in Florida, Mississippi, Virginia, and Wisconsin and found that students who received such instruction were no more likely than students in the control groups to abstain from or delay sexual intercourse, nor were they more likely to have fewer sexual partners.¹¹²

After more than 30 years of work on sex education, Douglas Kirby arrived at a similar conclusion: “[T]here do not currently exist any abstinence-only programs with strong evidence that they either delay sex or reduce teen pregnancy.”¹¹³ Moreover, summarizing his work and knowledge on what works in sex education while responding to Heather D. Boonstran’s

107 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

108 *Ibid.*

109 SIECUS – The Sexuality Information and Education Council of the United States. <http://siecus.org/index.cfm?fuseaction=Page.viewPage&pageId=472>, accessed December 17, 2011.

110 Collins, C., Alagiri, P., and Summers, T. (2002). *Abstinence Only vs. Comprehensive Sex Education*. Policy Monograph Series. San Francisco, CA: AIDS Research Institute. <http://ari.ucsf.edu/science/reports/abstinence.pdf>, accessed January 2, 2012.

111 U.S. House of Representatives, Special Investigations Division. 2004. *The Content of Federally Funded Abstinence-Only Education Programs*. Washington, DC: U.S. House of Representatives. http://www.apha.org/apha/PDFs/HIV/The_Waxman_Report.pdf, accessed January 2, 2012.

112 Trenholm, C., et al. (2007). *Impacts of Four Title V, Section 510 Abstinence Education Programs*. Princeton, NJ: Mathematica Policy Research, Inc. <http://www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf>, accessed January 27, 2012.

113 Kirby, D. (2007). Abstinence, Sex, and STD/HIV Education Programs for Teens: Their Impact on Sexual Behavior, Pregnancy, and Sexually Transmitted Disease. *Annual Review of Sex Research* 18, 143-177.

questions in 2007, Kirby actually called for ending funding for abstinence-only sex education in favor of comprehensive sex education programs.¹¹⁴

Leading scholars have also found factual errors in abstinence-only-until-marriage sex education curricula,¹¹⁵ and that erroneous information may harm women and girls.¹¹⁶ For example, one middle school abstinence-only curriculum (*I'm in Charge of the FACTS*) states, “The actual ability of condoms to prevent the transmission of HIV/AIDS even if the product is intact, is not definitively known.” This is a distortion of the CDC’s finding on the effectiveness of condoms, which states that “Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS.”¹¹⁷ Another example is the *Me, My World, My Future* abstinence-only curriculum which states that “studies have shown that 5 to 10 percent of women will never again be pregnant after having a legal abortion.” The truth is an elective abortion does not alter fertility.¹¹⁸

The facts show that abstinence-only-until-marriage programs commonly contain misleading information at best, and erroneous and harmful messaging at worst. This has led some states to refuse federal funding for abstinence-only-until-marriage sex education programs.¹¹⁹ However, only one of the 10 Southern states included in this study (Virginia) is among the 21 states (plus the District of Columbia) that did not apply for Title V abstinence-only funding for the 2009 fiscal year.

Much of the discussion of sexual health education in the United States has been fueled by emotional arguments about the appropriateness of abstinence-only education.^{120, 121, 122} Today,

114 Boonstra, H.D. (2007). “The Case for a New Approach to Sex Education Mounts; Will Policymakers Heed the Message?” *Guttman Policy Review* 10(2). <http://www.guttman.org/pubs/gpr/10/2/gpr100202.html>, accessed February 27, 2012.

115 Trenholm, C., et al. (2007). *Impacts of Four Title V, Section 510 Abstinence Education Programs*. Princeton, NJ: Mathematica Policy Research, Inc. <http://www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf>, accessed January 27, 2012.

116 Kay, J.F. and Jackson, A. (2009). *Sex, Lies & Stereotypes: How Abstinence-Only Programs Harm Women and Girls*. New York, NY: Legal Momentum Advancing Women’s Rights.

117 U.S. Centers for Disease Control and Prevention (CDC). *Condoms and STDs: Fact Sheet for Public Health Personnel*. http://www.cdc.gov/condomeffectiveness/docs/Condoms_and_STDS.pdf, accessed January 2, 2012.

118 Union of Concerned Scientists. (2004). Abstinence Only Sex Education Curriculum. http://www.ucsusa.org/scientific_integrity/abuses_of_science/abstinence-only-curriculum.html (references 12 and 13), accessed December 31, 2011.

119 Raymond, M., Bogdanovich, L., Brahmi, D., Cardinal, L.J., Fager, G.L., Frattavelli, L.C., Hecker, G., Jarpe, E.A., Viera, A., Kantor, L.M., and Santelli, J.S. (2008). State Refusal of Federal Funding for Abstinence-Only Programs. *Sexuality Research & Policy* 5 (3). <http://www.cfwr.org/Document.Doc?id=285>, accessed January 2, 2012. See also <http://blog-aauw.org/2008/03/12/list-of-states-rejecting-abstinence-only-funding-grows/>.

120 Constantine, N.A. (2007). Review of the Book *When Sex Goes to School: Warring Views on Sex-and Sex Education-Since the Sixties*. *Sex Education* 7, 441-443.

121 Luker, K. (2007). *When Sex Goes to School: Warring Views on Sex-and Sex Education-Since the Sixties*. New York, NY: Norton and Company.

122 Irvine, J.M. (2002). *Talk About Sex: Battles Over Sex Education in the United States*. Berkeley, CA: University of California Press.

there is compelling evidence that abstinence-only-until-marriage programs are not effective and that parents do overwhelmingly support more comprehensive approaches to sex education.^{123, 124}

Medically Accurate, Age-Appropriate Sexual Health Education Programs Improve Sexual Health

Medically accurate, age-appropriate sexual health education programs promote abstinence while also teaching about contraception and ways to prevent sexually transmitted infections and HIV. According to the Centers for Disease Control and Prevention, best practices are those behavioral interventions that have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy (i.e., eliminate or reduce sex, reduce the rate of new HIV/STD infections, or increase HIV-protective behaviors).¹²⁵

Well-designed, well-implemented programs can significantly decrease sexual risk behaviors, including:

- Delaying first sexual intercourse;
- Reducing the number of sexual partners;
- Decreasing the number of times young people have unprotected sex;
- Increasing condom use.¹²⁶

Characteristics of best practices

Best practices are those sexual health programs or curricula that are based on well-designed scientific models, with clear goals and objectives, and well-developed strategic implementation plans. Analyzing the school-based programs of sex education, Douglas Kirby identified 17 essential characteristics, which can be applied to all sexual health programs.¹²⁷

123 Kohler, P.K., Manhart, L.E., and Lafferty, W.E. (2008). Abstinence-only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy. *Journal of Adolescent Health* 42(4), 344-351.

124 Constantine, N.A. (2008). Converging Evidence Leaves Policy Behind: Sex Education in the United States (Editorial). *Journal of Adolescent Health* 42: 324-326.

125 Center for Disease Control and Prevention. 2011. Complete Listing of Risk Reduction Evidence-based Behavioral Interventions. <http://www.cdc.gov/hiv/topics/research/prs/print/RRcomplete-list.htm>, accessed January 6, 2012.
A review of the scientific literature on evidence-influenced practices shows different levels of effectiveness. For example, CDC's review of 73 evidence-based interventions resulted in 42 best-evidence practices that are suitable for individual and group interventions, and 1 best-evidence practice for community-level intervention, as well as 25 good-evidence practices that are suitable for individual and group interventions, and 5 good-evidence practices for community-level intervention.

126 Centers for Disease Control and Prevention (CDC). 2011. *Effective HIV and STD Prevention Programs for Youth*. http://www.cdc.gov/healthyouth/sexualbehaviors/effective_programs.htm, accessed January 27, 2012.

127 Douglas, K. (2007). "Emerging Answers 2007: Characteristics of Effective Curriculum-Based Programs," The National Campaign to Prevent Teen and Unplanned Pregnancy; available from <http://www.thenationalcampaign.org/ea2007/characteristics.pdf>; accessed January 26, 2012.

Research design:

- 1) Created by a research team with multiple people and varied expertise;
- 2) Assessment of relevant needs and assets of the target group;
- 3) Logic model approach that specifies health goals and the associated challenges and opportunities;
- 4) Design activities consistent with community values and available resources;
- 5) Pilot-tested.

Clear curriculum goals and objectives:

- 6) With identified health goals;
- 7) Goals for modifying specific types of behavior;
- 8) Addressing psychosocial risk and protective factors.

Activities and teaching methodologies that include:

- 9) A safe social environment;
- 10) Multiple activities to change targeted risk and protective factors;
- 11) Sound interactive teaching methods;
- 12) Employ teaching methods that are age-appropriate and relevant to the teenagers culture;
- 13) Cover material in a logical sequence.

Implementation plans, including:

- 14) Garnering support from the school district and community organizations;
- 15) Provide training, monitoring and support for educators;
- 16) Recruit teenagers;
- 17) Implement virtually the entire program.¹²⁸

¹²⁸ Douglas, K. (2007) "Emerging Answers 2007: Characteristics of Effective Curriculum-Based Programs," The National Campaign to Prevent Teen and Unplanned Pregnancy; available from <http://www.thenationalcampaign.org/ea2007/characteristics.pdf>; accessed January 26, 2012.

From the evidence-based programs approved for use by the federal government under TPP and PREP programs in 2010, we identified four medically accurate, age-appropriate curricula that teach about both abstinence and contraception that are being used in the Southern states: (1) *Becoming a Responsible Teen*, (2) *Be Proud! Be Responsible*, (3) *¡Cuidate!*, (4) and *SiHLE*.¹²⁹ These curricula are described below:

1. *Become a Responsible Teen (BART)*: *BART* is an 8 module, group-level educational and behavioral skills training intervention designed to reduce risky sexual behaviors and improve safer sex skills. Participants acquire behavioral change skills through discussions, games, videos, presentations, demonstrations, role plays, and practice. One key aspect of this intervention is it encourages participants to share the information they learn with their friends and family and to provide support for their peers to reduce risky behaviors. An evaluation of the program published in the *Journal of Consulting and Clinical Psychology* found that *BART* is associated with the reduction of the frequency of sexual intercourse, reduction of the initiation of sex, and a decrease in unprotected sex.¹³⁰ This curriculum has been used or recommended in Georgia, Louisiana, Mississippi, and West Virginia. More information about this intervention can be found at <http://www.etr.org/>, <http://www.cdc.gov/hiv/>, and <http://www.thenationalcampaign.org/>.
2. *Be Proud! Be Responsible!*: This 6 module behavioral change program helps modify and build knowledge, understanding, and a sense of responsibility regarding STD/HIV risk in youths. The program is delivered through group discussions and exercises, videos, games, and role-play. An evaluation of *Be Proud! Be Responsible!* published in *Family and Community Health* found that this curriculum significantly reduces the number of sex partners, reduces the likelihood of having unprotected sex, and increases condom use.¹³¹ This curriculum has been used or recommended in Georgia, Louisiana, North Carolina, and South Carolina. More details are available at <http://www.childtrends.org/>; <http://www.hhs.gov/ash/oah/oah-initiatives/>; and <http://www.findyouthinfo.org/>.
3. *¡Cuidate! (Take Care of Yourself)*: This intervention is intended for use in small-groups to prevent sexually transmitted diseases, including HIV, through the use of role plays, videos, music, interactive games, and hands-on practices. Originally designed for Hispanic groups, the intervention curriculum is now available in English and Spanish.

129 SIECUS. (2011) "A Portrait of Sexuality Education and Abstinence-Only-Until-Marriage Programs in the States (Fiscal Year 2010 Edition)". <http://siecus.org/index.cfm?fuseaction=Page.viewPage&pagelD=487&parentID=478>, accessed February 27, 2012.

130 St. Lawrence, J., Brasfield, T., Jefferson, K., Alleyne, E., O'Bannon, R., and Shirley, A. (1995). Cognitive-Behavioral Intervention to Reduce African American Adolescents' Risk for HIV Infection. *Journal of Consulting and Clinical Psychology* 63(2), 221-37.

131 Koniak-Griffin, D., Lesser, J., Nyamathi, A., Uman, G., Stein, J.A., and Cumberland, W.G. (2003). Project CHARM: An HIV Prevention Program for Adolescent Mothers. *Family and Community Health* 26(2), 94-107.

The evaluations of the *Take Care of Yourself* program published in *Archives of Pediatric & Adolescent Medicine* and in *Journal of Associated Nurses AIDS Care* show that this curriculum leads to reduced frequency of sex, reduced number of sex partners, increased condom use, and decreased unprotected sex.^{132, 133} This curriculum has been used or recommended in Georgia and Virginia. Additional information on this intervention is available at <http://www.neac.org/resources/cuidate>, <http://www.cdc.gov/hiv/topics/>, and <http://choicehiv.org/interventions/>.

4. *SiHLE*, an acronym for *Sisters Informing, Healing, Living, and Empowering*, is an evidence-based intervention initially designed for African-American females ages 14–18 who are sexually active and at high risk for HIV. It is a peer-led, social skills training intervention based on social cognitive and gender relations theories. An evaluation of the program published in the *Journal of the American Medical Association* found a significant reduction in the likelihood of becoming pregnant and a significant increase in condom use.¹³⁴ This curriculum has been used or recommended in Louisiana, South Carolina, Tennessee, and West Virginia. More information about this program is available at <http://effectiveinterventions.org/en/Interventions/SIHLE.aspx>.

By giving teenagers the information they need to make responsible choices, teenagers are given the opportunity to change the course of their lives. This can be done by implementing the “best” sexual health programs from the models systematically selected by the Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services, and others, depending on the needs and age of the target populations.^{135, 136}

132 Jemmott, J. and Jemmott, L. (1996). Strategies to Reduce the Risk of HIV Infection, Sexually Transmitted Diseases, and Pregnancy among African American Adolescents. In: Resnick, R., Rozensky, R., eds. *Health psychology through the life span: practice and research opportunities*. Washington, DC: American Psychological Association.

133 Jemmott, J., Jemmott, L., and Fong, G. (1992). Reductions in HIV Risk-associated Sexual Behaviors among Black Male Adolescents: Effects of an AIDS Prevention Intervention. *American Journal of Public Health* 82(3), 372–377

134 DiClemente, R.J., Wingood, G.M., Harrington, K.F., Lang, D.L., Davies, S.L., Hook III, E.W., Oh, M.K., Crosby, R.A., Hertzberg, V.S., Gorgon, A.B., Hardin, J.W., Parker, S., and Robilliard, A. (2004). Efficacy of an HIV Prevention Intervention for African American Adolescent Girls: A Randomized Controlled Trial. *Journal of American Medical Association* 292(2), 171-179.

135 U.S. Department of Health and Human Services. 2011a. Fact Sheet: Personal Responsibility Education Program. <http://www.acf.hhs.gov/programs/fysb/content/programs/tpp/prep-facts.htm>, accessed January 6, 2012.

136 U.S. Department of Health and Human Services. 2011b. Program Directory. <http://www.findyouthinfo.gov/programsearch.aspx>, accessed January 6, 2012.

CONCLUSION

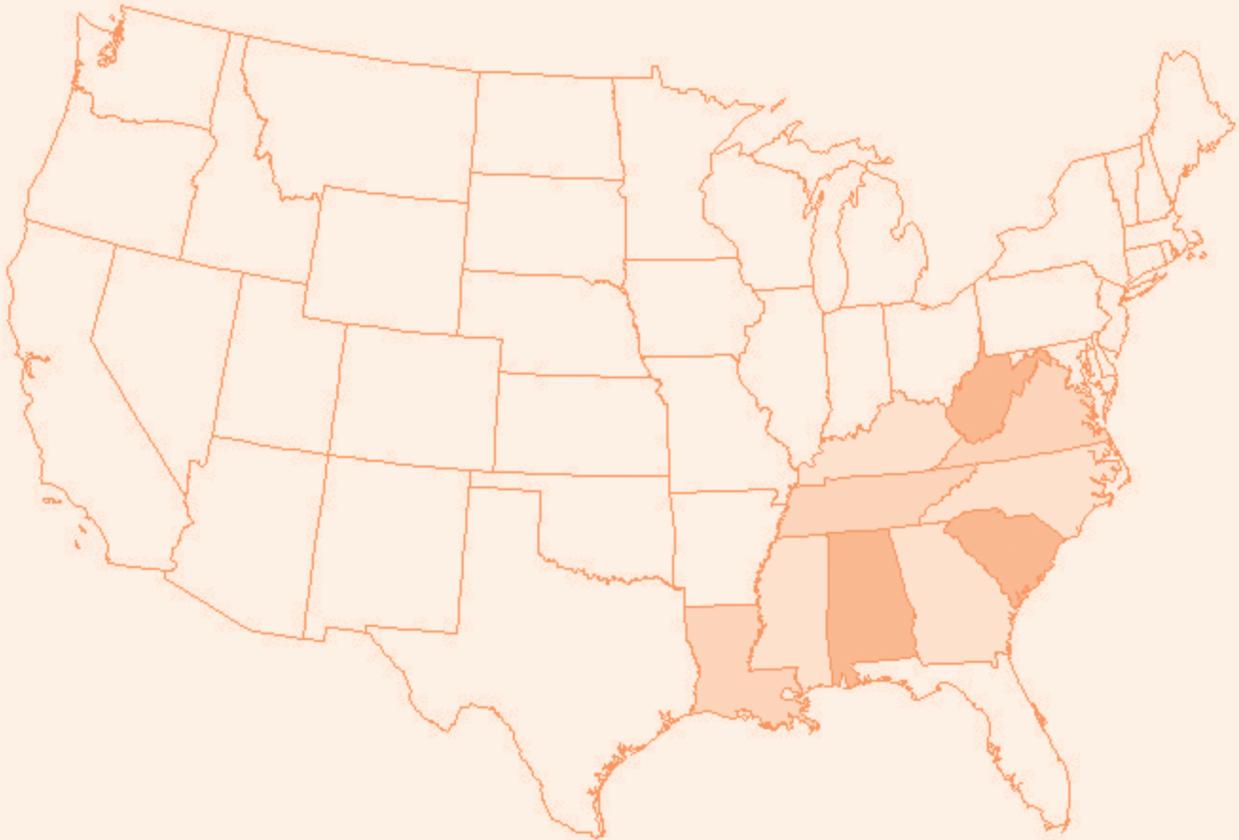
The data show that the Southern region ranks lower than the nation as a whole in sexual health, due to sociodemographic factors such as poverty, and due in part to a lack of investment in the region in implementing medically accurate, age-appropriate, evidence-based and evidence-informed sexual health programs (prior to 2010). None of the 10 states has legal impediments for schools wishing to offer medically accurate, age-appropriate sexual health education programs. In most cases, school districts have the option to use curriculum based on scientific methods, hard data, rigorous evaluations, and empirical results that establish effective strategies.^{137, 138}

This report highlights the specific challenges facing young people in the South related to sexual health, and the long-term negative impact poor sexual health can have on both the individual and the community as a whole. At this moment in time, decision-makers have the opportunity to improve the sexual health of young people in this region. New, more flexible federal funding programs, strong majorities of public support, proven tools and curricula supporting the teaching of medically accurate, age-appropriate, evidence-based and evidence-informed sexual health education and information can change lives and improve the overall sexual health of young people in the South if prioritized. Leaders in education, policy-makers, parents, teachers and communities throughout the South have the opportunity to change the outlook for teenagers by giving them the information they need to make responsible choices that can change the course of their lives.

137 Alford, S., Leon, J., and Sugland, B.W. (2004). *Science-Based Practices: A Guide for State Teen Pregnancy Prevention Organizations*. Center for Applied Research and Technical Assistance. <http://www.advocatesforyouth.org/component/content/article/486-science-based-practices-a-guide-for-state-teen-pregnancy-prevention-organizations>, accessed December 31, 2011.

138 Kirby, D., Roller, L.A., and Wilson, M.M. (2007). *Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs*. Washington, DC: Healthy Teen Network. <http://www.etr.org/recapp/documents/programs/tac.pdf>, accessed January 6, 2012.

APPENDIX A: STATE PROFILES





Sexual Health of Alabama Teenagers

Alabama has a higher teenage birth rate than the United States; in 2009, teenage birth rate was 50.7 per 1,000 among Alabama females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.¹³⁹ Alabama ranked 16th in teenage pregnancy rates among the 50 states and District of Columbia.¹⁴⁰

Data from the 2009 Youth Risk Behavior Surveillance show that Alabama teenagers were less

likely to have used a condom at their most recent sexual intercourse than U.S. teenagers.¹⁴¹ The same survey reported that 79.3 percent of sexually active Alabama teenagers reported that they did not use birth control pills before their last sexual encounter; the U.S. figure is 80.2 percent.

Sexual Health Profile	AL	US
Teenage Birth Rate per 1,000 (2009)	50.7	39.1
Percent Low Birth-weight (2009)	10.6	8.2
Infant Mortality Rate per 1,000 (2005-2007)	9.5	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	4,895.1	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	982.9	566.0
HIV Diagnoses per 100,000 (2009)	16.7	17.4

Sexually Transmitted Infections

Sexually transmitted infection rates are higher among Alabama women ages 15–19, than in the U.S as a whole. In 2009, 4,895.1 per 100,000 Alabama females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 612.4 and 478.8 per 100,000, respectively for Alabama and the United States.¹⁴² The same pattern was observed for Gonorrhea.¹⁴³ Overall, Alabama ranked 5th and 6th among the 50 states, plus DC, for Chlamydia and Gonorrhea for females ages 15–19, and 9th and 7th for the same sexually transmitted infections among females 20 years and older.

Alabama has a slightly lower rate for HIV incidence than the United States. There were 16.7 new HIV cases per 100,000 people in Alabama in 2009, compared to 17.4 per 100,000 for the US.¹⁴⁴

139 Ventura, S.J. and Hamilton, B.E. (2011). "U.S. Teenage Birth Rate Resumes Decline". National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

140 Guttmacher Institute. (2010). *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPTrends.pdf>, accessed December 17, 2011.

141 Centers for Disease Control and Prevention (CDC). 2010. *Youth Risk Behavior Surveillance—United States, 2009. Surveillance Summaries*. Morbidity & Mortality Weekly Report. 2010. 59 (SS-5). <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>, accessed September 13, 2011.

142 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

143 *Ibid.*

144 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

Alabama ranked 11th in HIV incidence in 2009, among all states for which comparable data were available.

According to a 2011 study, 66.2 percent of unintended births in Alabama were paid for by public dollars, compared to 64.0 percent nationally. The expenditure amount per unintended birth was estimated as \$8,660 and \$11,647, respectively for Alabama, and the United States.¹⁴⁵ The public costs of having a child before age 20 are high; in Alabama, teenage childbearing cost taxpayers at least \$192 million.¹⁴⁶

Population Size, Educational Attainment, and Poverty Data

Alabama's poverty rate is high. Among children between the ages of 0–17, 24.6 percent are living in poverty versus 20 percent for the United States.¹⁴⁷ The general population in Alabama living in poverty is 17.5 percent versus the United States at 14.3 percent. The population of Alabama grew by 7.5 percent in the last decade.

Demographics	AL	US
Population in 2010	4,779,736	308,745,538
White (%)	67.0	63.7
African-American (%)	26.0	12.2
Hispanic (%)	3.9	16.3
Other (%)	3.1	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	21.9	28.2
Poverty Rate in 2009 (%)	17.5	14.3
Poverty Rate 0–17 year olds (%)	24.6	20.0

Although 82.1 percent of Alabama's students graduate from high school,¹⁴⁸ only 21.9 percent of Alabama's residents 25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.¹⁴⁹ Alabama's 2010 average annual unemployment rate was slightly lower than the national figure (9.5% v.9.6%).¹⁵⁰

145 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 43(2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

146 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-west-virginia.pdf>, accessed December 17, 2011. These are net cost, not gross costs.

147 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saipe/national.cgi?year=2009&ascii>, accessed December 17, 2011.

148 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

149 *Ibid.*

150 U.S. Department of Labor, Bureau of Labor Statistics. *Unemployment Rates for States*. <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

Sexual Health Education

In 2010, Alabama applied for all the new federal grant opportunities and was awarded a total of \$2,083,402. This grant money was distributed as follows: \$426,172 (or 20.5%) for TPP; \$789,678 (or 37.9%) for PREP; and \$876,552 (or 41.6%) for Title V abstinence-only initiatives.¹⁵¹ More funding in Alabama went to support abstinence-only sex education than either PREP or TPP programs. The state contribution for that year was only in-kind. Details of the projects supported by these grants are available online at SIECUS website.¹⁵²

In Alabama, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

Success stories: *Reducing the Risk in Birmingham*

The *Reducing the Risk* curriculum has been utilized at a Birmingham, Alabama high school by Drs. Tina Simpson and Yu-Mei Schoenberger and their colleagues (at the [Adolescent Health Center](#)). The Teen Health Program at the University of Alabama at Birmingham's Minority Health and Health Disparities Center has trained a group of high school students as community health advisors. These young community health advisors incorporate sexual health education into day-to-day interactions with their peers and sponsor school-wide activities that promote reduced sexual risk behaviors.

Although this program is in its first year of implementation, the comments from students are positive and the impact of these youth gaining and disseminating knowledge and skills to prevent risk-taking sexual behavior is expected to have a far-reaching effect on students at this high school and beyond. This program will be tracked over the next few years to document its effectiveness.

Success stories: *Making a Difference in Montgomery*

The *Making a Difference* program is conducted by the [Montgomery Area Campaign to Prevent Teen Pregnancy](#), a project of the Gift of Life Foundation. During the 2010-2011 school year, the Montgomery Campaign transitioned from an abstinence-based curriculum they had used for several years to an evidence-based teenage pregnancy prevention program. The *Making a Difference* program has been favorably reviewed and endorsed by administrators, staff, and educators from Montgomery Public Schools.

The *Making a Difference* program is delivered by fully trained health educators from the Gift of Life Foundation to all seventh grade students in Montgomery Public Schools. There are plans to begin a pilot project this year in a Montgomery high school focused on implementing the

¹⁵¹ Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

¹⁵² SIECUS website www.siecus.org/alabama2010, accessed December 28, 2011.

Reducing the Risk teenage pregnancy prevention program. This transition from an abstinence program to evidence-based programs is a significant accomplishment.

Success stories: Perspective From a State Policy-Maker

Alabama State Representative Patricia Todd is a champion of HIV/AIDS awareness and teenage pregnancy prevention, as well as other health issues. She has chaired the Governor's Poverty Task Force and is a leading voice stressing the need for policies and programs that help people live healthy lives. Recently, Representative Todd was asked by some of her fellow lawmakers to create and deliver an HIV/AIDS and teenage pregnancy prevention program in a rural Alabama county. She is interested in identifying an evidence-based program for this project. Her long-term goal is to use this pilot project as an example to her colleagues of what can be done in communities to provide knowledge and skills to young people that will help them avoid sexual risk-taking behaviors.

GEORGIA: Sexual Health Profile



Sexual Health of Georgia Teenagers

Georgia has a higher teenage birth rate than the United States; in 2009, teenage birth rate was 61.0 per 1,000 among Georgia females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.¹⁵³ Georgia ranked 8th in teenage pregnancy rates among the 50 states and District of Columbia.¹⁵⁴

Sexual Health Profile	GA	US
Teenage Birth Rate per 1,000 (2009)	61.0	39.1
Percent Low Birth-weight (2009)	9.6	8.2
Infant Mortality Rate per 1,000 (2005-2007)	8.1	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	3,248.6	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	794.9	566.0
HIV Diagnoses per 100,000 (2009)	32.9	17.4

Sexually Transmitted Infections

Sexually transmitted infection rates are also high among Georgia women ages 15–19. In 2009, 3,248.6 per 100,000 Georgia females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 483.6 and 478.8 per 100,000, respectively for Georgia and the United States.¹⁵⁵ The same pattern was observed for Gonorrhea.¹⁵⁶ Overall, Georgia ranked 22nd and 11th among the 50 states, plus the District of Columbia, for Chlamydia and Gonorrhea for females ages 15–19, and 23rd and 13th for the same sexually transmitted infections among females 20 years and older.

Georgia has nearly double the rate for HIV incidence than the United States. There were 32.9 new HIV cases per 100,000 people in Georgia in 2009, compared to 17.4 per 100,000 for the US.¹⁵⁷ Georgia ranked 2nd in HIV incidence in 2009, among all states for which comparable data were available.

According to a 2011 study, 70.7 percent of unintended births in Georgia were paid for by public dollars, compared to 64.0 percent nationally.¹⁵⁸ The expenditure amount per unintended birth was

153 Ventura, S.J. and Hamilton, B.E. (2011). "U.S. Teenage Birth Rate Resumes Decline." National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

154 According to 2005 data from Guttmacher Institute. 2010. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

155 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

156 *Ibid.*

157 Centers for Disease Control and Prevention. 2009. HIV Surveillance Report. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

158 Sonfield A, Kost K, Gold RB, and Finer LB. 2011. "The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates." *Perspectives on Sexual and Reproductive Health* 43 (2): 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

estimated as \$13,128 and \$11,647, respectively, for Georgia and the United States.¹⁵⁹ The public costs of having a child before age 20 are high; in Georgia, teenage childbearing cost taxpayers at least \$465 million.¹⁶⁰

Population Size, Educational Attainment, and Poverty Data

Georgia's poverty rate is high. Among children between the ages of 0–17, 22.7 percent are living in poverty versus 20 percent for the United States.¹⁶¹ The general population in Georgia living in poverty is 16.6 percent versus the United States at 14.3 percent. The population of Georgia grew by 18.3 percent in the last decade.

Demographics	GA	US
Population in 2010	9,687,653	308,745,538
White (%)	55.9	63.7
African-American (%)	30.0	12.2
Hispanic (%)	8.8	16.3
Other (%)	5.3	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	27.3	28.2
Poverty Rate in 2009 (%)	16.6	14.3
Poverty Rate 0–17 year olds (%)	22.7	20.0

Although 84.3 percent of Georgia's students graduate from high school,¹⁶² 27.3 percent of Georgia's residents 25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.¹⁶³ Georgia's 2010 average annual unemployment rate was slightly higher than the national figure (10.2% v.9.6%).¹⁶⁴

Sexual Health Education

In 2010, Georgia applied for all the new grant opportunities and was awarded a total of \$9,800,967. This grant money was distributed as follows: \$6,283,418 (64.1%) for TPP; \$1,707,218 (or 17.4%) for PREP; and \$1,810,331 (or 18.5%) for Title V abstinence-only initiatives.¹⁶⁵ More funding in Georgia went to support abstinence-only sex education than

159 Sonfield A, Kost K, Gold RB, and Finer LB. 2011. "The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates." *Perspectives on Sexual and Reproductive Health* 43 (2): 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

160 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-georgia.pdf>, accessed December 17, 2011. These are net cost, not gross costs.

161 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saiper/national.cgi?year=2009&ascii>, accessed December 17, 2011.

162 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder2.census.gov/>, accessed February 25, 2010.

163 *Ibid.*

164 U.S. Department of Labor, Bureau of Labor Statistics. "Unemployment Rates for States." <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

165 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

PREP programs, less than TPP programs. Georgia provided \$642,280 to support sexual health programs in 2010. Details of the projects supported by these grants are available online at SIECUS website.¹⁶⁶

In Georgia, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

Success stories: Giving Young Mothers a Second Chance

In partnership with the Georgia Department of Human Services, Georgia Campaign for Adolescent Pregnancy Prevention (G-CAPP) operates a network of 7 Second Chance Homes, which are designed to address the myriad issues related to teenage pregnancy. The Second Chance Home network helps teenage mothers become self-sufficient by providing them a safe, stable living environment, educational support to complete high school, parenting skills, and life skills, putting the young mothers on a firm path toward long-term economic independence and avoiding a repeat teenage pregnancy. Since the first Second Chance Home opened in 2001, the program has served more than 400 young mothers and their children. When young mothers completed their stay at Second Chances Homes:

- Only 4% of the teenagers became pregnant again, compared to the state repeat teenage pregnancy rate of 27%;
- 72% of girls 18 and over had graduated from high school;
- 10% were enrolled in college or vocational school;
- 67% were employed; and
- 73% of the children were still being cared for by their mother.

Success stories: Increase in access to medically accurate, age-appropriate prevention programs

In the last two years, Georgia has seen an increase in the number of medically accurate, age-appropriate teenage pregnancy prevention programs being implemented across the state from just a handful to over 100 Community-based organizations, schools, public agencies, and faith-based organizations are implementing effective programs for their young people—many of whom are considered to be at risk, such as youth in foster care, juvenile justice, or out-of-school.

In 2010, Georgia was able to secure approximately \$62.5 million of federal funding for five years from the President's Teen Pregnancy Prevention Initiative (TPPI) that funds public and private entities to implement medically accurate, age-appropriate, evidence-based or innovative program models to reduce teenage pregnancy. Through the TPPI initiative, nine Georgia entities are supporting teenage pregnancy prevention programs at more than 65 community and faith-based organizations, public health and child welfare agencies.

¹⁶⁶ SIECUS website www.siecus.org/Georgia2010, accessed December 28, 2011.

In addition, Georgia is one of eight states (and one of only two southern states) funded in the national 5-year pilot “Working to Institutionalize Sex Education” (WISE) initiative, funded by the Grove Foundation. The WISE initiative is building the state’s infrastructure to institutionalize sex education in school districts. Since 2009, G-CAPP (the lead organization) has trained 96 teachers in 41 elementary, middle, and high schools to implement the medically accurate and age-appropriate curricula, reaching over 12,000 students in 2011 alone.

Medically accurate, age-appropriate programs such as *Making a Difference*, *Making Proud Choices*, *Reducing the Risk*, *Teen Outreach Program*, *Carrera Teen Pregnancy Prevention Model*, *SiHLE*, and others are now being implemented in pockets of the state: the highest concentration of programs occur in the 10 counties that account for 40% of the teenage births in the state.



Sexual Health of Kentucky Teenagers

Kentucky has a higher teenage birth rate than the United States; in 2009, teenage birth rate was 51.3 per 1,000 among Kentucky females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.¹⁶⁷ Kentucky ranked 22nd in teenage pregnancy rates among the 50 states and District of Columbia.¹⁶⁸

Data from the 2009 Youth Risk Behavior Surveillance show that Kentucky teenagers were less

likely to have used a condom at their most recent sexual intercourse than U.S. teenagers.¹⁶⁹ The same survey reported that 76.6 percent of sexually active Kentucky female teenagers reported that they did not use birth control pills before their last sexual encounter; the U.S. figure is 80.2 percent.

Sexual Health Profile	KY	US
Teenage Birth Rate per 1,000 (2009)	51.3	39.1
Percent Low Birth-weight (2009)	9.2	8.2
Infant Mortality Rate per 1,000 (2005-2007)	7.0	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	2,739.2	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	537.7	566.0
HIV Diagnoses per 100,000 (2009)	9.1	17.4

Sexually Transmitted Infections

Sexually transmitted infection rates are slightly lower than the national average among Kentucky women ages 15–19. In 2009, 2,739.2 per 100,000 Kentucky females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 340.5 and 478.8 per 100,000, respectively for Kentucky and the United States.¹⁷⁰ This same pattern was observed for Gonorrhea.¹⁷¹ Overall, Kentucky ranked 31st and 23rd among the 50 states, plus DC, for Chlamydia and Gonorrhea for females ages 15–19, and 42nd and 25th for the same sexually transmitted infections among females 20 years and older.

Kentucky has a notably lower rate for HIV incidence than the United States. There were 9.1 new HIV cases per 100,000 people in Kentucky in 2009, compared to 17.4 per 100,000 for the U.S.¹⁷² Kentucky ranked 21st in HIV incidence in 2009, among all states for which comparable data were available.

167 Ventura, S.J. and Hamilton, B.E. (2011). "U.S. Teenage Birth Rate Resumes Decline". National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

168 Guttmacher Institute. (2010). "U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity". <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

169 Centers for Disease Control and Prevention (CDC). (2010). Youth Risk Behavior Surveillance—United States, 2009. Surveillance Summaries. Morbidity & Mortality Weekly Report. 2010. 59 (SS-5). <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>, accessed September 13, 2011.

170 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

171 *Ibid.*

172 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

According to a 2011 study, 78.4 percent of unintended births in Kentucky were paid for by public dollars, compared to 64.0 percent nationally.¹⁷³ The expenditure amount per unintended birth was estimated as \$13,344 and \$11,647, respectively, for Kentucky and the United States.¹⁷⁴ The public costs of having a child before age 20 are high; in Kentucky, teenage childbearing cost taxpayers at least \$177 million.¹⁷⁵

Population Size, Educational Attainment, and Poverty Data

Kentucky's poverty rate is high. Among children between the ages of 0–17, 25.3 percent are living in poverty versus 20 percent for the United States.¹⁷⁶ The general population in Kentucky living in poverty is 18.4 percent versus the United States at 14.3 percent. Kentucky is ranked 3rd and 5th in the nation for poverty as a whole and for children ages 0–17. The population of Kentucky grew by only 7.4 percent in the last decade.

Demographics	KY	US
Population in 2010	4,339,367	308,745,538
White (%)	86.3	63.7
African-American (%)	7.7	12.2
Hispanic (%)	3.1	16.3
Other (%)	2.9	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	20.5	28.2
Poverty Rate in 2009 (%)	18.4	14.3
Poverty Rate 0–17 year olds (%)	25.3	20.0

Although 81.9 percent of Kentucky's students graduate from high school,¹⁷⁷ only 20.5 percent of Kentucky's residents 25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.¹⁷⁸ Kentucky's 2010 average annual unemployment rate was higher than the national figure (10.5% v.9.6%).¹⁷⁹

173 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 43(2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

174 *Ibid.*

175 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-Kentucky.pdf>, accessed December 17, 2011. These are net cost, not gross costs.

176 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saipe/national.cgi?year=2009&ascii>, accessed December 17, 2011.

177 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

178 *Ibid.*

179 U.S. Department of Labor, Bureau of Labor Statistics. "Unemployment Rates for States." <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

Sexual Health Education

In 2010, Kentucky applied for all the new federal grant opportunities and was awarded a total of \$2,499,680. This grant money was distributed as follows: \$963,331 (or 38.5%) for TPP; \$696,997 (or 27.9%) for PREP; and \$839,352 (or 33.6%) for Title V abstinence-only initiatives.¹⁸⁰ A higher percentage of federal funding in Kentucky went to support abstinence-only sex education than PREP programs, less than TPP programs. Kentucky is one of two states in the study that provided state matching funds to support sexual health education programs in 2010. Details of the projects supported by these grants are available online at SIECUS website.¹⁸¹

In Kentucky, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

Success stories: The Young Parents Program at the University of Kentucky

For nearly 30 years, the Young Parents Program (YPP) at the University of Kentucky has been working to reduce the repeat teenage pregnancy rate. The Young Parents Program uses a comprehensive, clinical, multidisciplinary approach to teenage mothers and their children. Expectant mothers 19 and younger can participate in the program from pregnancy through the child's fifth birthday. Teenagers are referred to the program by the university's obstetrics-gynecology department and the local health department.

A peer-reviewed study of 1,386 young mothers, who were between the ages of 11 and 19 at the time of first pregnancy and who participated in the program for at least three years from 1999 to 2003, showed significant positive results from the YPP. Of these 1,386 mothers, only **11 (0.79 %)** had repeat pregnancies during the three-year period, in sharp contrast to statewide statistics, which show repeat pregnancy in mothers under age 20 at **18.7 percent**.¹⁸²

Success stories: CHAMPS at Louisville University

In 2010, the University of Louisville's Kent School of Social Work received a \$4.8 million grant from the U.S. Department of Health and Human Services to implement Creating Healthy Adolescents through Meaningful Prevention Services (CHAMPS). Under this five-year project, the University will work with several community youth-serving organizations to help teenagers avoid unhealthy relationships and risky behavior and prevent teenage pregnancy and sexually transmitted infections, including HIV/AIDS. CHAMPS will reach and educate nearly 1,300

¹⁸⁰ Calculated using data received from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

¹⁸¹ SIECUS website <http://www.siecus.org/kentucky2010>, accessed December 28, 2011.

¹⁸² Omar, H.A., Fowler, A., and McClanahan, K.K. (2008). Significant Reduction of Repeat Teen Pregnancy in a Comprehensive Young Parent Program. *Journal of Pediatric and Adolescent Gynecology* 21(5), 283-287.

young adults and teenagers over the 5 years.¹⁸³ CHAMPS is a randomized control trial comparing two programs, one aimed at curbing risky sexual behavior in teenagers and reducing teenage pregnancies, teenage violence and STIs, and the other group serving as a control group.

¹⁸³ Information about the CHAMPS program can be found at these websites:

<http://www.facebook.com/pages/Creating-Healthy-Adolescents-through-Meaningful-Prevention-Services/167351459993730>;
<http://www.identigene.com/std-testing/blog/2011/01/teen-education-may-help-reduce-the-spread-of-stds/>;
<http://louisville.edu/uoftoday/campus-news/kent-school-program-aims-to-reduce-teen-pregnancy-disease-risk>.

LOUISIANA: Sexual Health Profile



Sexual Health of Louisiana Teenagers

Louisiana has a higher teenage birth rate than the United States; in 2009, teenage birth rate was 52.7 per 1,000 among Louisiana females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.¹⁸⁴ Louisiana ranked 18th in teenage pregnancy rates among the 50 states and District of Columbia.¹⁸⁵

Sexual Health Profile	LA	US
Teenage Birth Rate per 1,000 (2009)	52.7	39.1
Percent Low Birth-weight (2009)	10.8	8.2
Infant Mortality Rate per 1,000 (2005-2007)	9.7	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	4,986.5	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	1,128.4	566.0
HIV Diagnoses per 100,000 (2009)	28.8	17.4

Sexually Transmitted Infections

Sexually transmitted infection rates are higher than the national average among Louisiana women ages 15–19. In 2009, 4,986.5 per 100,000 Louisiana females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 721.4 and 478.8 per 100,000, respectively for Louisiana and the United States.¹⁸⁶ The same pattern was observed for Gonorrhea.¹⁸⁷ Overall, Louisiana ranked 4th among the 50 states, plus the District of Columbia, for both Chlamydia and Gonorrhea for females ages 15–19, and 4th and 3rd for the same sexually transmitted infections among females 20 years and older.

Louisiana has a higher rate for HIV incidence than the United States. There were 28.8 new HIV cases per 100,000 people in Louisiana in 2009, compared to 17.4 per 100,000 for the U.S.¹⁸⁸ Louisiana ranked 4th in HIV incidence in 2009, among all states for which comparable data were available.

According to a 2011 study, 80.5 percent of unintended births in Louisiana were paid for by public dollars, compared to 64.0 percent nationally.¹⁸⁹ The expenditure amount per unintended birth was estimated as \$14,523 and \$11,647, respectively, for Louisiana and the United States.¹⁹⁰ The public

184 Ventura, S.J. and Hamilton, B.E. (2011). "U.S. Teenage Birth Rate Resumes Decline". National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

185 Guttmacher Institute. (2010). *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

186 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

187 *Ibid.*

188 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

189 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 43(2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

190 *Ibid.*

costs of having a child before age 20 are high; in Louisiana, teenage childbearing cost taxpayers at least \$169 million.¹⁹¹

Population Size, Educational Attainment, and Poverty Data

Louisiana's poverty rate is high. Among children between the ages of 0–17, 24.8 percent are living in poverty versus 20 percent for the United States.¹⁹² The general population in Louisiana living in poverty is 17.6 percent versus the United States at 14.3 percent. Louisiana is ranked 6th in the nation for poverty as a whole and for children ages 0–17. The population of Louisiana grew by only 1.4 percent in the last decade.

Demographics	LA	US
Population in 2010	4,533,372	308,745,538
White (%)	60.3	63.7
African-American (%)	31.8	12.2
Hispanic (%)	4.2	16.3
Other (%)	3.7	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	21.4	28.2
Poverty Rate in 2009 (%)	17.6	14.3
Poverty Rate 0–17 year olds (%)	24.8	20.0

Although 81.9 percent of Louisiana's students graduate from high school,¹⁹³ 21.4 percent of Louisiana's residents 25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.¹⁹⁴ Louisiana's 2010 average annual unemployment rate was lower than the national figure (7.5% v.9.6%).¹⁹⁵

Sexual Health Education

In 2010, Louisiana applied for all the new federal grant opportunities and was awarded a total of \$6,897,882. This grant money was distributed as follows: \$5,151,518 (or 74.7%) for TPP; \$696,997 (or 11.2%) for PREP; and \$976,757 (or 14.1%) for Title V abstinence-only initiatives.¹⁹⁶ A higher percentage of federal funding in Louisiana went to support abstinence-

191 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-Louisiana.pdf>, accessed December 17, 2011. These are net cost, not gross costs.

192 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saiper/national.cgi?year=2009&ascii>, accessed December 17, 2011.

193 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

194 *Ibid.*

195 U.S. Department of Labor, Bureau of Labor Statistics. "Unemployment Rates for States." <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

196 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

only sex education than PREP programs, but less than TPP programs. Details of the projects supported by these grants are available online at SIECUS website.¹⁹⁷

In Louisiana, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

¹⁹⁷ SIECUS website <http://www.siecus.org/louisiana2010>, accessed December 28, 2011.



Sexual Health of Mississippi Teenagers

Mississippi has a higher teenage birth rate than the United States; in 2009, teenage birth rate was 64.2 per 1,000 among Mississippi females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.¹⁹⁸ Mississippi ranked 5th in teenage pregnancy rates among the 50 states and District of Columbia.¹⁹⁹

Data from the 2009 Youth Risk Behavior Surveillance show that Mississippi teenagers were less

likely to have used a condom at their most recent sexual intercourse than U.S. teenagers.²⁰⁰ The same survey reported that 85.7 percent of sexually active Mississippi female teenagers reported that they did not use birth control pills before their last sexual encounter; the U.S. figure is 80.2 percent.

Sexual Health Profile	MS	US
Teenage Birth Rate per 1,000 (2009)	64.2	39.1
Percent Low Birth-weight (2009)	11.8	8.2
Infant Mortality Rate per 1,000 (2005-2007)	10.6	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	7,186.3	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	1,576.6	566.0
HIV Diagnoses per 100,000 (2009)	21.3	17.4

Sexually Transmitted Infections

Sexually transmitted infection rates are also high among Mississippi women ages 15–19. In 2009, 7,186.3 per 100,000 Mississippi females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 871.7 and 478.8 per 100,000, respectively for Mississippi and the United States.²⁰¹ The same pattern was observed for Gonorrhea.²⁰² Overall, Mississippi ranked 2nd among the 50 states, plus the District of Columbia, for both Chlamydia and Gonorrhea for females ages 15–19, and 3rd and 2nd for the same sexually transmitted infections among females 20 years and older.

Mississippi has a higher rate for HIV incidence than the United States. There were 21.3 new HIV cases per 100,000 people in Mississippi in 2009, compared to 17.4 per 100,000 for the

198 Ventura, S.J. and Hamilton, B.E. (2011). *U.S. Teenage Birth Rate Resumes Decline*. National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

199 According to 2005 data from Guttmacher Institute. 2010. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPTrends.pdf>, accessed December 17, 2011.

200 Centers for Disease Control and Prevention (CDC). 2010. *Youth Risk Behavior Surveillance—United States, 2009. Surveillance Summaries*. 2010. Morbidity & Mortality Weekly Report. 2010. 59 (SS-5). <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>, accessed September 13, 2011.

201 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

202 *Ibid.*

U.S.²⁰³ Mississippi ranked 6th in HIV incidence in 2009, among all states for which comparable data were available.

According to a 2011 study, 81 percent of unintended births in Mississippi were paid for by public dollars, compared to 64.0 percent nationally.²⁰⁴ The expenditure amount per unintended birth was estimated as \$6,136 and \$11,647, respectively, for Mississippi and the United States.²⁰⁵ The public costs of having a child before age 20 are high; in Mississippi, teenage childbearing cost taxpayers at least \$159 million.²⁰⁶

Population Size, Educational Attainment, and Poverty Data

Mississippi's poverty rate is high. Among children between the ages of 0–17, 30.7 percent are living in poverty versus 20 percent for the United States.²⁰⁷ The general population in Mississippi living in poverty is 21.8 percent versus the United States at 14.3 percent. Mississippi is ranked 1st in the nation for poverty as a whole and for children ages 0–17. The population of Mississippi grew by only 4.3 percent in the last decade.

Demographics	MS	US
Population in 2010	2,967,297	308,745,538
White (%)	58.0	63.7
African-American (%)	36.9	12.2
Hispanic (%)	2.7	16.3
Other (%)	2.4	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	19.5	28.2
Poverty Rate in 2009 (%)	21.8	14.3
Poverty Rate 0–17 year olds (%)	30.7	20.0

Although 81.0 percent of Mississippi's students graduate from high school,²⁰⁸ only 19.5 percent of Mississippi's residents 25 years and older had earned a bachelor's degree or higher, compared to

203 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

204 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. . (2011). "The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates." *Perspectives on Sexual and Reproductive Health* 43 (2): 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

205 *Ibid.*

206 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-Mississippi.pdf>, accessed December 17, 2011. These are net cost, not gross costs.

207 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saiper/national.cgi?year=2009&ascii>, accessed December 17, 2011.

208 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

28.2 percent for the United States.²⁰⁹ Mississippi's 2010 average annual unemployment rate was slightly higher than the national figure (10.4% v.9.6%).²¹⁰

Sexual Health Education

In 2010, Mississippi applied for all the new federal grant opportunities and was awarded a total of \$2,876,173. This grant money was distributed as follows: \$1,514,493 (or 52.7%) for TPP; \$537,218 (or 18.7%) for PREP; and \$824,462 (or 28.7%) for Title V abstinence-only initiatives.²¹¹ A higher percentage of federal funding in Mississippi went to support abstinence-only sex education than PREP programs, but less than TPP programs. Details of the projects supported by these grants are available online at SIECUS website.²¹²

In Mississippi, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

Success stories: Southeast Mississippi Rural Health Initiative—Hattiesburg

Southeast Mississippi Rural Health Initiative, Inc. (SeMRHI) is a federally qualified health center organization in Hattiesburg that operates 13 medical clinics and 1 dental clinic in a 5 county area. In 2010, SeMRHI received a 5-year grant to provide the evidence-based *Making a Difference* curriculum to 500 adolescents, ages 11–15, in Forrest and Lamar Counties. This program has been implemented in public schools, and in faith and community-based settings since September 2011, and is expected to reduce unintended pregnancies and lower risky-sexual behaviors.

Success stories: Working with Youth to Prevent Unintended Pregnancies—Jones County

When Barbara Davenport, Executive Director of Countrywide Family Life Center, began to notice rapidly increasing rates of unintended pregnancies among teenagers in 2004, she decided to bring accurate information about contraception and other aspects of sexual health to Jones County. One of her students, Tymeke, wrote a position paper on the need for sex education, saying, “When our bodies have these feelings, we don’t have anyone to talk with to find out why.” Barbara operates her program now with limited resources, but she hopes that students like Tymeke will in the future be able to lead this work and gather more resources in order to address this issue in their community.

²⁰⁹ *Ibid.*

²¹⁰ U.S. Department of Labor, Bureau of Labor Statistics. “Unemployment Rates for States.” <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

²¹¹ Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

²¹² SIECUS website <http://www.siecus.org/mississippi2010>, accessed December 28, 2011.

Success stories: Dr. Persharon Dixon and Teen Sexual Health—Gulfport

Dr. Persharon M. Dixon, MD (Ob-GYN), Director of the Coastal Family Health Center in Gulfport, came to the Mississippi Gulf Coast in 2005 to operate a mobile health clinic in the aftermath of Hurricane Katrina. Dixon's frustrations began when she started seeing more and more pregnant 13 year-old girls come to her clinic. The teenagers did not have vital information about pregnancy prevention and their parents confided to Dixon that they were uncomfortable talking to their children about sex.

Dixon is currently working with her sorority, Alpha Kappa Alpha, and other community-based organizations to offer programs to students outside of school. For the past three summers these groups have hosted a one-day event, called Saving Our Sisters, for thousands of young girls from throughout the tri-county coastal area. Dixon knows this is not enough; she hopes the school system will add medically accurate, age-appropriate sexual health education to the curriculum to provide necessary information to the thousands of young people who are not otherwise being reached.

Success stories: Mississippi's Abstinence-Plus Sex Education

Members of Jackson-based [Mississippi First](#), a grantee of the [Women's Fund of Mississippi](#), are traveling to local school districts with high teenage birth rates and advocating for the adoption of medically accurate, age-appropriate sexual health education programs. In June 2011, three school boards with high teenage birth rates adopted an evidence-based sex education policy; this is the first time any school district in Mississippi has adopted an "abstinence-plus" and not "abstinence-only" program. *Mississippi First* is working with the Mississippi State Department of Health, a recipient of federal PREP (Personal Responsibility Education Program) dollars to support this effort. This is promising, as research has clearly demonstrated that "abstinence-plus" can achieve positive behavioral changes among young people and reduce unintended pregnancies and sexually transmitted infections, including HIV.²¹³

213 Realini, J.P., Buzi, R.S., Smith, P.B., and Martinez, M. (2010). Evaluation of 'Big Decisions': An Abstinence-Plus Sexuality Curriculum. *Journal of Sex & Marital Therapy* 36(4), 313-326.



Sexual Health of North Carolina Teenagers

North Carolina has a higher teenage birth rate than the United States; in 2009, teenage birth rate was 44.9 per 1,000 among North Carolina females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.²¹⁴ North Carolina ranked 14th in teenage pregnancy rates among the 50 states and District of Columbia.²¹⁵

Sexual Health Profile	NC	US
Teenage Birth Rate per 1,000 (2009)	44.9	39.1
Percent Low Birth-weight (2009)	9.1	8.2
Infant Mortality Rate per 1,000 (2005-2007)	8.5	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	4,107.7	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	875.7	566.0
HIV Diagnoses per 100,000 (2009)	9.1	17.4

Sexually Transmitted Infections

Sexually transmitted infection rates are higher than the national average among North Carolina women ages 15–19. In 2009, 4,107.7 per 100,000 North Carolina females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 554.0 and 478.8 per 100,000, respectively for North Carolina and the United States.²¹⁶ The same pattern was observed for Gonorrhea.²¹⁷ Overall, North Carolina ranked 11th and 10th among the 50 states, plus the District of Columbia, for Chlamydia and Gonorrhea for females ages 15–19, and 12th and 8th for the same sexually transmitted infections among females 20 years and older.

North Carolina has a higher rate for HIV incidence than the United States. There were 19.7 new HIV cases per 100,000 people in North Carolina in 2009, compared to 17.4 per 100,000 for the US.²¹⁸ North Carolina ranked 8th in HIV incidence in 2009, among all states for which comparable data were available.

According to a 2011 study, 74.1 percent of unintended births in North Carolina were paid for by

214 Ventura, S.J. and Hamilton, B.E. (2011). *U.S. Teenage Birth Rate Resumes Decline*. National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

215 According to 2005 data from Guttmacher Institute. 2010. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

216 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

217 *Ibid.*

218 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

public dollars, compared to 64.0 percent nationally.²¹⁹ The expenditure amount per unintended birth was estimated as \$12,859 and \$11,647, respectively, for North Carolina and the United States.²²⁰ The public costs of having a child before age 20 are high; in North Carolina, teenage childbearing cost taxpayers at least \$392 million.²²¹

Population Size, Educational Attainment, and Poverty Data

North Carolina's poverty rate is high. Among children between the ages of 0–17, 22.5 percent are living in poverty versus 20 percent for the United States.²²² The general population in North Carolina living in poverty is 16.2 percent versus the United States at 14.3 percent. North Carolina is ranked 12th and 14th in the nation for poverty as a whole and for children ages 0–17. The population of North Carolina grew by 18.5 percent in the last decade.

Demographics	NC	US
Population in 2010	9,535,483	308,745,538
White (%)	65.3	63.7
African-American (%)	21.2	12.2
Hispanic (%)	8.4	16.3
Other (%)	5.1	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	26.5	28.2
Poverty Rate in 2009 (%)	18.4	14.3
Poverty Rate 0–17 year olds (%)	25.3	20.0

Although 84.7 percent of North Carolina's students graduate from high school,²²³ 26.5 percent of North Carolina's residents 25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.²²⁴ North Carolina's 2010 average annual unemployment rate was higher than the national figure (10.6% v.9.6%).²²⁵

219 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 43(2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

220 *Ibid.*

221 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. [http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-North Carolina.pdf](http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-North%20Carolina.pdf), accessed December 17, 2011. These are net cost, not gross costs.

222 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saiper/national.cgi?year=2009&ascii>, accessed December 17, 2011.

223 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

224 *Ibid.*

225 U.S. Department of Labor, Bureau of Labor Statistics. Unemployment Rates for States. <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

Sexual Health Education

In 2010, North Carolina applied for all the new federal grant opportunities and was awarded a total of \$5,897,725. This grant money was distributed as follows: \$2,768,066 (or 46.9%) for TPP; \$1,544,312 (or 26.2%) for PREP; and \$1,585,347 (or 26.9%) for Title V abstinence-only initiatives.²²⁶ A higher percentage of funding in North Carolina went to support abstinence-only sex education than PREP programs, but less than TPP programs. Only a portion of this funding goes to help schools satisfy the requirements of the state's sexual health education requirements. Most money was used to support community-based programs, extracurricular programs, or family support programs. Details of the projects supported by these grants are available online at SIECUS website.²²⁷

In North Carolina, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

226 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

227 SIECUS website <http://www.siecus.org/northcarolina2010>, accessed December 28, 2011.



Sexual Health of South Carolina Teenagers

South Carolina has a higher teenage birth rate than the United States; in 2009, teenage birth rate was 49.1 per 1,000 among South Carolina females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.²²⁸ South Carolina ranked 10th in teenage pregnancy rates among the 50 states and District of Columbia, same level as Tennessee.²²⁹

Sexual Health Profile	SC	US
Teenage Birth Rate per 1,000 (2009)	49.1	39.1
Percent Low Birth-weight (2009)	9.9	8.2
Infant Mortality Rate per 1,000 (2005-2007)	8.8	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	5,690.4	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	1,246.4	566.0
HIV Diagnoses per 100,000 (2009)	19.9	17.4

Data from the 2009 Youth Risk Behavior Surveillance show that South Carolina teenagers were less likely to have used a condom at their most recent sexual intercourse than U.S. teenagers.²³⁰

Sexually Transmitted Infections

Sexually transmitted infection rates are higher than the national average among South Carolina women ages 15–19. In 2009, 5,690.4 per 100,000 South Carolina females age 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000 15–19. Among females age 20 and older, the Chlamydia rates were 682.9 and 478.8 per 100,000, respectively for South Carolina and the United States.²³¹ The same pattern was observed for Gonorrhea.²³² Overall, South Carolina ranked 3rd among the 50 states, plus the District of Columbia, for Chlamydia and Gonorrhea for females ages 15–19, and 5th and 4th for the same sexually transmitted infections among females 20 years and older.

South Carolina has a higher rate for HIV incidence than the United States. There were 19.9 new HIV cases per 100,000 people in South Carolina in 2009, compared to 17.4 per 100,000 for the U.S.²³³

228 Ventura, S.J. and Hamilton, B.E. (2011). *U.S. Teenage Birth Rate Resumes Decline*. National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

229 According to 2005 data from Guttmacher Institute. 2010. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPTrends.pdf>, accessed December 17, 2011.

230 Centers for Disease Control and Prevention (CDC). 2010. *Youth Risk Behavior Surveillance—United States, 2009. Surveillance Summaries*. 2010. Morbidity & Mortality Weekly Report. 2010. 59 (SS-5). <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>, accessed September 13, 2011.

231 CDC’s WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

232 *Ibid.*

233 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

South Carolina ranked 7th in HIV incidence in 2009, among all states for which comparable data were available.

According to a 2011 study, 77.5 percent of unintended births in South Carolina were paid for by public dollars, compared to 64.0 percent nationally.²³⁴ The expenditure amount per unintended birth was estimated as \$10,509 and \$11,647, respectively, for South Carolina and the United States.²³⁵ The public costs of having a child before age 20 are high; in South Carolina, teenage childbearing cost taxpayers at least \$197 million.²³⁶

Population Size, Educational Attainment, and Poverty Data

South Carolina's poverty rate is high. Among children between the ages of 0–17, 24.4 percent are living in poverty versus 20 percent for the United States.²³⁷ The general population in South Carolina living in poverty is 17.1 percent versus the United States at 14.3 percent. South Carolina is ranked 9th in the nation for poverty as a whole and 8th for children ages 0–17. The population of South Carolina grew by 15.3 percent in the last decade.

Demographics	SC	US
Population in 2010	4,625,364	308,745,538
White (%)	64.1	63.7
African-American (%)	27.7	12.2
Hispanic (%)	5.1	16.3
Other (%)	3.1	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	24.5	28.2
Poverty Rate in 2009 (%)	17.1	14.3
Poverty Rate 0–17 year olds (%)	24.4	20.0

Although 84.1 percent of South Carolina's students graduate from high school,²³⁸ only 24.5 percent of South Carolina's residents 25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.²³⁹ South Carolina's 2010 average annual unemployment rate was higher than the national figure (11.2% v.9.6%).²⁴⁰

234 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. . (2011). "The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates." *Perspectives on Sexual and Reproductive Health* 43 (2): 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

235 *Ibid.*

236 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. [http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-South Carolina.pdf](http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-South%20Carolina.pdf), accessed December 17, 2011. These are net cost, not gross costs.

237 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saipe/national.cgi?year=2009&ascii>, accessed December 17, 2011.

238 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

239 *Ibid.*

240 U.S. Department of Labor, Bureau of Labor Statistics. "Unemployment Rates for States." <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

Sexual Health Education

In 2010, South Carolina applied for all the new federal grant opportunities and was awarded a total of \$4,538,541. This grant money was distributed as follows: \$2,955,712 (or 65.1%) for TPP; \$760,906 (or 16.8%) for PREP; and \$821,923 (or 18.1%) for Title V abstinence-only initiatives.²⁴¹ A higher percentage of funding in South Carolina went to support abstinence-only sex education than PREP programs, but less than for TPP programs. Details of the projects supported by these grants are available online at SIECUS website.²⁴²

In South Carolina, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

Success story: *Tell Them*

*Tell Them*²⁴³ is a grassroots e-advocacy network that informs and organizes South Carolina voters about reproductive health policies and issues. Every 6 years the South Carolina Board of Education revises the Health and Safety Curriculum Standards, and in 2009, *Tell Them* launched an online campaign to update what was being taught in South Carolina schools. Their request was that Board members require at least 12 hours of comprehensive sex education before South Carolina students enter high school. Over 800 people took action and sent the South Carolina Board of Education messages supporting good sexual health education policies that require pregnancy and sexually transmission infections prevention education before high school.

On the day of the Board vote, *Tell Them* organized a series of testimonies from local stakeholders. These included [Dr. Billy Ogelsby](#), an HIV/AIDS expert; [Margaret Pruitt](#), a high school biology teacher and lifelong educator; [Amy Lessor](#), a social worker; [Dr. Melisa Holmes](#), an OBGYN and author of *Girology*; [Dr. Rev. Virginia Barfield](#), Dean of the Columbia Lutheran Seminary; and Jill Bennett, a recent South Carolina high school graduate and teenage mother. Jill Bennett's testimony was the highlight of the meeting. She carried her 6-week-old daughter to the podium and told the Board of Education members that it had been their jobs to prepare her and her fellow students for the future and that they failed her. She then asked if there were any other students who wanted to be properly prepared to stand up for themselves. At that moment, 20 young women (who *Tell Them* based in from partner programs) stood up behind Jill.

The Board of Education revised the [Health and Safety Curriculum Standards](#) for all South Carolina schools to require that each student receive STD prevention education in 6th, 7th, and 8th grades. This was a huge step forward in responsible reproductive health policy in South Carolina.

241 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

242 SIECUS website <http://www.siecus.org/southcarolina2010>, accessed December 28, 2011.

243 More Information can be found at the *Tell Them* website, www.tellthemsc.org.



Sexual Health of Tennessee Teenagers

Tennessee has a higher teenage birth rate than the United States; in 2009, teenage birth rate was 50.6 per 1,000 among Tennessee females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.²⁴⁴ In 2005, Tennessee ranked 9th in teenage pregnancy rates among the 50 states and the District of Columbia, same level as South Carolina.²⁴⁵

Data from the 2009 Youth Risk Behavior Surveillance show that Tennessee teenagers were less likely to have used a condom at their most recent sexual intercourse than U.S. teenagers.²⁴⁶

Sexual Health Profile	TN	US
Teenage Birth Rate per 1,000 (2009)	50.6	39.1
Percent Low Birth-weight (2009)	9.2	8.2
Infant Mortality Rate per 1,000 (2005-2007)	8.6	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	4,300.8	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	787.9	566.0
HIV Diagnoses per 100,000 (2009)	17.2	17.4

Sexually Transmitted Infections

Sexually transmitted infection rates are higher than the national average among Tennessee women ages 15–19. In 2009, 4,300.8 per 100,000 Tennessee females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 518.4 and 478.8 per 100,000, respectively for Tennessee and the United States.²⁴⁷ The same pattern was observed for Gonorrhea.²⁴⁸ Overall, Tennessee ranked 10th and 12th among the 50 states, plus the District of Columbia, for Chlamydia and Gonorrhea for females ages 15–19, and 14th and 15th for the same sexually transmitted infections among females 20 years and older.

Tennessee has a slightly lower rate for HIV incidence than the United States. There were 17.2 new HIV cases per 100,000 people in Tennessee in 2009, compared to 17.4 per 100,000 for the U.S.²⁴⁹ Tennessee ranked 10th in HIV incidence in 2009, among all states for which comparable data were available.

244 Ventura, S.J. and Hamilton, B.E. (2011). *U.S. Teenage Birth Rate Resumes Decline*. National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

245 Guttmacher Institute. 2010. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

246 Centers for Disease Control and Prevention (CDC). 2010. *Youth Risk Behavior Surveillance—United States, 2009. Surveillance Summaries*. 2010. Morbidity & Mortality Weekly Report. 2010. 59 (SS-5). <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>, accessed September 13, 2011.

247 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

248 *Ibid.*

249 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

According to a 2011 study, 67.9 percent of unintended births in Tennessee were paid for by public dollars, compared to 64.0 percent nationally.²⁵⁰ The expenditure amount per unintended birth was estimated as \$11,647, the same as the United States.²⁵¹ The public costs of having a child before age 20 are high; in Tennessee, teenage childbearing cost taxpayers at least \$272 million.²⁵²

Population Size, Educational Attainment, and Poverty Data

Tennessee's poverty rate is high. Among children between the ages of 0–17, 24.0 percent are living in poverty versus 20 percent for the United States.²⁵³ The general population in Tennessee living in poverty is 17.2 percent versus the United States at 14.3 percent. Tennessee is ranked 8th in the nation for poverty as a whole and 11th for children ages 0–17. The population of Tennessee grew by 11.5 percent in the last decade.

Demographics	TN	US
Population in 2010	4,625,364	308,745,538
White (%)	75.6	63.7
African-American (%)	16.5	12.2
Hispanic (%)	4.6	16.3
Other (%)	3.3	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	23.1	28.2
Poverty Rate in 2009 (%)	17.2	14.3
Poverty Rate 0–17 year olds (%)	24.0	20.0

Although 83.6 percent of Tennessee's students graduate from high school,²⁵⁴ only 23.1 percent of Tennessee's residents 25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.²⁵⁵ Tennessee's 2010 average annual unemployment rate was slightly higher than the national figure (9.7% v.9.6%).²⁵⁶

250 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. . (2011). "The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates." *Perspectives on Sexual and Reproductive Health* 43 (2): 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

251 *Ibid.*

252 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-Tennessee.pdf>, accessed December 17, 2011. These are net cost, not gross costs.

253 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saipe/national.cgi?year=2009&ascii>, accessed December 17, 2011.

254 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

255 *Ibid.*

256 U.S. Department of Labor, Bureau of Labor Statistics. "Unemployment Rates for States." <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

Sexual Health Education

In 2010, Tennessee applied for all the new federal grant opportunities and was awarded a total of \$5,156,561. This grant money was distributed as follows: \$3,002,846 (or 58.2%) for TPP; \$1,012,182 (or 19.6%) for PREP; and \$1,141,533 (or 22.1%) for Title V abstinence-only initiatives.²⁵⁷ A higher percentage of funding in Tennessee went to support abstinence-only sex education than PREP programs, but less than TPP programs. Details of the projects supported by these grants are available online at SIECUS website.²⁵⁸

In Tennessee, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

257 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

258 SIECUS website <http://www.siecus.org/tennessee2010>, accessed December 28, 2011.

VIRGINIA: Sexual Health Profile



Sexual Health of Virginia Teenagers

Virginia has a lower teenage birth rate than the United States; in 2009, teenage birth rate was 31.0 per 1,000 among Virginia females ages 15–19, compared to 39.1 per 1,000 for the entire U.S.²⁵⁹ Virginia ranked 30th in teenage pregnancy rates among the 50 states and District of Columbia.²⁶⁰

Sexual Health Profile	VA	US
Teenage Birth Rate per 1,000 (2009)	31.0	39.1
Percent Low Birth-weight (2009)	8.3	8.2
Infant Mortality Rate per 1,000 (2005-2007)	7.4	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	3,173.2	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	606.3	566.0
HIV Diagnoses per 100,000 (2009)	17.2	17.4

Sexually Transmitted Infections

Sexually transmitted infection rates are about the same as the national average among Virginia women ages 15–19. In 2009, 3,173.2 per 100,000 Virginia females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 456.4 and 478.8 per 100,000, respectively for Virginia and the United States.²⁶¹ The same pattern was observed for Gonorrhea.²⁶² Overall, Virginia ranked 24th and 20th among the 50 states, plus the District of Columbia, for Chlamydia and Gonorrhea for females ages 15–19, and 27th and 23rd for the same sexually transmitted infections among females 20 years and older.

Virginia also has an HIV incidence rate roughly equal to the national average. There were 17.2 new HIV cases per 100,000 people in Virginia in 2009, compared to 17.4 per 100,000 for the US.²⁶³ Virginia ranked 10th in HIV incidence in 2009, among all states for which comparable data were available.

According to a 2011 study, 44.6 percent of unintended births in Virginia were paid for by public dollars, compared to 64.0 percent nationally.²⁶⁴ The expenditure amount per unintended birth was

259 Ventura, S.J. and Hamilton, B.E. (2011). *U.S. Teenage Birth Rate Resumes Decline*. National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

260 Guttmacher Institute. (2010). *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

261 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

262 *Ibid.*

263 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

264 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 43(2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

estimated as \$14,666 and \$11,647, respectively, for Virginia and the United States.²⁶⁵ The public costs of having a child before age 20 are high; in Virginia, teenage childbearing cost taxpayers at least \$215 million.²⁶⁶

Population Size, Educational Attainment, and Poverty Data

Virginia's poverty rate is high. Among children between the ages of 0–17, 14.0 percent are living in poverty versus 20 percent for the United States.²⁶⁷ The general population in Virginia living in poverty is 10.6 percent versus the United States at 14.3 percent. Virginia is ranked 33rd in the nation for poverty as a whole and 37th for children ages 0–17. The population of Virginia grew by 13.0 percent in the last decade.

Demographics	VA	US
Population in 2010	8,001,024	308,745,538
White (%)	64.8	63.7
African-American (%)	19	12.2
Hispanic (%)	7.9	16.3
Other (%)	8.3	7.8
Persons 25+ with Bachelor's Degrees or Higher in 2010 (%)	34.2	28.2
Poverty Rate in 2009 (%)	10.6	14.3
Poverty Rate 0–17 year olds (%)	14.0	20.0

Eighty-six and a half percent of Virginia's students graduate from high school,²⁶⁸ and 34.2 percent of Virginia's residents 25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.²⁶⁹ Virginia's 2010 average annual unemployment rate was lower than the national figure (6.9% v.9.6%).²⁷⁰

Sexual Health Education

In 2010, Virginia applied for all the new federal grant opportunities and was awarded a total of \$1,823,880. This grant money was distributed as follows: \$933,907 (or 51.2%) for PREP and

265 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 43(2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011..

266 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-Virginia.pdf>, accessed December 17, 2011. These are net cost, not gross costs.

267 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saipe/national.cgi?year=2009&ascii>, accessed December 17, 2011.

268 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

269 *Ibid.*

270 U.S. Department of Labor, Bureau of Labor Statistics. "Unemployment Rates for States." <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

\$889,973 (or 48.8%) for Title V abstinence-only initiatives.²⁷¹ Nearly half (48.8%) of Virginia's 2010 federal grant money went to pay for abstinence-only sex education. (Virginia is the only one of the 10 Southern states included in this report that did not receive a TPP grant in 2010.) Details of the projects supported by these grants are available online at SIECUS website.²⁷²

In Virginia, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

Success Stories: Galvanizing parental support for comprehensive sexuality education

The Virginia Board of Education has set standards of learning and guidelines for Family Life Education curriculum that can be implemented in schools. The guidelines, which are not mandated, promote parental involvement and abstinence, but do not include evidenced-based, medically accurate, age-appropriate sexual health education. Through separate campaigns, both NARAL Pro-Choice Virginia Foundation (NARAL)²⁷³ and Planned Parenthood Health Systems, Inc. (PPHS)²⁷⁴ determined the areas of Virginia in which sex education could be improved and are working to build local support for medically accurate, age-appropriate sexual health education programs.

NARAL created the Sex Education Awareness NOW! (SEdA NOW!) program, which convened a group of 10 coalition partners representing a diverse range of groups, including the domestic violence community, local churches, community revitalization organizations, local schools, local activists, and parents.²⁷⁵ NARAL also commissioned a poll of parents in three Virginia cities (Hopewell, Petersburg, and Colonial Heights), which found that 81 percent of Tri-Cities area parents with children in the public school system believe sex education should be taught in Tri-Cities area public schools beginning in at least middle school.²⁷⁶ NARAL has been sharing the poll results with elected officials, school officials, and school board members and is working with local media to publicize the poll results.

PPHS commissioned a poll of parents of school-aged children in Roanoke, Charlottesville,

271 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

272 SIECUS website <http://www.siecus.org/virginia2010>, accessed December 28, 2011.

273 The NARAL Pro-Choice Virginia Foundation website is <http://www.naralva.org/>.

274 The Planned Parenthood Health Systems, Inc. website is <http://www.plannedparenthood.org/health-systems/>.

275 **SEdA NOW! Partners include:** Annie Mickens, educator and former mayor of Petersburg; Curtis Johnson, minister at New First Baptist Church, Petersburg; Chana Ramsey, CEO of the James House (working in the areas of sexual assault and domestic violence), Petersburg; Susie Brown, former educator and community member, Petersburg; Jackie Owens, mentoring program coordinator at Pathways (community restoration organization), Petersburg; Reverend Betty Jackson, pastor at First Baptist Church, Petersburg; and Mark Kitchens, HIV/AIDS activist, Petersburg.

276 Public Policy Polling, 2010. Survey of 363 Roanoke City Schools parents and Survey of 445 Charlottesville City/ Albemarle County parents. www.publicpolicypolling.com.

and Albemarle County.²⁷⁷ The results indicate strong support for sexuality education in public schools and overwhelming recognition that such education is appropriate to teach at the middle-school level. After publicizing the poll results, PPHS met with Roanoke and Charlottesville school administrators and educators to discuss the poll results and teenage pregnancy rates, and PPHS educators were subsequently invited to train health educators in both Roanoke and Charlottesville.

PPHS hosted a sexuality education workshop for 43 of the 45 health educators at the elementary, middle, and high school levels in Roanoke in August 2010, including sessions on the importance of medically accurate, age-appropriate sexual health education and on how to talk about sexuality. In February 2011, PPHS hosted a similar workshop for 14 health educators in Charlottesville. Feedback was positive and PPHS presented how their programs can assist in school efforts to provide comprehensive sexuality education. PPHS educators have also facilitated the family life course for tenth, eleventh, and twelfth graders at Roanoke's William Flemming High School.

²⁷⁷ Public Policy Polling, 2010. Survey of 363 Roanoke City Schools parents and Survey of 445 Charlottesville City/Albemarle County parents. www.publicpolicypolling.com.



Sexual Health of West Virginia Teenagers

West Virginia high school students have a higher rate of teenage sexual activity than the national average: 53.6 percent vs. 46.0 percent.²⁷⁸ Reported condom use in 2009 is lower than the national average; 45.6 percent of West Virginia teenagers did not use a condom at last intercourse, compared to 38.9 percent of U.S. teenagers. Data from the 2009 Youth Risk Behavior Surveillance show that West Virginia teenagers were less likely to have used a condom at their most recent sexual intercourse than U.S. teenagers.²⁷⁹

Sexual Health Profile	WV	US
Teenage Pregnancy Rate per 1,000 (2005)	62.0	70.0
Teenage Birth Rate per 1,000 (2009)	49.8	39.1
Percent Low Birth-weight (2009)	9.5	8.2
Infant Mortality Rate per 1,000 (2005-2007)	7.5	6.8
Chlamydia Rate Among Teenage Women per 100,000 (2009)	1,869.0	3,314.7
Gonorrhea Rate Among Teenage Women per 100,000 (2009)	117.4	566.0
HIV Diagnoses per 100,000 (2009)	5.1	17.4

The same survey reported that 76.9 percent of sexually active West Virginia female teenagers reported that they did not use birth control pills before their last sexual encounter; the U.S. figure is 80.2 percent. West Virginia has higher teenage birth rates; in 2009, teenage birth rates were 49.8 per 1,000 among West Virginia females ages 15–19, compared to 39.1 per 1,000 for the entire US.²⁸⁰ West Virginia ranked 22nd in teenage pregnancy rates among the 50 states and District of Columbia.²⁸¹

Sexually Transmitted Infections

Sexually transmitted infection rates are lower among WV women ages 15–19, than in the U.S. as a whole. In 2009, 1,869.0 per 100,000 West Virginia females ages 15–19 were diagnosed with Chlamydia, compared to a national rate of 3,314.7 per 100,000. Among females age 20 and older, the Chlamydia rates were 222.7 and 478.8 per 100,000, respectively for West Virginia and the United States.²⁸² The same pattern was observed for Gonorrhea.²⁸³ Overall, West Virginia ranked 46th and 47th among the 50 states, plus the District of Columbia, for Chlamydia and Gonorrhea

278 Centers for Disease Control and Prevention (CDC). 2010. *Youth Risk Behavior Surveillance—United States, 2009. Surveillance Summaries*. 2010. Morbidity & Mortality Weekly Report. 2010. 59 (SS-5). <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>, accessed September 13, 2011.

279 *Ibid.*

280 Ventura, S.J. and Hamilton, B.E. (2011). *U.S. Teenage Birth Rate Resumes Decline*. National Center for Health Statistics 58. <http://www.cdc.gov/nchs/data/databriefs/db58.pdf>, accessed January 20, 2012.

281 Guttmacher Institute. 2010. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed December 17, 2011.

282 CDC's WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

283 *Ibid.*

for females ages 15–19, and 48th and 37th for the same sexually transmitted infections among females 20 years and older.

West Virginia also has a lower rate for HIV incidence than the United States. There were 5.1 new HIV cases per 100,000 people in West Virginia in 2009, compared to 17.4 per 100,000 for the U.S.²⁸⁴ West Virginia ranked 29th in HIV incidence in 2009, among all states for which comparable data were available.

According to a 2011 study, 72.1 percent of unintended births in West Virginia were paid for by public dollars, compared to 64.0 percent nationally. The expenditure amount per unintended birth was estimated as \$10,999 and \$11,647, respectively, for West Virginia and the United States.²⁸⁵ The public costs of having a child before age 20 versus having a child at age 20 or 21 are high. In 2008, teenage childbearing cost taxpayers at least \$67 million.²⁸⁶

Population Size, Educational Attainment, and Poverty Data

West Virginia’s poverty rate is high. Among children between the ages of 0–17, 24.1 percent are living in poverty versus 20 percent for the United States.²⁸⁷ The general population in West Virginia living in poverty is 17.8 percent versus the United States at 14.3 percent. The population of WV grew by only 2.5 percent in the last decade.

Demographics	WV	US
Population in 2010	1,852,994	308,745,538
White (%)	93.2	63.7
African-American (%)	3.4	12.2
Hispanic (%)	1.2	16.3
Other (%)	2.2	7.8
Unemployment Rate in 2010 (%)	9.1	9.6
Persons 25+ with Bachelor’s Degrees or Higher in 2010 (%)	17.5	28.2
Poverty Rate in 2009 (%)	17.8	14.3

Although 83.2 percent of West Virginia students graduate from high school,²⁸⁸ only 17.5 percent of West Virginia residents

284 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

285 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 43 (2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.

286 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/fact-sheet-west-virginia.pdf>, accessed December 17, 2011.

287 Census Bureau’s Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saiper/national.cgi?year=2009&ascii>, accessed December 17, 2011.

288 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012.

25 years and older had earned a bachelor's degree or higher, compared to 28.2 percent for the United States.²⁸⁹ West Virginia's 2010 average annual unemployment rate was slightly lower than the national figure (9.1% v.9.6%).²⁹⁰

Sexual Health Education

In 2010, West Virginia applied for all the new federal grant opportunities and was awarded a total of \$2,354,208. This grant money was distributed as follows: \$1,764,347 (or 74.9%) for TPP; \$276,094 (or 11.7%) for PREP; and \$313,767 (or 13.3%) for Title V abstinence-only initiatives.²⁹¹ A higher percentage of funding in West Virginia went to support abstinence-only sex education than PREP programs, but less than for TPP programs. In their grant proposals, West Virginia included state matching funds.²⁹² Details of the projects supported by these grants are available online at SIECUS website.²⁹³

In West Virginia, there are no legal barriers to providing students medically accurate, age-appropriate, sexual health education.

Sexual health advocacy through peer mentoring – A nurse success story

In Charleston, Capital High School's Nurse, Angie Cavendar, has always taken an active role in promoting improved mental and physical health for the students at her school. Along with other faculty and administration, she helps ensure that students are taught accurate information about sexual health in health classes. However, the small amount of time devoted to teaching sexual health has continually failed to meet the full needs of the students.

Nurse Cavendar reached out to numerous community and state organizations like the Adolescent Pregnancy Prevention Initiative (APPI) and WV Free and learned that a "Peer Mentor Group" might help students navigate difficult relationship and sexual health topics. Cavendar gained the support of Principal Clinton Giles, and help from a young, enthusiastic teacher, Tiffany McCann. The "Healthy Relationship Peer Mentor Club" was formed, with McCann as the advisor.

Each month focused on a new topic, including how to be a "peer mentor," healthy vs. abusive relationships, effective contraception methods and services at health clinics, emergency contraception and how to advocate for yourself and your peers. The "Healthy Relationships Peer

289 Calculated using data from the 2010 American Community Survey, Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 25, 2012..

290 U.S. Department of Labor, Bureau of Labor Statistics. "Unemployment Rates for States." <http://www.bls.gov/lau/lastrk10.htm>, accessed December 28, 2011.

291 Calculated using data from the Sexuality Information and Education Council of the United States (SIECUS), accessed August 12, 2011.

292 *Ibid.*

293 SIECUS website <http://www.siecus.org/westvirginia2010>, accessed December 28, 2011.

Mentor Club” ended the year with a field trip to West Virginia’s State Capitol, where students utilized their new advocacy skills by speaking with legislators, asking them to address problems that they saw amongst their peers. Problems they identified included high teenage pregnancy rates, lack of knowledge about STIs, low graduation rates, and a discriminatory environment that is not accepting of others’ differences. The students promised to “act as role models” within their school and asked legislators to address these concerns through policy that would allow teenagers to have “knowledge and access to effective contraception options” and ensure that “health education and safe sex is taught in schools at an early age.”

The “Healthy Relationships Peer Mentor Club” at Capital High School acted as a safe space for teenagers to learn and ask questions about relationships and sexual health.

APPENDIX B:

DATA AND METHODS

Data

This report is based on the review of refereed publications and other major works on sexual health in the United States, as well as analysis of data from the Census Bureau, the Centers for Diseases Control and Prevention, General Social Survey, and selected data from the public health departments of some states.

To compare data between and among states and regions, we selected only those sources for which similar information was available for the same year. Therefore, some data used here are relatively old compared to others. For example, we used teenage pregnancy rate data for the year 2005, which is the most recent year for which such data were available for all the states. Nonetheless, we also mention recent teenage pregnancy data for states which have such data.

Sociodemographic variables such as the total population and racial/ethnic composition are from the 2010 and 2000 Summary File 1 (SF1) of the last decennial censuses.^{294,295} Statistics on poverty were compiled from the Census Bureau's Small Area Income and Poverty Estimates (SAIPE) website.²⁹⁶

Teenage pregnancy information was compiled from a report published by the Guttmacher Institute in 2010 entitled "U.S. Teenage Pregnancies, Births, and Abortions: National and State Trends and Trends by Race" (Table 3.1).²⁹⁷ Teenage birth rates came from the Centers for Disease Control and Prevention's (CDC) National Vital Statistics Reports, Vol. 60: 1, entitled "Births: Final Data for 2009" (Tables 12 and B).²⁹⁸ Percent of low birth-weight babies came from the CDC's National Vital Statistics Reports, Volume 59: 1, released on December 8, 2010 under the title "Births: Final Data for 2008" (Table I-9).²⁹⁹

Infant mortality rate was obtained from the National Vital Statistics Reports, Volume 59: 6 released by the CDC on June 29, 2011 under the title "Infant Mortality Statistics from the 2007

294 U.S. Census Bureau's American Fact Finder website, Table DP-1: Profile of General Population and Housing Characteristics: 2010. <http://factfinder2.census.gov/>, accessed December 18, 2011.

295 U.S. Census Bureau's American Fact Finder website, DP-1: Profile of General Demographic Characteristics: 2000. <http://factfinder2.census.gov/>, accessed December 18, 2011.

296 Census Bureau's Small Area Income and Poverty Estimates website. <http://www.census.gov/cgi-bin/saипе/national.cgi?year=2009&ascii>, accessed December 17, 2011.

297 Guttmacher Institute. (2010). *U.S. Teenage Pregnancies, Births, and Abortions: National and State Trends and Trends by Race*. Table 3.1. <http://www.guttmacher.org/pubs/USTPTrends.pdf>, accessed December 18, 2011.

298 Martin JA, Hamilton BE, Ventura SJ, Osterman MJ, Kirmeyer S, Mathews TJ, and Wilson E. 2011. *Births: Final Data for 2009*. Vital Statistics Reports, Volume 60, Number 1. Tables 12 and B.

299 Centers for Disease Control and Prevention. (2010). Births: Final Data for 2008. National Vital Statistics Reports, Volume 59, Number 1. Table I-9. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01_tables.pdf, accessed December 17, 2011.

Period Linked Birth/Infant Death Data Set” (Table 3).³⁰⁰ Statistics on Chlamydia and gonorrhea were obtained from the CDC’s WONDER Database.³⁰¹ Likewise, HIV diagnosis data came from the CDC’s HIV Surveillance Report, Volume 21 (Table 19).³⁰²

Information on education came from the Census Bureau’s American Community Survey (ACS) for the year 2010.³⁰³ As with any survey statistics, ACS data are subject to sampling errors. Unemployment rate were obtained from the U.S. Department of Labor’s Bureau of Labor Statistics for 2010 (Table 1, Press Release of February 25, 2011 – USDL-11-0239).³⁰⁴

The data on the public cost of unintended pregnancy were from two sources. First, the data on the cost of teenage childbearing to states came from the figures published by the National Campaign to Prevent Teen and Unplanned Pregnancy in 2011.³⁰⁵ Percentage distributions of public cost of births resulting from intended and unintended pregnancies were obtained from a peer-reviewed article published by Adam Sonfield and colleagues in 2011.³⁰⁶

Methods

All variables were compiled in one file and classified by states. Then, regional indexes were computed for those variables for which sufficient information was available to do so. For example, the HIV rate in “Region A” was obtained by dividing the sum of new HIV cases reported in all states of that region divided by the total population of the reporting states in the same region times 100,000. This approach worked well for those variables for which adequate raw data were available.

Descriptive analysis on a number of data sets such as the American Community Survey and the General Social Survey was conducted to derive statistics that were not readily available from published data. Small sample size prevented running multivariate analysis on the compiled data set; rather, we evaluated peer-reviewed publications with relevant information to show the association between sexual health variables and sociodemographic factors analyzed.

300 Matthews, T.J. and MacDorman, M.F. (2011). Infant Mortality Statistics from the 2007 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports, Volume 59, Number 6, released by CDC on June 29, 2011. Table 3. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_06.pdf, accessed December 18, 2011.

301 CDC’s WONDER Database website. <http://wonder.cdc.gov/controller/datarequest/D57;jsessionid=6E97AC5B24CF0A9E538C95027B5F6F9F?stage=results&action=hide&measure=D57.M2>, accessed December 18, 2011.

302 Centers for Disease Control and Prevention. 2009. *HIV Surveillance Report*. Vol. 21. Table 19. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf>, accessed December 18, 2011.

303 The 2010 American Community Survey. Table S1501 in the Census Fact Finder site. <http://factfinder.census.gov/>, accessed February 24, 2012.

304 U.S. Department of Labor’s Bureau of Labor Statistics for the year 2010 (Table 1, Press Release of February 25, 2011 – USDL-11-0239). http://www.bls.gov/news.release/archives/srgune_02252011.pdf, accessed December 18, 2011.

305 The public costs of teen childbearing obtained from the National Campaign to Prevent Teen and Unplanned Pregnancy website. <http://www.thenationalcampaign.org/costs/#AL>, accessed December 17, 2011.

306 Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The Public Costs of Birth Resulting from Unintended Pregnancies: National and State-Level Estimates. *Perspectives on Sexual and Reproductive Health* 43(2), 94-102. <http://www.guttmacher.org/pubs/journals/4309411.html>, accessed December 17, 2011.



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