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# STRICTS

R E P O R T

CULTURALLY COMPETENT SEXUALITY EDUCATION:  
EDUCATING AND EMPOWERING COMMUNITIES

WINTER 2004

# SIECUS

## R E P O R T

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## TAKING CULTURE INTO ACCOUNT

Tamar Kreinin, M.H.S.A.

I am particularly excited about this issue of the *SIECUS Report* because it is made up entirely of resources, recommendations, and examples from the field. Throughout my career, I have found that nothing re-energizes my own work as much as hearing about the exciting activities that others in this field are undertaking.

In recent years, SIECUS has made a point of bringing our readers more examples of ground-breaking programs from across the country and around the world. We began with a publication from our family project called *Innovative Approaches to Increase Parent-Child Communication about Sexuality: Their Impact and Examples from the Field*. This publication looked at research on parent-child communication and highlighted diverse programs that took a variety of approaches to this subject. More recently we dedicated an issue of this journal to spotlighting integrated programs that overcame funding and other barriers to simultaneously address HIV, STDs, and unintended pregnancy among teens.

For this issue, we wanted to take a different approach and examine culturally competent programs that are working to both inform and empower a community by targeting the activities and materials to a specific group. The issue of cultural competency is particularly relevant today as many communities are facing increased immigration and/or migration, and overall changes in demographics.

## COMMUNITIES OF COLOR

When we talk about culturally competent prevention interventions, whether they focus on HIV, STDs, or unintended pregnancy, we often talk about traditionally underserved communities and think largely of communities of color.

This is understandable because these communities face disproportionate rates of STDs and teen pregnancy. For example, while the United States Census reports that Blacks represent 13 percent of the population, 42 percent of people living with AIDS in 2002 were Black.<sup>1</sup> In addition, while the overall teen pregnancy rate decreased by 25.5 percent between 1990 and 1999, the teen pregnancy rate among Latinas declined only 14.6 percent during that same period.<sup>2</sup>

The reasons for these disparities are clearly rooted in the complex social, economic, and political landscape of our nation and are difficult to understand completely. Still, the

Centers for Disease Control and Prevention suggest several important factors including the distribution of poverty, availability and quality of health care, the level of drug use in some communities, multiple sexual partners, and sexual networks with high STD prevalence.

While these communities continue to struggle, the problems of STDs, HIV, and unintended pregnancy are not limited to those areas that have traditionally been underserved.

## WE ARE ALL UNDERSERVED

In fact, the unfortunate truth today is that we are all, to some degree, underserved when it comes to prevention efforts. The federal government has chosen to allow ideology to trump science by continuing to invest exorbitant sums of money in unproven abstinence-only-until-marriage programs. At the same time, they placed restrictions on science-based HIV-prevention programs both domestically and abroad. States are facing some of the worst fiscal crises in recent memory and many state-funded prevention programs have had their budgets dramatically reduced if not slashed entirely. On the local level, resource-strapped schools that are being forced to “teach to the test” are cutting health and prevention programs in order to spend more time focusing on core topics such as math and reading.

When it comes to providing high-quality sexuality education and helping both youth and adults prevent unintended pregnancy and STDs, including HIV, we are in essence a nation made up of underserved communities. Certainly some communities have more resources and are faring better than others; nonetheless we need to do better everywhere and for everyone.

## ASPECTS OF CULTURE

We have always believed that providing good programs starts with meeting a community where they are and targeting the activities and materials not only to the community’s needs but to their culture as well. Communities may share the common bond of race or ethnicity but there are many other aspects of culture that should be considered such as language, traditions, values, religion, norms, gender roles, immigration, acculturation, family structure, health beliefs, and political power.

Each of these issues can play an important role in how individuals make decisions that affect their sexual health and may need to be addressed or at least understood when planning a prevention program. One powerful example of this is a study conducted a few years ago with Hmong-American adolescents. A majority of these students had accurate basic knowledge of STDs and HIV—87 percent knew that you could get an STD from having sex and 80 percent knew that you could not get AIDS from a toilet seat or a public phone. At the same time, 70 percent of participants believed that there was a tree in Laos that could prevent them from getting “the AIDS virus” if they drank a tea made from its leaves, and 50 percent believed that if they ate a lot of hot peppers they would not get AIDS.<sup>3</sup> No intervention with this group of teens would be complete or effective without addressing these beliefs.

In order to be effective, however, program planners need to focus on much more than just health-related knowledge or behavior. They need to know such simple things as what language or dialect is spoken and which expressions or gestures are commonly used and accepted. Planners also need to be aware of other cultural communication issues that might be harder to recognize such as issues of whether eye contact is viewed as polite or rude or if emotions are freely expressed.

### CULTURAL COMPETENCE

Many phrases have been used to describe programs that take these issues into account from *cultural awareness* to *cultural sensitivity* to *cultural competence*. In some ways discussing cultural competence ensures that a program will be lacking. The phrase implies outsiders coming into a community and figuring out how to do what they want, rather than what the community wants and needs. It is important to recognize that cultural competence involves such things as language, images that reflect the community, and lessons that take community values into account. But it should go beyond that as we see in many of the programs highlighted in this issue. The community should be involved in shaping the program as is described in “Gay-Boy Talk” and “Cultivating Advocates.” Staffing should reflect the community as discussed in the descriptions of *Set the P.A.C.E.!* and the

*Promotoras* projects. And projects must be willing to adjust like the *Hablando Claro* program did by allowing participants to help determine the course.

The ultimate goal remains knowing the audience and tailoring the intervention to that audience, whether it is a group of young people bonded by youth culture, a community of adults who speak the same language, or a group of young men who have sex with men who come from different backgrounds but share common experiences.

### PROGRAM HIGHLIGHTS

For this issue we solicited information on programs across the country that were doing just that—targeting a specific group of people in order to talk to them most effectively. The programs that we found work with young people and adults in communities bound together by race, ethnicity, religion, experience, and geographical location. We found programs that were teaching fathers and sons to communicate, girls of all ages to be critical thinkers, and adult members of communities to be ambassadors for reproductive health. We found traditional curriculum-based intervention and new ideas such as radio broadcasts.

Most importantly, however, we confirmed our belief that there are numerous dedicated individuals and organizations across the country working to make sexual health a reality in their community. I hope that you are as inspired as I am by these examples of programs that are educating and empowering our communities.

1. U.S. Census Bureau, *Race and Hispanic or Latino, 2000*, April 2000; and Centers for Disease Control and Prevention, *HIV Surveillance Report 2002*, vol. 14.
2. National Campaign to Prevent Teen Pregnancy, “Fact Sheet: Teen Sexual Activity, Pregnancy and Childbearing Among Latinos in the United States,” 2003, accessed on line at [www.teenpregnancy.org](http://www.teenpregnancy.org) on Feb. 6, 2004.
3. B.E. Robinson, et al., “HIV/STD Knowledge, Attitudes, and Risk Behaviors in Hmong-American Adolescents: An Unstudied Population,” *Journal of Sex Education and Therapy*, 24, nos. 1& 2, (1999) 37–46.

# CULTIVATING ADVOCATES IN UNDERSERVED COMMUNITIES

**Desiree Flores**

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**I**n 2001, the Ms. Foundation for Women developed *New Partners, New Initiatives: Improving Youth Access to Sexuality Education and Services*, a program designed to increase community-based advocacy for improved access to sexuality education and services for young people by groups representing non-typical advocates.

This three-year initiative, in partnership with the David and Lucile Packard Foundation, provides funds, technical assistance, networking, and learning opportunities to six groups in underserved communities (three groups in Arizona and three in Washington). The project seeks to galvanize existing but silent support and bring new actors into the movement to secure reproductive freedom in this country.

## THE ROOTS OF THE PROJECT

The seeds of this project go back to 1989. The U.S. Supreme Court ruling in *Webster vs. Reproductive Health Services* gave broader power to states in regulating reproductive health. In response, the Ms. Foundation for Women created the Reproductive Rights Coalition and Organizing Fund (RRCOF) to build a strong community-based movement in support of reproductive choice by supporting the legislative work of state coalitions.

In 1999, RRCOF commissioned *Social Movements and Grassroots Organizing: Lessons for Reproductive Rights and Health Organizations*, a study that looked at the civil rights movement, women's movement, environmental justice movement, and the conservative right to determine the factors necessary to build a successful community-centered movement. Based on this study's findings, the Ms. Foundation expanded the original strategy, deepened its technical assistance to coalitions, and broadened its grantmaking scope to support a wide range of grassroots organizing structures.

RRCOF now complements its work with state reproductive rights coalitions by supporting other community-based mobilizing structures that link their grassroots organizing to policy or institutional change. In an effort to embrace and activate a wider constituency, many of the groups frame their messages in broader social justice language and work to highlight the connections between reproductive rights and other community concerns.

*New Partners, New Initiatives* grew out of lessons learned over the past two decades. By engaging non-traditional advocates and highlighting sexuality education, an issue of concern to most young people, and one that has significant support among the general public, the project is working to secure not just access to sexuality education but reproductive freedom across this country.

## FINDING NEW ADVOCATES

Conservative groups have used young people's access to reproductive health services as a particularly effective tool to chip away at general access to these services. These attacks—parental notification, “informed consent,” “child custody protection,” and abstinence education—are crafted to appear innocuous, even beneficial to young people. At their heart, however, is the intent to broadly limit access to abortion and other reproductive healthcare.

Focusing on sexuality education holds great promise for addressing these restrictions and advancing a proactive reproductive health agenda. A key component for ensuring reproductive health, sexuality education enjoys broad-based support in the United States. This issue has proven to be an effective tool for galvanizing young people in and out of high schools and has the potential to link health services, education, and advocacy groups in new ways. In addition, the community monitoring and mapping skills needed to mount an effective campaign in support of sexuality education and the links between these local priorities and state and federal legislation can be transferred to other reproductive health issues.

After extensive explorations and discussions with national and state-level actors involved in adolescent pregnancy prevention, reproductive health and rights, and broader social justice work, the Ms. Foundation for Women recommended focusing this project in Washington and Arizona. These states offered a diverse group of potential grantees and ones that might serve as models to others in the region as well as nationwide. These states also offered different political contexts for advocacy efforts around sexuality education. Washington enjoys a strong infrastructure both in terms of youth organizing and the broader reproductive health and rights movement. It is a relatively liberal state with a state legislature that is receptive to changes in their

sexuality education policies. In contrast, Arizona has a weaker progressive infrastructure, a higher teen pregnancy rate (the third-highest in the country), and more restrictive policies for adolescents.

All of the grantees in Washington hail from the eastern and more rural part of the state. Eastern Washington contrasts with the more urban, western part of the state (including Seattle, Tacoma, and Olympia) that has traditionally housed clusters of progressive activity such as community education, advocacy, and youth organizing. All of the grantees in Arizona are situated in the southern part of the state. Arizona's placement along the U.S.–Mexico border lends a violent edge to the state's race politics, including the rise of militias and vigilantes who have committed themselves to policing undocumented immigrants. By selecting states and communities with different demographics and political contexts, we hoped to demonstrate the importance and potential for this organizing model in diverse contexts.

### THE APPROACH

Operating on the theory that many people who care about reproductive rights would—but currently do not—participate in the struggle to preserve and expand those rights, *The New Partners, New Initiatives* project aims to:

1. Broaden the base of people willing and prepared to stand up in defense of comprehensive, accessible sexuality education, particularly in low-income communities and communities of color.
2. Help groups build a wide range of alliances on reproductive rights issues, including school administrators and teachers, parents, reproductive health organizations, youth organizations and others.
3. Emphasize the importance of non-traditional constituencies in debates about access to services and education.
4. Bolster local advocacy capacity to hold public officials accountable.

This project works to ensure that young people have access to essential information and services and brings new constituencies (working together across generations) to support reproductive/sexual rights. *New Partners, New Initiatives* encourages organizations with strong ties to their communities to develop their own activities that promote more active local support for sexuality education. Together, these groups can systematically advocate for young people's needs and rights to information and services as well as build alliances to address existing barriers.

All of the grantees represent non-traditional partners or members of underserved and low-income communities. The project aims to show that communities can effect change at

the state and local level regardless of their makeup. This project also aims to prove that the power to frame the debate, the language, and the support for sexuality education and reproductive rights can lie within the community itself as well as within each of its members.

As part of this project, the Ms. Foundation is working with the Applied Research Center (ARC), a public policy, educational, and research institute whose work emphasizes issues of race and social change. ARC works as an outside evaluator to both build the skills of participating grantee organizations and provide an independent perspective on the project's accomplishments. The following challenges and lessons learned are based on some of their reflections.

### UNIQUE CHALLENGES

It is important to remember that these advocates face the unique challenges of working in small, underserved, and rural communities. For example, the communities in which these grantees operate are those that have been specifically targeted by conservative organizations like the Christian Coalition and Operation Rescue since the early 1980s. While conservative constituencies are not necessarily large, they are vocal and effective in addressing incidents and policy matters within a variety of private and public institutions, such as both public and private schools.

In addition, there are long traditions of political disengagement in underserved communities that create an intimidating impression of what it means to do policy work. These external factors, many of which preceded the founding of the grantee organizations, influence the speed and visibility with which groups publicly push their issues. They face real threats of retaliation for activities that would be more easily tolerated in settings with a longer history of work on these issues. Acknowledging factors such as these suggests that the path to building a politically active constituency outside of major urban centers may take different forms and proceed at a different pace.

Each victory resonates even stronger when put into this context. And in fact, the groups have been able to make real progress and provide education to communities that are otherwise ill-served by schools and public health systems not designed to meet the needs of young people in racially diverse, rural, or low-income communities. Perhaps the most exciting work to come out of this project thus far, however, has been the way in which many of these groups have begun to transform community perception around sexuality education starting with their own internal organizational structures. They are also becoming visible partners and advocates for changes in how sexuality education is (or is not) provided in the schools, in their communities and, in Washington, across the state.

## INNOVATIVE IDEAS

For example, the Arizona group, Luz Social Services, introduced the “*Conocimiento es Poder*” or the “Knowledge is Power” civics class. As part of basic lessons on civic and civil rights, students do research in their communities and, as an example, learn about the Supreme Court through discussions of *Roe v. Wade*. By not taking a specific position, but rather outlining the issues involved and how decisions are made, the students engage in in-depth discussions of reproductive rights issues while learning about civics. Project staff have also been creative about engaging the community. They have found their most effective vehicle has been an end-of-year celebration of the students’ work that includes a community banquet and presentations by the students on their projects. The event is televised to the broader community. This year several students spoke about teen pregnancy and critiqued federal and state policies supporting abstinence-only programs. This is a large step in a community that has relied on abstinence-only funding.

Another example is the Washington group, Odyssey Youth Center. Started as an anonymous teen drop-in center, they have, with *New Partners* support, emerged as a strong advocate in local policy and advocacy efforts related to sexuality education. This past year, the group took a stand against a Teen Aid-sponsored abstinence rally in a Washington school district. The group drafted a letter of concern to the ACLU, handed out flyers about comprehensive sexuality education at the event, and had youth members write letters to local newspapers. Odyssey Youth have also been involved in educational and outreach efforts in support of comprehensive, medically accurate, age-appropriate sexuality education programs in Washington’s public schools. These organizing efforts led to local press coverage, the establishment of a Gay-Straight Alliance in a local high school, and increased inclusion of

lesbian, gay, bisexual, and questioning (LGBTQ) youth at community events.

## LESSONS LEARNED

These are just a few ways that groups at the local level are seizing leadership around the issue of sexuality education in their communities. The *New Partners, New Initiatives Project* is ongoing but we have already learned some concrete lessons about supporting organizing efforts in underserved communities. First, the act of creating a sexuality education curriculum that is specifically tailored to a particular community is an important step in establishing organizational commitment to the issue. This first step allows grantees to begin providing services that would be otherwise unavailable to their communities. Grantees have often found it important to tailor existing curricula or create a new curriculum that speaks to the needs of their communities and, in several cases, to link sexuality education to broader cultural struggles. In fact, many of the curricula include explicit information and activities focused on social change.

In small and rural communities, the role of personal relationships in community work is critical. For this reason alliances—with each other, with other local and regional organizations, and with national groups such as SIECUS—are key to helping community-based organizations solve problems and fight isolation.

We expect to share these and other more detailed lessons as we work to expand the base of support for sexuality education as well as the many other issues under the umbrella of reproductive rights. We hope that the fact that the organizations involved in this work are not traditionally identified as reproductive rights advocates will garner the attention of other social movements seeking to expand their constituencies and advocacy efforts in communities with fewer resources.

## NEW PARTNERS, NEW INITIATIVES GRANTEES

### WASHINGTON

#### *Family Planning of Chelan Douglas—Wenatchee, WA*

This nonprofit family planning clinic has served north-central Washington for almost 30 years. Family Planning of Chelan Douglas (FPCD) is a full-service family planning clinic for women and men. However, it does not provide abortion services on site, instead referring women to Seattle and Spokane. Its *New Partners* project involves mother-daughter groups that meet with a sexuality educator from FPCD for a series of discussions

and question-and-answer sessions. These groups are available in both English and Spanish.

In addition, FPCD provides speakers and programs for local middle and high schools, and is now beginning to train graduates from its programs in advocacy and activism. FPCD hosted an advocacy training session that was attended by more than 45 young people and adults from the community.

#### *Northwest Community Education Center—Granger, WA*

NCEC is the home of Radio KDNA—the oldest and largest Spanish-speaking community radio station in

Washington, serving a five-county region focused on the Yakima Valley (south-central WA). Started as a farm worker education and advocacy project, NCEC has literacy and ESL programs, GED certification classes, computer literacy programs, citizenship classes, and radio programming that encourage community participation and “the right-to-know.”

Their *New Partners* work engages students in middle and high schools in establishing a parent and community advisory board and building youth advocates for sexuality education. In addition, they use the radio station for a youth talk radio program and a radio “novella” that deals with sexuality education issues.

#### ***Odyssey Youth Center—Spokane, WA***

Odyssey is a relatively new LGBTQ youth outreach and education center, providing safe space for sexual minority youth from eastern Washington, northern Idaho, and western Montana. Its *New Partners* project involves youth panels speaking to middle and high schools, on-site training for youth, and youth leadership development in sexuality education. It utilizes paid interns to create programs. Odyssey has just won the *Chase Youth Leadership Award* from the city of Spokane. To further the consistency and accuracy of curricula throughout Spokane Valley, staff serve on many school and community curricula committees. Staff and youth have emerged as an active advocacy voice in local debates and forums concerned with sexuality education.

## **ARIZONA**

#### ***Luz Social Services—Tucson, AZ***

Luz is a large service organization that provides direct services, education, community development, and drug abuse prevention through its offices in Tucson and the rural mining towns to the northeast of Tucson. Luz also runs charter middle and high schools that serve the predominately Latino and largely low-income west and south side neighborhoods of Tucson. Luz’ program provides two year-long classes in their charter high school. The first is *Conocimiento es Salud/Knowledge is Health*, a health class that investigates Latino health and includes sexual health as a main topic. Sexual health issues include teen pregnancy, HIV and STD awareness, violence, body image, traditional healing, and public policy. *Conocimiento es Poder/Knowledge is Power* is a civics class that looks at the history of grassroots

civic participation, including movements such as the farm worker and Chicano movements. Consideration of reproductive health and sexual self-determination are included as part of that review.

#### ***Omeyocan YES (a project of the Southern Arizona AIDS Foundation)—Tucson, AZ***

*Omeyocan Youth Empowerment and Sexuality (Omeyocan YES)*, is a mixed-gender holistic prevention project designed to stem the rise of HIV among young (high-school age) Latinas in Tucson. The emphasis of the program is on the development of optimal health of mind, body, spirit, and community with a focus on leadership and advocacy training. Participating youth are all low-income, and live in socioeconomically disadvantaged areas including the City of South Tucson, the south side of Tucson, and the central area barrios. Omeyocan staff designed and facilitate a comprehensive formal sexuality education curriculum that reinforces the Chicana/o and indigenous cultural norms that provide the basis for balanced sexual health. The curriculum, as well as complementing advocacy skills, are now taught at local charter schools and in several after-school programs.

#### ***Southeastern Arizona Behavioral Health Services (SEABHS) New Turf Prevention’s Youth Advocates—Sierra Vista, AZ***

Southeastern Arizona Behavioral Health Services (SEABHS) is a large behavioral and mental health service provider for four rural counties to the south and east of Tucson. New Turf Prevention is SEABHS’ prevention division, providing community development assistance and substance abuse/gang/violence-prevention services to the same area. The area includes three U.S.–Mexico ports of entry, small ranching and agricultural towns, tourist destinations, and a large military base.

The New Turf Youth Advocates facilitate teams of active youth in each rural town to develop internal organizational and youth capacity around sexuality education and other issues of importance to young people in these communities. Issues addressed range from increasing parent consciousness of youth sexuality, to addressing the basic sexual health infrastructure, such as rape crisis response, to working with a middle school on including sexual development information.

# ADDRESSING HIV/AIDS LATINO PERSPECTIVES AND POLICY RECOMMENDATIONS

National Alliance of State  
and Territorial AIDS Directors

Washington, DC

**E**ditor's Note: In July 2003, the National Alliance of State and Territorial AIDS Directors (NASTAD) published a report that provides recommendations on how to develop programs and policies to effectively address the AIDS epidemic among Latinos.

NASTAD recommends offering ongoing training consultation to Latinos about HIV prevention and care-planning; creating public information and awareness campaigns that educate Latinos about their rights and available local services; and developing Latino leadership and expertise within government at the local, state, and national levels.

The report was developed by NASTAD's Latino Advisory Committee, staff, and consultants. Dr. George Ayala and Monica Nuño of AIDS Project Los Angeles served as primary authors. We have reprinted the Executive Summary of the report in its entirety with permission from NASTAD. To read the complete document visit NASTAD's web site at [www.nastad.org](http://www.nastad.org). For more information contact Alberto M. Santana, MS, HIV Prevention Program Manager, NASTAD, 444 North Capitol Street, N.W., Suite 339, Washington, D.C. 20001-1512; phone: 202/434.8090; fax: 202/434.8092.

## EXECUTIVE SUMMARY

The HIV/AIDS epidemic among Latinos in the United States is as complicated as Latinos are diverse. The term Latino is a politically useful umbrella term with a potentially unifying effect. While useful, the term Latino masks significant differences among the populations included in the term: Mexican Americans (currently 60% of the Latino population), Puerto Ricans (about 15%), Cuban Americans (about 10%) and immigrants from the Dominican Republic, Central America, and South America. Latinos have settled in many parts of the country, including the Midwest and Northwest. Chicago, with 750,000 Latinos, now has the third largest Latino population in the country. Hence, the HIV/AIDS epidemic among Latinos is shaped by ethnic/cultural differences, migration, immigration policy, socioeconomic status, regional differences (Border States, Puerto Rico, air-bridge cities), and geography (rural vs. urban), as well as behavioral risk.

Latinos are now officially the largest ethnic/racial minority group in the U.S. (13% of the population), and account for 20% of persons living with AIDS, 19% of the

cumulative AIDS cases reported through December 2001, and 19% of cases reported in 2001. Although men continue to make up the majority (80%) of AIDS cases among Latinos, Latina women represent a growing share of new AIDS cases reported among all Latinos each year.

Changing trends in the Latino population create specific demands on service delivery systems and require creative, coordinated and consistent uses of public resources. Moreover, resource allocations must keep pace with changes in the epidemic as well as population shifts.

Access to appropriate health care is hampered by numerous factors including: funding, stigma, racial discrimination, prejudice, fear of deportation, cultural and linguistic insensitivity, lack of knowledge about rights and available entitlements, quality of programming, and weak or fragile community-based capacity. There is a need to protect and enhance public insurance programs like the Ryan White CARE Act (RWCA) and the AIDS Drug Assistance Program (ADAP), given the relatively large proportions of Latinos dependent on these programs for care and treatment services. HIV prevention is under-funded and there are too few evidence-based interventions available to community-based providers targeting Latinos, especially Latinos at highest risk for HIV infection, namely, Latino men who have sex with men and injection drug users.

In some jurisdictions, community/participatory-planning processes<sup>1</sup> have been less than effective in addressing the specific HIV/AIDS prevention, care and treatment needs of Latinos. Latinos are not well represented on some planning bodies. Language barriers and the unwillingness or inability to provide interpretation services keep Latinos away. There is a continued divide between community stakeholders (planning members, community providers, consumers) and government (health departments), with many community stakeholders expressing suspicion about the actions of governmental officials. Suspicion expressed is rooted in histories of unethical and hurtful treatment of Latinos in public policies and research. Tokenism (the practice of making only a perfunctory effort or symbolic gesture towards accomplishing representation on planning bodies), the lack of ongoing training for planners, the unchecked politics of planning and the resulting lack of specificity in care and prevention plans all conspire to create planning processes that are less than adequate.

Latino communities are sometimes divided. Collaboration is often undermined by competition over limited resources, cultural and class differences, homophobia, and differences in philosophical approach. The bureaucratization<sup>2</sup> of the AIDS industry has created a disconnect between grassroots advocates and professionals, producing apathy on the part of highly impacted segments of the Latino population and making community mobilization difficult. This is troubling in light of some evidence that highlights the importance of community involvement and social activism at the grassroots level in promoting ownership of the issues. In some states or jurisdictions with large Latino populations there is a need to mobilize large, ethnically diverse and sometimes fractured Latino communities, to inspire their confidence and trust in the public health response to HIV/AIDS.

Race continues to be understood in dichotomous terms, Black and White. Latinos are often categorized or asked to self-select into racial groups, usually White or Black. Since racial categories are socially constructed, being “racialized” makes little sense to many Latinos for whom race has little salience. As a result, African Americans, Latinos and other people of color often feel pitted against each other, usually in competition for limited resources and political status, fueling already contentious planning processes and shutting down the possibility of multiracial/ethnic collaboration.

This policy document contains recommendations that can be used by governors, legislators, national partners, health departments and AIDS directors to address the challenges associated with HIV/AIDS in Latino communities discussed in further detail below. Recommendations offered are based on key issues that emerged from six months of research conducted in preparation for the development of this document. An extensive literature review was conducted in the following areas: policy, HIV/AIDS prevention, health services, and epidemiological research. In addition, 19 brief semi-structured phone interviews were conducted, audio taped and transcribed. Key informants were randomly selected from a master list provided by NASTAD of more than 100 Latinos from around the country, including Puerto Rico. Key informants included public health officials, behavioral/social scientists, community planning leaders, and staff from community-based organizations in large Latino population states and local jurisdictions and states and local jurisdictions where Latino populations were smaller and/or undergoing dramatic growth.

Twenty-five recommendations are offered that can be organized into six categories, and summarized as follows:

## **1. Work to improve access to prevention, care, and treatment services for Latinos regardless of their immigration or citizen status.**

- Provide additional resources to support services to Latinos, including increased funding to Puerto Rico and states currently experiencing dramatic increases in Latino populations. Create, fund, and sustain services tailored to monolingual Spanish speaking and migrant/immigrant Latinos without regard to citizenship status. Create and support HIV prevention and care services to Latinos in and transitioning from correctional settings.
- Work to improve the coordination of services within and between states/territories and local jurisdictions.
- Combine RWCA/ADAP with state and local resources to expand prescription drug and medical services for uninsured Latinos.
- Support increased funding for the National Minority HIV/AIDS Initiative (MHAI). Now in its fourth year, the MHAI is a critical tool in the national efforts to eliminate HIV/AIDS related health disparities among racial and ethnic groups.
- Develop resource allocation methodologies that are consistent with, and that anticipate, local need. States, territorial and local health departments should work in close collaboration with planning bodies to ensure that resource allocations are commensurate with systematically demonstrated need.
- Support basic HIV/AIDS educational efforts targeting Latinos. Information about HIV/AIDS including modes of exposure, strategies for preventing HIV infection, the natural history of the disease, the importance of early detection and early treatment, and current treatment approaches should be broadly disseminated and constantly updated.
- Create public information and awareness campaigns that educate Latinos about their rights and entitlements as well as the availability and location of services locally.
- Build and support local, community-based capacity.
- Establish and uphold the highest standards for culturally competent care.
- Provide and support cultural competency training.

## **2. Make participatory planning processes more responsive to Latinos.**

- Request and endorse a broader range of participatory mechanisms and greater clarity from the CDC and HRSA regarding the roles of various stakeholders in planning processes.
- Actively guard against conflict of interest when seating a community planning group or planning council.

- Offer ongoing training and consultation to Latinos about planning.
- Offer interpretation services whenever possible and appropriate.

### **3. Tap into, develop, and support Latino leadership.**

- Acknowledge and seek out the contributions and counsel of Latino leaders regarding critical public health issues and decisions affecting Latino communities.
- Develop Latino leadership and expertise inside of health departments at the state and local levels and within federal agencies at the national level.
- Build and support advocacy capacity in Latino communities on policy issues.

### **4. Organize and mobilize Latinos.**

- Encourage and support coalition work within Latino communities and between Latinos and other people of color.

### **5. Support local and national research.**

- Identify opportunities and resources for research.
- Support formative research as part of the program design and development process.
- Promote a strong research/practice interface. Community-based research should, by design, create genuine opportu-

nities for meaningful input and involvement of Latinos beginning with the definition of the problem and including research design, analysis and interpretation.

- Collect and report user-friendly data on Latinos for planning and program development purposes.

### **6. Consider establishing international collaborations.**

- Establish bi-lateral memorandum of understanding (MOU) with health departments in Mexico, Puerto Rico, the Dominican Republic, Cuba, and countries in the Caribbean, South and Central America as appropriate.
- Engage and support Latin American consulates to deliver public health and HIV prevention messages to Latinos.
- Actively engage non-governmental organizations working to address HIV/AIDS in Latin American countries.

It is our hope that health departments and other public health officials at the state and federal levels will find these recommendations useful as they formulate proactive responses to the epidemic within Latino communities in their respective jurisdictions.

1. References to planning processes in this document will refer to the activities of both Ryan White CARE Planning Councils and HIV Prevention Community Planning Groups unless otherwise specified.
2. The term “bureaucratization” refers to the creation of administrative systems, marked by hierarchical authority among numerous offices, in which the need or inclination to follow rigid or complex procedures impedes effective action.

## **NEW RESOURCE FROM ADVOCATES FOR YOUTH**

The January 2004 issue of *Transitions*, a publication of Advocates For Youth, focuses on serving youth of color. The publication includes information on Asian and Pacific Islander Youth, Latino Youth, and GLBTQ Youth. Articles discuss social justice, culturally competent programs, barriers to care, masculinity, partner communication, and prevention through the arts. The publication also includes a lesson plan on negotiating sexual risk reduction and pieces written by youth advocates.

*For more information: Advocates for Youth, 2000 M Street, NW, Washington, D.C., 20036, phone: 202/419-3420, [www.advocatesforyouth.org](http://www.advocatesforyouth.org)*

# IN THEIR OWN WORDS: SEXUALITY WITHIN BLACK URBAN YOUTH CULTURE

MEE Production  
Philadelphia, PA

**B**lack inner-city youth have expressed their struggles around sexuality in their actions and their words. Within low-income Black urban youth culture, engaging in early sexual relations and participating in risky sexual behaviors have become a reality. Such activity is not necessarily viewed as unhealthy, negative, or wrong—at least from the youth perspective. They are having sex earlier than ever, often with serial multiple partners. These youth do not use condoms consistently and they often drink alcohol or use drugs before or during sexual activity. Yet somehow, they still do not perceive themselves as truly at risk for HIV/AIDS or other sexually transmitted diseases.

MEE wanted to understand how Black urban youth are being affected by the negative, conflicting, and often destructive messages about sex and sexuality that they see and hear. This effort resulted in *This is My Reality: The Price of Sex*, a report that provides a unique opportunity to add young people's voices to the dialogue about sex in America's inner cities.

The report reflects the lives of Black urban youth and young adults, ages 16–20, from households with less than \$25,000 in annual income. The year-long data-gathering process included a literature review, expert interviews, more than 40 focus groups, and a media consumption and lifestyle survey of 2,000 individuals. Research sites included Baltimore, MD; New York, NY; Los Angeles/Long Beach and Oakland/Richmond, CA; Chicago, IL; New Orleans, LA; Detroit, MI; Philadelphia, PA; and Atlanta, GA.

The following is a representative sample of how females are coping in today's "battle of the sexes."

## ABSTINENCE, COMMITMENT, AND MARRIAGE ARE NOT REALITY

"Everybody's curious. They're not tryin' to be with the same person all their life."

—New York young adult

"It's too many boys out there to stay with one."

—Baltimore teen

"Me personally, if the first one don't do it right, I'm going to the next one... I don't have time to be staying with one person."

—Baltimore young adult

"If a person is not fulfilling your needs, maybe you should go somewhere else."

—Baltimore young adult

"My Mom tried to kill my daddy... I'll never get married."

—Los Angeles teen

"I see people who are married, and they are boring."

—Los Angeles teen

"I'm too young to settle down..."

—Chicago teen

"I don't want to be tied down to that one person..."

—Chicago teen

"I think you should have a spare [sexual partner]... but not just anyone."

—Los Angeles young adult

"A lot of the older women (like our mothers) say 'Don't let the right hand know what the left hand is doing.'"

—Los Angeles young adult

"I want a wedding more than a marriage. But a husband? I don't know."

—New Orleans teen

"I think it [Commitment] comes from example... I have friends from single-parent homes and they follow their example."

—Los Angeles young adult

"I don't want to be committed to someone for the rest of my life..."

—Oakland young adult

## PEER PRESSURE DRIVES MANY DECISIONS

"Everybody I see condemns virgins..."

—Chicago young adult

"It's [having sex is] not something they want to do, but because they are being pressured, they do it"

—Baltimore teen

"Boys have the tendency to lie on their dick [say they're sexually active, even if they're not]."

—Baltimore teen

“For females it’s [starting sex] more curiosity, more so than to fit in, like males...”  
—*Detroit teen*

“Somebody tells you they just had sex with a boy and you’re like, ‘Damn, I haven’t had sex.’”  
—*New Orleans teen*

“Peer pressure shouldn’t be the reason you have sex.”  
—*New York teen*

“The guys will say ‘I love you’ and the girls will fall for that.”  
—*New Orleans teen*

### “WISH I WOULDVA WAITED”

“I think that if I could go back in time, I would have waited [to have sex].”  
—*Baltimore teen*

“I didn’t know about the consequences of sex until I started having sex.”  
—*New York teen*

“If I could be a virgin again, I would... I would’ve waited a while... Maybe things would have been different.”  
—*Baltimore young adult*

“I wish I had waited, because I want a ring... If someone had talked to me and said ‘it’s alright’... I probably would have waited.”  
—*Chicago young adult*

“Sex is really emotional, and if it is the wrong guy, you are gonna be hurt.”  
—*New York young adult*

“When you lose your virginity and meet the right guy afterwards, you will wish you had waited.”  
—*Detroit young adult*

### RELATIONSHIPS BETWEEN ADULT MALES AND TEEN FEMALES

*On why some adult males like to date teen females:*

“An independent woman is too advanced for him and ain’t no dummy.”  
—*Baltimore teen*

“It’s easier for him [an adult male] to get those girls without giving up too much.”  
—*Baltimore teen*

“Young girls are not hip to the game yet...so they don’t know anything.”  
—*Baltimore young adult*

“This happens a lot in Detroit—they [adult males] ride up to the schools just to get the young girls.”  
—*Detroit young adult*

“I’ve always talked to older guys... but he feels like I am his child... they have a control thing over younger girls.”  
—*Los Angeles teen*

“Younger girls give it up easier.”  
—*New Orleans young adult*

“When I was a [high school] freshman, I dated a freshman in college.”  
—*Chicago teen*

“I mess with [men in their] thirties and forties... I like to go out and be taken out.”  
—*New York teen*

### SAME-SEX RELATIONSHIPS

“It’s [same sex relationship] starting to be a trend... they do it for attention or to try something different.”  
—*Baltimore teen*

“If that’s their thing, they should go ahead and do it.”  
—*Baltimore teen*

“A girl asked me ‘Are you fun?’ or ‘Do you like Skittles?’ or ‘Do you like the rainbow?’”  
—*Detroit teen*

“I’m just tired of the [male] shit...so that’s why I prefer females...”  
—*New York teen*

“Girls say they go with girls because they communicate better...”  
—*New York teen*

### USING CONDOMS

“Girls should bring their own condoms, because boys will always say they don’t have one.”  
—*New Orleans teen*

“A lot of people don’t use protection during oral sex.”  
—*Baltimore young adult*

“It’s not the same sensation with the condom”  
—*New York young adult*

“If you’ve been with them [the same partner] for a while, they might be suspicious if you ask to use a condom.”  
—*New York young adult*

“My boyfriend told me that if I try to use a condom, that means I’m cheating.”  
— *Chicago teen*

“I didn’t know how to use a condom, so I got pregnant.”  
— *Baltimore young adult*

“I don’t like the way condoms feel—that’s why I’m not having sex.”  
— *New York teen*

“I don’t use condoms because I’ve been with my partner 1? years.”  
— *New York teen*

“Girls don’t like condoms — they like to feel the real skin.”  
— *Baltimore young adult*

“Once it gets hot, you don’t want to spoil the mood with getting a condom.”  
— *New York young adult*

“If the female doesn’t say anything about it [using a condom], the male doesn’t say nothing about it.”  
— *Detroit young adult*

“Some girls want to be pregnant—or say they have to die anyway, so they don’t use condoms.”  
— *New Orleans teen*

## **PARENTS’ BEHAVIOR IMPACTS THE SEXUALITY OF YOUTH**

“I know some people’s parents who don’t care...they smoke weed together...they are on drugs and have no control over their kids.”  
— *Baltimore young adult*

“When we were growing up, older people would say ‘Stop that,’ but now they just talk about us.”  
— *Los Angeles teen*

“My mom doesn’t tell me about sex because she says I don’t need to do it.”  
— *Oakland young adult*

“It’s hard to talk to parents nowadays about sex.”  
— *Detroit teen*

“My parents don’t talk about sex — that’s why kids get pregnant.”  
— *Los Angeles teen*

“She [my mother] made it clear that I can come to her about anything.”  
— *Los Angeles teen*

“Youth feel more comfortable talking to strangers than people in their house.”  
— *Oakland young adult*

“They should say ‘If there is anything you want to talk about, you can come to me.’”  
— *Baltimore young adult*

“When my mother says no, I want to go do it even more.”  
— *Chicago teen*

“You feel embarrassed talking to your mother about sex.”  
— *New York young adult*

“They [my parents] know I’m sexually active, because one day my father went to get my birth control pills — but we don’t talk about it.”  
— *Baltimore young adult*

“Keeping your kid on lock-down is not helping your kid learn from their mistakes.”  
— *Chicago teen*

“My mother doesn’t talk to me about it [sex] because she’s afraid I’ll get pregnant.”  
— *Baltimore young adult*

“Our neighbors get involved and confront me, and will also tell our parents.”  
— *New Orleans teen*

“We need more nosy adults...[like] back in the day...”  
— *Oakland young adult*

“Adults should say ‘Sex does feel good, and you should wait until you are ready to have a baby...’”  
— *Detroit teen*

“If she [my mother] had talked to me when I was younger, I don’t think I would have gotten pregnant.”  
— *Baltimore young adult*

“My parents don’t talk to me about sex, because I tell them they do not know what it’s like nowadays.”  
— *Detroit young adult*

“It’s a double standard [for boys]. My mother knew when my brother first had sex...it was like ‘pat on the back’...but not for me.”  
— *Baltimore young adult*

“My mom looks at me like the one who is going to make it — so she thinks I have my head on straight — and I am responsible, but I can’t tell her I am having sex — so I talk to my older sister.”  
— *Detroit teen*

“My mother never told me anything — she’s shy.”  
— *New York teen*

“My father doesn’t like the fact that I’m having sex, but he knows he can’t stop me, he can only help me.”  
— *New York teen*

### **SEX EDUCATION IS NOT MEETING THE NEEDS OF YOUTH**

“They should show those STD pictures earlier...Maybe that would scare teens to not having sex or wearing a condom if they do.”  
— *Chicago young adult*

### **THE MEDIA**

“TV doesn’t show people using protection.”  
— *Los Angeles teen*

“Stop sugar-coating [stuff] on TV and make it real.”  
— *Detroit young adult*

Suggested message slogan: “Strap it up or scratch it off. Sex is like a scratch-off ticket, because you don’t know what’s on the other side of it!”  
— *Detroit young adult*

“That’s all you see on TV is sex.”  
— *Los Angeles teen*

“They same way they promote clothes and shoes, they [the media] should promote safe sex.”  
— *Los Angeles teen*

“Media should have some respect to clean up some of the stuff they throw out there.”  
— *Los Angeles teen*

### **THE IMPACT OF DRUGS AND ALCOHOL**

“Weed makes me horny, so if I’m sitting next to my [male] friend, I’m gonna want to [have sex].”  
— *Baltimore young adult*

“You end up doing things you don’t normally do during sex...kiss somewhere you wouldn’t normally kiss...”  
— *Chicago teen*

### **NAVIGATING TODAY’S RELATIONSHIPS**

“If you respect your body, a male will respect you.”  
— *Baltimore teen*

“This year it’s my time, I’m gonna play those guys like they play me.”  
— *Baltimore young adult*

“Most boys are sneaky and liars, too.”  
— *Los Angeles teen*

“[My] man is forever, and [girl] friends are temporary.”  
— *New York young adult*

“I can trust a guy more than a girl...the females I hang around talk too much.”  
— *Los Angeles teen*

### **HEALTHCARE IS ACCESSIBLE BUT NOT USER FRIENDLY**

“You could tell your counselor one thing, and before you know it, it’s all around the school.”  
— *Chicago teen*

“I don’t feel comfortable telling a new doctor I’m having unprotected sex.”  
— *Los Angeles teen*

“She [counselor] showed my auntie everything in my health file...”  
— *Chicago teen*

“People think when you go into a clinic there has to be something wrong.”  
— *Los Angeles teen*

### **SENDING CREDIBLE SAFE SEX MESSAGES**

“[Use] adults—they have been there and done that, so they can teach you.”  
— *New Orleans teen*

“Use youth who have been through what I have been through.”  
— *New Orleans young adult*

## EXAMPLES FROM THE FIELD: CULTURALLY COMPETENT SEXUALITY EDUCATION PROGRAMS

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**E**ditor's Note: This fall, SIECUS put out a call to professionals across the country asking for information about the strategies, programs, and approaches they use to reach their communities. We were impressed with both the volume and quality of the responses we received. SIECUS wants to thank all of those organizations who sent information on their programs; unfortunately because of space limitations, we were unable to include everything we received.

We have selected a handful of programs that reflect the variety and creativity of the examples we received. By sharing these diverse, innovative approaches, we hope to raise awareness, stimulate ideas, and provide encouragement to professionals and organizations. Finally, we hope to show that it is possible to provide high-quality, culturally competent sexuality education to a wide range of audiences.

### *Brighter Futures & Promotoras*

#### **Planned Parenthood of Houston and Southeast Texas**

*Community served: Mexican and El Salvadoran immigrant community*

Planned Parenthood of Houston and Southeast Texas (PPHST) has a two-pronged Hispanic Outreach Program located at a church in the heart of their community. This program serves a Spanish-speaking community of immigrants, 90 percent of whom are from Mexico with the other 10 percent from El Salvador. On average the families have been in Texas between two and eight years. They live in a neighborhood which includes many undocumented immigrants and their children are the first generation of United States citizens. The families served by these programs are primarily Catholic.

*Brighter Futures* is a replication of the CAS-Carrera Model, a comprehensive program that takes a youth development approach to preventing adolescent pregnancy and to teaching about sexuality. The primary goals of the program are to prevent teen pregnancy and school drop-out; however, the true results are developing independent, responsible high school graduates. It serves 30 teens and their families.

The program includes daily after-school programming with lifetime sports, education enhancement and tutorials, creative self-expression, sexuality education, mental health groups, physical exams, and a job club. Typical afternoons

are spent learning to keep a bank account, discovering a new creative part of oneself, writing a resume, researching a homework project on the computer, engaging in a sex education discussion, or improving in a new sport such as golf, racquetball, or bicycling. The parents, both fathers and mothers, attend monthly education sessions and receive daily communication from the staff.

PPHST believes that the staff are the key to the success of the program. The students attend the program from sixth grade through high school graduation and the same staff interact with them daily, reach out to their families, and visit the schools to check on participants' progress and attendance. The program is currently serving its second group of young people and continues to have ongoing communication with graduates from the original group. In fact, students from the first group tutor the younger teens.

Housed in the same church office is the *Promotoras* program. Working side by side with the *Brighter Futures* staff, twelve Spanish-speaking women educate their community about the importance of talking with family members about sexuality and receiving consistent sexual and reproductive health care. Some *Brighter Futures* mothers are involved in the *Promotoras* outreach program.

The *promotoras* receive five days of classroom instruction on anatomy and physiology, contraception, sexually transmitted infections/HIV, domestic violence, positive sexual attitudes, women's health care, healthy relationships, and self-esteem. The classroom instruction is followed by two days of role play and teaching practice. Once trained, the *promotoras* act as ambassadors for health in their immigrant communities. For example, the *promotoras* have made healthcare appointments, provided transportation, and accompanied women to their clinic visits. They have worked in the clinic for free Pap day or free HIV testing day.

The *promotoras* are paid hourly when they work in the clinic or at a health fair and receive \$25 for each teaching session they facilitate. They are required to be able to read and write and must be documented to receive compensation.

PPHST consistently has between nine and 11 active *promotoras*. One *promotora* works half-time as the coordinator. She markets the program to schools, health fairs, agencies, and clinics and coordinates the speaking engagements. The *promotoras* reached 1662 women during the last year with a positive message about healthy sexuality.

The two programs, nestled in the heart of the community they serve, ensure that a once hard-to-serve population can now find trusted community people, like themselves, to get the information and services they need for healthy sexuality.

Contact information: Meryl Cohen, M.Ed., LMSW-ACP, Vice President of Education and Counseling, Planned Parenthood of Houston and Southeast Texas, 3601 Fannin, Houston, TX, 77004, phone: 713/831-6521, email: meryl.cohen@ppfa.org.

**En El Aire: Temas de Salud Para La Mujer Latina**  
(On the Air Health Resources for Latinas)

**Wake County (North Carolina) Human Services**

Community served: Spanish-speaking radio audience

Wake County Human Services coordinates a call-in radio broadcast on WETC 540 AM (La Super Mexican). The objectives of the radio series are to raise awareness of health issues, improve access to services by reducing fears around intimate subjects, and increase listeners' knowledge of local services providers.

This 25-week live, call-in radio broadcast provides expert information and advice in Spanish for Latinas and their families. The broadcasts are staffed by volunteers and professional staff from community organizations who are experts in the topics of the week. These experts share information and answer questions prompted by the radio host as well as by calls from the listening audience.

The radio station's listening audience primarily consists of first- and second-generation Mexican immigrants working in landscaping, construction, and hospitality as well as stay-at-home mothers and single women. The average age of listeners is between 19 and 23. In planning the radio series, Wake County Human Services works to include topics relevant to this population.

The series, which was supported in part by the March of Dimes for the past three years, began again in January 2004 with funding from participating organizations. The topics scheduled for this year include HIV prevention, drinking and driving, obesity in children, STDs, and the relationship between STDs and birth defects.

Contact information: Maria Ines Rabayo, Wake County Human Services, 10 Sunnybrook Road, Ste 301A, Raleigh, NC, 27610, phone: 919/250-3882, email: Maria.Robayo@co.wake.nc.us.

**Entre Amigas**

**Planned Parenthood of Minnesota/South Dakota**

Community served: Spanish-speaking adult Latinas

Planned Parenthood of Minnesota/South Dakota's (PPM/SD) *Entre Amigas* is a lay health advisor program for adult Spanish-speaking Latinas. The objective of *Entre Amigas* (Spanish for "Between Friends") is to train women

in the Latino community to provide information and education on healthy sexuality and related reproductive health care topics as well as referrals for subsidized family planning services. The program is designed to build on the strengths of Latinas in the community in order to help improve community health.

*Entre Amigas* serves the Spanish-speaking immigrant communities in the Twin Cities of Minneapolis and St. Paul. These communities are primarily low-income, with diverse religious backgrounds and nationalities; however, the majority of Latino immigrants in the Twin Cities are Mexican. Many members of this community do not have insurance or are underinsured and, because they are recent immigrants, they are often not fully aware of the services available in the community. For many, preventative medicine and early detection are new concepts. Women and families who do not speak English are not reached by traditional means, and thus, extra efforts need to be made to accommodate language differences.

Twice a year, eight to ten new participants join the program and complete a 12-week workshop. Each weekly session consists of two-and-a-half hours of training on topics such as sexuality, reproductive anatomy, birth control methods, sexually transmitted infections, HIV/AIDS, talking to your kids about sex, domestic violence and sexual abuse, sexual orientation, reproductive cancers, self-esteem, sexual response, community resources, and peer education skills.

The program was adapted from PPM/SD's *Reach One/Teach One Program*, a peer education program for teens ages 13–18, and *Neighbor Aid*, an adult peer education program. All sessions are held in Spanish and the literature and materials distributed in the community by the health advisors are also in Spanish. The program is sensitive to cultural traditions and experiences. Latina women facilitate workshops whenever possible, so the participants can see them as role models as well as community resources. In order to maximize attendance and encourage women from different backgrounds to participate, the *Entre Amigas* program provides free on-site childcare, transportation assistance, and light meals.

After receiving training on each topic, participants are encouraged to teach other people in their community about what they have learned. The participants receive a stipend based on the amount of education they do in the community. The education is done informally, either one-to-one or with a small group of friends, relatives, or community members. The average *Entre Amigas* training group reaches 300–500 individuals. Since the program began, the peer educators have reached approximately 3,600 individuals in the community.

In evaluations of the program, participants regularly report high satisfaction with the program, increased comfort

in talking about reproductive health with others, and plans to refer friends to the program in the future. Participants also regularly report that the information they learned during the program will positively change their lives, as well as the lives of their spouses and children

*Contact information: Migdalia Loyola Meléndez, Community Education Programs Manager, Planned Parenthood of Minnesota and South Dakota, 1200 Lagoon Avenue, Minneapolis, MN 55408, phone: 612/821-6123, e-mail: mloyola@ppmsd.org.*

### **Focus on Kids and ImPact Wayne State University**

*Community served: African-American parents and teens*

*Focus on Kids* (FOK) is a community-based HIV/STD prevention program for high-risk urban youth ages 9–15. It is designed to help youth learn the skills and gain the knowledge they need to protect themselves from HIV and other sexually transmitted diseases. The curriculum uses fun, interactive activities such as games, role plays, discussions, and community projects. FOK has been identified by the Centers for Disease Control and Prevention's Division of Adolescent and School Health (CDC-DASH) as an effective program that reduces adolescent sexual risk behavior. FOK was designed for and evaluated in urban public housing developments located in Baltimore, Maryland. Over 95% of participants were African American.

In an attempt to broaden the positive effects of FOK, a team of researchers at Wayne State University has been investigating the effects of parental monitoring interventions on adolescent risk behaviors. Parents can help their children evoke and reinforce health-seeking behaviors. Therefore, the team has developed, implemented, and is currently evaluating ImPACT, an intervention designed to increase parental supervision and communication.

ImPACT is delivered by two educators in the youth's home. It includes a 20-minute video (tailored to the community) that emphasizes several concepts of parental monitoring and communication (e.g., "it is important to know where and with whom your child is," and "talk with your children about sex"). The video is followed by an interactive role-play in which the parent is confronted with evidence that his/her child is sexually active. After role playing between the parent and the youth is completed, the educators offer suggestions that reinforce the main talking points of the video, and conduct a condom demonstration.

The researchers are currently conducting a randomized, controlled trial of FOK with and without the addition of ImPACT and additional FOK "boosters" among 800+ African-American youth ages 12 to 16 and one of their parents. Results indicate that ImPACT added to the FOK intervention increases a wide range of healthy behaviors by

adolescents up to 12 months after intervention. For example, six months after intervention, youth in families that received FOK plus ImPACT reported significantly lower rates of sexual intercourse and sexual intercourse without a condom than youth in families that were assigned to the FOK intervention only. In addition, at both six and 12 months after intervention, rates of alcohol, cigarette and marijuana use, as well as overall risk intention were lower among youth who received FOK plus ImPACT compared with FOK-only youths. Researchers are currently analyzing data from 18 and 24 months follow-up.

These results suggest that the inclusion of a parental monitoring and communication intervention can provide additional protection from involvement in adolescent risk behaviors.

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### **Goddess Girls Girls Incorporated of Metro Denver**

*Community served: Latina girls ages 9–11*

Girls Incorporated of Metro Denver inspires all girls to be strong, smart, and bold™ through three program departments: Center Programs, Outreach Programs, and Health & Sexuality Programs. The Health & Sexuality Programs Department works to prevent teenage pregnancy and sexually transmitted diseases among girls in metro Denver and to empower girls to make healthy decisions about their own sexuality.

The majority of the girls served by the Health and Sexuality Programs Department live with a single parent, belong to an ethnic minority (about 75% of the girls are Latina), and come from a family with an annual income of \$25,000 or less. Many attend under-funded schools with high dropout rates—an overall climate that typically discourages them from continuing their education.

Teenage pregnancy is also a challenge that girls in the Denver community face. In Denver County, where Girls Incorporated is located, the teen fertility rate for 15–17 year old Hispanics was 116 per 1,000. For White Non-Hispanics, the teen fertility rate was 23 per 1,000. Therefore, the Hispanic fertility rate is estimated to be five times the White rate in Denver. Significant disparities regarding teenage pregnancy demand culturally competent programs.

Although sexuality education is integrated into the educational standards for the Denver public schools, many of the 7,000 students in the district do not receive formal sex education. Girls Incorporated works to fill this void through the direct delivery of sexuality education classes with girls ages

9–18 at various sites in the community including schools, community-based organizations, juvenile justice facilities, and faith-based organizations. Although most of their classes are based on the nationally developed and evaluated *Preventing Adolescent Pregnancy*<sup>SM</sup> curriculum, Girls Inc. of metro Denver has developed another component to their sexuality education program called *Goddess Girls*.

*Goddess Girls* is a ten-week class (one hour per week) designed to help girls ages 9–11 learn about the changes that occur during this time and to develop a healthy body image. The class is delivered at various sites throughout metro Denver. *Goddess Girls* aims to provide basic knowledge of female anatomy, reproduction, puberty, menstruation, feminine hygiene, and body image. In addition, it helps participants develop a positive attitude about the changes girls experience during puberty, allows them to explore the messages they receive about their bodies from the media and peers, and gives them the opportunity to practice asking questions about their bodies.

Girls Incorporated of Metro Denver has found that the best method for delivering culturally competent programs, especially when there is a need to reach a variety of groups, is to develop a program that acts as a foundation for teaching, such as *Goddess Girls*, and then encourage staff to tailor it to their audience. The staff members who teach *Goddess Girls* are all bi- or multi-cultural, bilingual, and passionate, dynamic young women. Each staff member integrates her own unique cultural experience into her teaching whether through the stories that she shares, by drawing out participants' experiences, or by bringing "Hot Cheetos" to class.

To date, the program has been implemented, in full, five times (all at different sites). The class has been well-liked and supported by participants, families, and host organizations. Program evaluations, completed by participants, indicate that the program is successful in teaching new information and skills, making them feel comfortable talking to adults about sexuality, and giving them a safe place to learn about their bodies and have fun.

Contact information: Gina Febbaro, MPH, Girls Incorporated of Metro Denver, Health & Sexuality Programs Department, 1499 Julian Street, Denver, CO, 80204, phone: 303/893-4363 x 106, email: gfebbaro.denver@girls-inc.org.

**Hablando Claro (Plain Talk for Parents)**  
**Teen Pregnancy Coalition of San Mateo County**  
Community served: Spanish-speaking parents and children

*Hablando Claro* or *Plain Talk for Parents* is a two-part workshop designed to help parents/caregivers improve their skills in talking with their children about sexuality issues. The Teen Pregnancy Coalition of San Mateo County purchased the curriculum from the White Center (based in Seattle,

Washington) in 1999, and adapted it to meet the unique needs of the community they serve. For example, they added additional discussions around issues having to do with acculturation and values clarification. Other cultural adaptations include a difference in approach towards homosexuality, less reliance on reading, and greater attention to discussion. Finally, a greater emphasis has been placed on practicing parent/child communication and new activities around the influence of the media.

*Plain Talk* consists of many activities, but perhaps the most important component of the program is role-playing. This technique gives parents the opportunity to practice answering commonly asked questions related to puberty and sexuality and allows them to become comfortable discussing sexuality issues. Through role-playing parents also gain an understanding of what is appropriate to teach children at different age levels. At the end of every *Plain Talk* session, parents receive a "parent packet" that has additional educational materials and resources that they can share with their children.

*Plain Talk* serves parents in San Mateo County, California. The program targets communities that have teen birth rates significantly higher than the state's rate. These communities are predominantly Latino, but include African-American and Filipino members. During the first three years, *Plain Talk* was mainly offered at elementary and junior high schools; however, parent turnout rates tended to be low. In effort to increase participation during the fourth year, the Teen Pregnancy Coalition of San Mateo County engaged in aggressive outreach to local community organizations. *Plain Talk* is now offered at community-based English tutoring groups, homeless shelters, foster care groups, and other community-based organizations that have established parent groups. The number of parents served has nearly doubled over the last two years.

Contact information: Glenda Jessica Ortez, Program Manager, Plain Talk/Teen Parent Panel, Teen Pregnancy Coalition of San Mateo County, 703 Woodside Road, Suite #7, Redwood City, CA, phone: 650/367-1937, e-mail: glenda@teenpregnancycoalition.org.

**Health Assessment Tool**  
**Opportunities Industrialization Center West**

Community served: African-American, Latino, and Pacific-Islander young people ages 14–24

Each year, several hundred young people between the ages of 14–24 participate in youth programs at Opportunities Industrialization Center West (OICW), which is located on the border of Menlo Park and East Palo Alto, California, roughly halfway between San Francisco and San Jose, in the heart of Silicon Valley. Youth involved in this program tend to come from low-income neighborhoods with higher rates of high school dropouts, teen pregnancy, STDs, substance

use, violence, and less access to health services than other neighborhoods. They are from predominantly African-American, Latino, and Pacific-Islander communities.

The mission of OICW's Youth Programs is to empower young people to lead successful and healthy lifestyles through education, job skills training, career exploration, placement, and youth development. OICW uses an innovative approach to adolescent pregnancy prevention by using targeted health education strategies in a youth development setting. Its programs for young people include employment opportunities, vocational training, academic assistance, basic skills training, leadership skills development, gender-specific support groups, individual health assessments, clinic referrals, and health workshops. While health education workshops have been used regularly as a pregnancy prevention strategy, in the spring of 2002 OICW's health educator saw the need to have more time with each individual participant and developed a Health Assessment tool to get more specific information about participants' overall health and behaviors in a one-on-one setting.

These meetings give participants the opportunity to ask more specific questions and get more detailed answers to questions they might not be comfortable asking in a larger classroom. The meetings have the added benefit of helping youth forge stronger connections with local clinics and resources in the community. Health Assessment meetings usually last at least 30 minutes but do vary and follow-up sessions are planned as needed.

The Health Assessment itself resembles a checklist and is composed of approximately 15 short-answer questions. These questions start out with non-threatening and factual items, such as name, age, high school, and grade level. General questions about the participant's background, family life, and future plans after high school follow. Personal questions come next, including topics about frequency of alcohol consumption, drug use, and sexual behavior. The Health Educator makes sure to cover all of the points on the questionnaire, prefacing the conversation by letting them know it is a completely confidential, non-judgmental, safe place, while trying to build genuine rapport with the participants. The primary objective is to fill in the gaps that are missing for the youth and connect them to the appropriate resources for maintaining sexual health and preventing pregnancy. As other issues inevitably come to the surface in these conversations, the Health Educator continues to connect youth to the appropriate resources for those needs.

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### **Healthy Choices**

#### **Planned Parenthood League of Massachusetts**

*Community served: Youth ages 10–20 involved with Department of Youth Services and the Department of Social Services*

The Keep Teens Healthy Project (KTH) is a program designed to provide health education to MassHealth (Massachusetts' state Medicaid program) members ages 10 through 20 at risk for becoming pregnant, fathering children, and/or contracting sexually transmitted infections, including HIV/AIDS. *Healthy Choices* is Planned Parenthood League of Massachusetts' KTH program which they provide in schools, community settings, Department of Youth Services (DYS) facilities, and Department of Social Services facilities.

DYS is the juvenile justice system in Massachusetts and the health risks faced by youth in this system are particularly acute. In 1999, the last year for which statistics are available, 90 percent of DYS youth were sexually active, four percent of females were pregnant at the time of intake, and five percent of males had fathered children. In addition, limited data suggest that 40 percent of males and 85 percent of females had experienced unwanted sexual contact during childhood and adolescence.

To meet the needs of these young people, PPLM has expanded *Healthy Choices* from single classes to a multiple-session sexuality education program aimed at reaching high-risk youth. The program also contains a one-on-one component where an educator and a student have an opportunity to discuss issues.

*Healthy Choices* begins with an overview of sexuality and relationships. This first class allows students to gain knowledge, examine personal attitudes, evaluate existing coping mechanisms, and set groundwork for the rest of the conversations. Future classes focus on sexual anatomy and physiology, STIs, living with HIV/AIDS, postponement and protection methods, healthy and unhealthy relationships, communication, peer pressure, risk taking, homophobia, and sexuality-related healthcare services. The program can be provided free to agencies and facilities if a minimum of eight students per facility are members of MassHealth.

The *Healthy Choices* program is an integral part of PPLM's mission. The curriculum delivers quality sexuality education and encourages participants to examine their own risk behaviors. Trained educators provide students with factual information, but also ask students to look at their own choices and make informed decisions about their own lives.

Contact information: Naomi Ninneman, Director of Education & Training, Planned Parenthood League of Massachusetts, 1055 Commonwealth Avenue, Boston MA, 02215, phone: 617/616-1657, email: Naomi\_Ninneman@ppplm.org.

### **HIV/AIDS Prevention and Care**

#### **Gay and Lesbian Asylum**

#### **Reproductive Health and Sex Education**

#### **Domestic Violence and Women Empowerment**

#### **Female Genital Mutilation Counseling**

#### **M.E.N.T.O.R.S**

*Community served: Arab-Americans, primarily women, gays and lesbians, and those affected by HIV*

M.E.N.T.O.R.S., Middle East Natives, Testing, Orientation, and Referral Services, provides a variety of services to Middle-Eastern and Arab communities in the New York City metropolitan area. The organization began by providing HIV counseling, outreach, walk-in services, case management, and referrals to local HIV/STD clinics and hospitals. Over the years, they have implemented other activities focused on reproductive health, domestic violence, and lesbian, gay, bisexual, transgender (LGBT) issues.

Clients are predominantly Middle Eastern and/or Arab individuals living in New York who are women, gays or lesbians, and people affected by HIV/AIDS.

Arab-Americans are not defined specifically by race, like some minority groups, but are united by culture and language. While they may be closely tied to their countries of origin, most Arab-Americans were born in the United States, and the majority have U.S. citizenship. This is reflected in the expression, "Truly Arab and fully American."

In the New York area, there are three major concentrations of Arab-Americans: Brooklyn, Queens, and Long Island. In addition, a large community lives in neighboring Jersey City and Paterson, New Jersey. Both Brooklyn and the New Jersey cities have a thriving business economy catering to Arab needs, with supportive services such as schools, churches, and mosques.

The Arab-American community is largely a community of intact and extended families. The vast majority of foreign-born Arabs in metropolitan New York are family reunification immigrants who are U.S. citizens or permanent residents. A much smaller proportion migrated to the U.S. because of their professional skills with a larger proportion undocumented.

The Arab community in New York is diverse. It includes doctors, lawyers, shopkeepers and workers; persons with high, moderate and low levels of education; and wealthy, middle-class, and economically disadvantaged members.

Arabs belong to many religions, including Islam, Christianity, Druze, and Judaism. There are further distinc-

tions within each of these, and some religious groups have evolved new identities and faith practices in the United States. It is therefore important to distinguish religion from culture. Although Arabs are connected by culture, they have different faiths. A common misperception identifies Arab traditions as Islamic, or Islam as a unifying force for all Arabs.

The Arabic language is one of the great unifying and distinguishing characteristics of Arab people. Even so, colloquial Arabic differs from place to place. Modern Standard Arabic (MSA) is a pan-Arabic language used in formal letters, books, and newspapers. It is also spoken at conferences and on television news. Not all Arab Americans know Arabic, of course, as many are second-, third- and fourth-generation Americans.

M.E.N.T.O.R.S. is the only comprehensive Arabic service provider in New York City for HIV counseling, outreach, walk-in services, case management, HIV/STD referrals, and sexuality education. In addition, it is the only organization in the area fighting for the right of Arab immigrants to seek asylum in the U.S. and Canada, based on their sexual orientation.

M.E.N.T.O.R.S. produces accurate and up-to-date information and analysis on legal and ethical issues related to HIV/AIDS and reproductive health that are culturally and linguistically adapted. M.E.N.T.O.R.S. produced a number of Arabic educational materials that are tailored to Arab clients and culture, including the first Arabic-language book about HIV/AIDS in the United States. M.E.N.T.O.R.S. has also produced a documentary about Arab clients who are infected with or affected by HIV/AIDS; educational curriculum guidelines focused on teenagers from Arab/Middle Eastern cultural and religious background; and a book about sexuality, sex education, and reproductive health in the Arab society.

Contact information: Wahba Ghaly, M.E.N.T.O.R.S., 110 W 40th St. Suite 1008, New York, NY 10018-3670, phone: 212/398-5992, email: ghaly@mentorsny.org

### **Set the P.A.C.E.!:**

#### **A Family Intervention to Promote Health in Children Emory University**

*Community served: Parents of elementary aged children in an urban African-American community*

*Set the P.A.C.E.!* (*Parents and Children Empowered*) is an HIV-prevention and parent education program that is being implemented as part of a research study affiliated with Emory University. A community-based organization (CBO) in metropolitan Atlanta, Georgia is a partner in the study and serves as the research site. The population served by the program is predominantly urban, lower-income, and African-American. Participants are mothers of chil-

dren ages 6–12 who are members of a mentoring and after-school program through the CBO.

The overall goals of *Set the P.A.C.E.!* are to promote resilience among six-to-twelve year olds to decrease factors that place them at risk for early initiation of sexual intercourse and other health-related risk behaviors. *Set the P.A.C.E.!* aims to influence children by intervening at the family level, specifically by involving the mother. The program works to increase the level of discussion between mothers and their children about sexual values and information; increase maternal monitoring, emotional attachment, and involvement in children's activities; enhance parenting self-efficacy; and ultimately to decrease the likelihood that children will report involvement in sexual-risk behaviors.

The program consists of 10 weekly, two-hour sessions. The first session serves as the introduction, where participants get to know one another and discuss the multiple roles they play in their lives and how they take care of themselves. The following two sessions help participants enhance their listening and communication skills. Sessions 4 through 7 focus on child and adolescent sexuality and are designed to help mothers increase knowledge, skills, and comfort in communicating with their children about sexuality issues. Sessions 8 and 9 involve discussions and activities related to parental monitoring, peer pressure, and parent-education involvement. The program ends with closing activities and a potluck dinner in Session 10.

The curriculum for *Set the P.A.C.E.!* was adapted from a previous program called *Keepin' It R.E.A.L.*, which was implemented in a similar setting with mothers and 11–14 year-old adolescents. Although *Set the P.A.C.E.!* is intended for a diverse population, participants are predominantly African-American. Thus, *Set the P.A.C.E.!* is culturally tailored in several ways. The recruiters and facilitators for the program are African-American women. Clips from television sitcoms depicting African-American families are used to demonstrate various communication skills. In addition, program planners work to ensure that materials such as brochures, books, and videos represent

African-American families.

The most significant challenge facing *Set the P.A.C.E.!* thus far has been ensuring attendance at all 10 sessions. In all of the groups run to date, the number of participants completing baseline interviews was higher than the number that actually attended sessions. In addition, attendance has tended to drop off after the first few sessions. To encourage mothers to attend as many sessions as possible, dinner is served at each session, childcare is provided, and incentives such as water bottles, t-shirts, lunch coolers, and magnets with the project logo are distributed. Books, brochures, and other resources related to program content are mailed to participants who have not attended the first five sessions.

Although outcome data addressing the above objectives will not be available until the end of 2005, preliminary process evaluation data suggest that participants feel they have benefited greatly from the program. *Set the P.A.C.E.!* is funded by the National Institute of Child Health and Human Development (1R01HD/MH39541-01).

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### **R. E. A. L. MEN: An HIV Prevention Program for Fathers and Their Sons** **Emory University**

*Community Served: Fathers and sons*

The R. E. A. L. MEN (*Responsible Empowered Aware Living*) project is an HIV-prevention intervention designed for fathers and their sons. The project was implemented as part of a research study funded by the National Institute of Mental Health. R.E.A.L. MEN was conducted in collaboration with a community-based youth organization (CBO) located in Atlanta, Georgia. The CBO has 21 sites in the metropolitan area and provides services to youth in predominantly urban and lower-income communities. Participants

## **SET THE P.A.C.E.! SUCCESS STORY**

One participant shared a touching story about how she applied her new skills with her 9-year-old daughter. After attending the group sessions that focused on enhancing open communication and effective listening, the mother and daughter were eating dinner at a restaurant and talking about the daughter's day at school. Apparently her new-found skills were quite evident. The conversation was overheard by the lady in the next booth who was amazed by how intently the mother listened to her child and how well the pair were communicating with each other. The lady explained that she had a teenager and wished that she could have the same communication with her child. The mother came to the next session beaming with pride that a complete stranger had noticed her effective listening and open communication skills.

in *R.E.A.L. MEN* were predominantly African-American.

Fathers and their adolescent sons, 11 to 14 years of age, were invited to participate in the program. Boys were permitted to participate with a male relative or family friend if they did not have an ongoing relationship with their own fathers.

The primary goal of the *R.E.A.L. MEN* project was to promote the father's involvement in the sexual education of sons. The long-term goal of the project was to contribute to the understanding of the influence fathers have on adolescent boys' sexuality, particularly in regard to abstinence and the acquisition of information about HIV/AIDS.

Fathers and sons were assigned to the HIV intervention group or to a control group. The intervention consisted of seven sessions held once per week. Each session lasted two hours and was conducted at the CBO. Fathers attended the first six sessions, and fathers and sons attended the seventh session together. In Session 1, participants were introduced to the concept of fathers as sex educators and offered ways to establish and maintain communication with their sons. Session 2 was devoted to basic communication skills and in Session 3 fathers learned about adolescent development and how to talk to their sons about puberty, values, and peer pressure. Session 4 focused on the transmission and prevention of HIV and other sexually transmitted infections. Sessions 5 and 6 were devoted to the task of talking to adolescents about sexuality-related issues and practicing the discussion of difficult topics through role plays. In the final session, sons joined their fathers in a discussion about issues facing adolescents today.

In this session, fathers and sons played the game *In the Know*. This game was developed by the project staff and is based on the *Newlywed Game*. Fathers and their sons were given a series of questions relevant to adolescents. Sons were asked to answer the question on their tablet and fathers used a separate tablet to predict their sons' answer. Answers were then shared with each other and the group. Discrepancies in responses generated considerable discussion about adolescent life and raised fathers' awareness of what they didn't know about their sons. Following the discussion, the participants viewed a documentary on adolescent life, which emphasized the fact that parents are not always aware of what their children are doing and the pressures that children face among their peer group.

In order to evaluate the program, all participants completed assessments prior to the intervention, and three, six, and 12 months later. Data from these assessments are currently being used to determine the effect of the intervention on the fathers' confidence and actual discussions of HIV and sex topics with their sons. Data obtained from satisfaction questionnaires indicates the *R.E.A.L. MEN* project has been well received by the fathers and the CBO. Many fathers noted that the sessions raised aware-

ness of issues that need to be addressed with adolescents and provided skills to facilitate discussions. Many also expressed disappointment that the project only included seven sessions. Plans are underway with the CBO to explore resources to extend the project.

*The R.E.A.L. Men Project is funded by The National Institute of Mental Health (5 R01 MH5901002).*

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### **Wisconsin Youth HIV Prevention Institute Diverse & Resilient**

*Community served: lesbian, gay, bisexual, transgender, and questioning youth*

Diverse & Resilient is a capacity-building, non-profit organization whose mission is the healthy development of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth in Wisconsin. There are currently nine community-based gay youth groups located in diverse Wisconsin communities providing youth development programming, including HIV prevention, for these young people. These community-based programs form a statewide network, the Rainbow Alliance for Youth, or RAY.

The bi-annual *Wisconsin Youth HIV Prevention Institute* is a strategy used by Diverse & Resilient to enhance the peer-education and HIV-prevention skills of LGBTQ youth affiliated with the RAY programs. In the most recent Prevention Institute, held July 8–10, 2003 on a college campus, more than 60 youth and young adults participated in a full schedule of experiential activities to develop peer-education skills, increase their motivation to avoid, delay, or reduce risks associated with sexual activity, reinforce prevention messages, and develop a community of youth to serve as a model of what is possible in schools and communities.

As part of the conference, the youth participated in a game called *Thrivers Challenge*, a take-off on TV's popular *Survivor* series. *Thrivers Challenge* is a cluster of activities in a challenge-course setting designed to help participants practice basic HIV-prevention skills including using barrier methods, negotiating safer sex, responding to coercion, and facilitating peer conversations that promote health and reduce risk. Teams of delegates have to complete all activities at each station and are "certified" as Thrivers once the entire team successfully completes the challenge. This approach reminds delegates that no one gets left behind; everyone has a part in the process of HIV prevention; human relationships are vitally important; and that the ulti-

mate goal is not merely surviving but thriving.

The Prevention Institute featured other experiential activities including caucuses based on social identity groups, a large group cultural exchange simulation, and the creation of a three-dimensional art project that reflects the themes of diversity, resiliency, big lives, and community. Participants for each RAY program then developed brief action plans explaining how they would share the information and skills they learned with their peers and use them to enhance programs in their community.

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### **Young Men's Program Long Island Crisis Center**

*Community served: Young men who have sex with men ages 13–20*

Long Island Crisis Center's *Young Men's Program*, an initiative of its Pride for Youth division, targets young men-who-have-sex-with-men (YMSM), ages 13–20, with an emphasis on African-Americans and Hispanics, in five Nassau County communities: Hempstead, Roosevelt, Freeport, Uniondale, and Westbury. This population includes young men who identify as gay, bisexual, and/or transgender, as well as those who engage in same-sex sexual behavior but do not identify as such.

The communities targeted by this initiative are working-class and low-income areas with social problems typical of many urban neighborhoods such as gang activity, crime, and poverty. More than 15 percent of the residents in these communities live below the federal poverty level. The majority of residents in the community are African-American or Hispanic with significant populations of Caribbean and Central American immigrants. The religious affiliations of residents include Protestant, Catholic, and Muslim. The communities have large numbers of Spanish-speaking households. In addition, in Westbury, there is a significant population of Haitian immigrants who speak French/Creole.

While all LGBT populations on Long Island can be described as underserved, these communities in particular lack a visible LGBT community and LGBT residents typically travel to New York City for social outlets. Conservative school districts provide very little education about LGBT sexuality, leaving these young people feeling isolated and poorly equipped to handle their developing sexuality.

Staff provide street outreach that delivers HIV education and safer-sex materials to street-involved YMSM. They also provide LGBT sensitivity workshops for health service providers, and recruit program participants from area high schools and youth groups.

Participants undergo a thorough process of biological, psychological, and social HIV-risk assessment as well as individual counseling.

Each year, eight YMSMs receive training to provide outreach and HIV-prevention education to their peers. These young people participate in an HIV/AIDS education theater program, publish and distribute a bi-monthly 'zine, and work side-by-side with staff to provide street outreach.

The program also operates a weekly, Friday-night drop-in center providing free, safe, recreational activities, creative and theater arts skill-building, drop-in counseling, crisis intervention, and nutritious snacks. Through a collaboration with outside service providers, the program provides quarterly, on-site HIV counseling and testing services at the drop-in center.

Accessibility to all services is maximized through the provision of van transportation, Metrocards (for subway and bus services), and commuter railroad ticket reimbursement.

Culturally competent services are built into the program through hiring staff members that are representative of the population, providing ongoing staff development, and offering services in both English and Spanish. Young people have an active role in service delivery through the use of peer educators, a youth advisory board, and representation on the Board of Directors.

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# TEACHING ABOUT SAFER-SEX ENSEÑANDO EL SEXO SEGURO IN ENGLISH AND EN ESPAÑOL

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The history of AIDS education takes us back to the 1980s, the decade when the world first learned about HIV and AIDS. First described as pneumocystis pneumonia<sup>1</sup> in 1981, the public came to erroneously understand AIDS as a disease that affected only (or mostly) gay men. There were 108 reported cases of AIDS in the United States that year, 1,641 two years later, and 10,000 in 1985.<sup>2</sup> By the end of the decade, more than a million Americans were infected with HIV.<sup>3</sup>

Early education efforts focused on the biochemistry of the disease. Classes taught people everything they needed to know about t-cells, retroviruses, and the like. Students became scholars in epidemiology, but learned little about prevention. If time *was* spent discussing decision-making about intercourse, or how to use condoms, it was almost as an afterthought to the main lecture.

## A NEW APPROACH

At the very end of the decade, Planned Parenthood of Bergen County<sup>4</sup> published the first edition of *Teaching Safer Sex*.<sup>5</sup> The manual represented a new approach, shifting the emphasis from medical education to practical, interactive lessons that would help people learn and talk about prevention of AIDS.

In the introduction, the authors stated, “In an age of AIDS, ‘safer sex’ must become the norm. We define ‘safer sex’ broadly as behavior that reduces the risk of any unwanted consequences of sexual activity.”<sup>6</sup>

Twenty lessons were assembled with nary a word on the epidemiology of AIDS. The new lessons emphasized the attitudes, values, and behaviors people needed to explore in order to reduce their risk.<sup>7</sup> Some of the educational concepts and principles employed in the first edition of *Teaching Safer Sex*, like actively engaging participants in their learning about safer sex, are now considered standard in all prevention efforts.

In 1998, Peggy Brick authored a new edition of *Teaching Safer Sex*. Responding to concerns raised by the

La historia de la educación sobre el SIDA comenzó en la década de los años 80, cuando el mundo se enteró por primera vez del VIH y el SIDA. Inicialmente descrito como neumonía por *Pneumocystis*<sup>1</sup> en 1981, el público equivocadamente supuso que el SIDA era una enfermedad que solamente (o en gran parte) afectaba a los hombres homosexuales. En ese año se informaron 108 casos de SIDA en los Estados Unidos, 1,641 dos años más tarde y 10,000 en 1985<sup>2</sup>. Al final de la década, más de un millón de estadounidenses estaban infectados con el VIH<sup>3</sup>.

Los primeros esfuerzos para la educación sobre este tema se enfocaron en los aspectos bioquímicos de la enfermedad. Se impartían clases que enseñaban sobre las células T, los retrovirus y otros aspectos científicos. Los/as estudiantes se hicieron eruditos en epidemiología, pero aprendieron poco sobre la prevención. Cuando se dedicó tiempo para hablar acerca de la toma de decisiones respecto a las relaciones sexuales, o cómo ponerse un condón, se presentaron estos temas casi como anecdóticos a la lección principal.

## UN NUEVO MODO DE ENSEÑANZA

Al final de la década, la organización *Planned Parenthood of Bergen County* publicó en inglés la primera edición del manual *Teaching Safer Sex*<sup>5</sup>. Este manual representaba un nuevo enfoque que cambió el énfasis en la educación médica hacia lecciones prácticas e interactivas que ayudarían a la población a aprender y hablar acerca de la prevención del SIDA.

En la introducción, los/as autores indicaron que: “En estos tiempos de SIDA, las ‘prácticas sexuales seguras’ tienen que ser la norma. Definimos ‘prácticas sexuales seguras’ en general como los comportamientos que reducen el riesgo de cualquier consecuencia no deseada al tener relaciones sexuales”<sup>6</sup>.

Se elaboraron veinte lecciones con pocas palabras relacionadas con la epidemiología del SIDA. Las nuevas lecciones pusieron énfasis en explorar las actitudes, los valores

Institute of Medicine<sup>8</sup> that HIV prevention was the only focus of safer-sex education, *The New Teaching Safer Sex*<sup>9</sup> reminded educators and young people not to forget about the many other bacteria, fungi, parasites, and viruses that cause even more cases of sexually transmitted infections each year. (It also reminded them to address the benefits of condoms in preventing unplanned pregnancy.) The new edition integrated the Transtheoretical Model of Behavior Change<sup>10</sup> and added new and expanded lessons. For example, it included many variations that sprung from “Don’t Pass It Along,” a lesson that appeared in the original manual.<sup>11</sup>

### TEACHING SAFER SEX IN SPANISH

Earlier this year, in an attempt to reach a new audience with the popular lessons of *Teaching Safer Sex*, Planned Parenthood of Greater Northern New Jersey (PPGNNJ) teamed with Fundación Mexicana Para La Planeación Familiar (MexFam) to produce *El Nuevo Enseñando el Sexo Seguro*.<sup>12</sup> Funded by teenwire.com, Planned Parenthood’s educational web site for teens (available in English and in Spanish), the new manual continues to actively engage young people, allowing them to focus on the knowledge, attitudes, and skills needed to practice safer sex but this time in Spanish. The lessons were updated to reflect current research about sexually transmitted infections and prevention, and new information about contraception. It was carefully reviewed by prominent sexuality educators of different Spanish nationalities to ensure that the manual’s messages would translate across a spectrum of Latinos in the United States and abroad. On reviewing *Enseñando el Sexo Seguro*, Elizabeth Amaya Fernandez, Director of Youth Initiatives for the National Latina Health Network commented,

*At last, the best safer sex strategies and lessons in Spanish! The user-friendly materials in this manual are fun, relevant, and adaptable to diverse Latino communities.*

The translation of the manual brought numerous cross-cultural challenges. Idiomatic language that is often taken for granted in English lacked its intended impact when translated into Spanish. For example, the lesson “Talk is a Four-Letter Word: Use It!” made no sense in Spanish, where “talk” is most often a six-letter word (depending on its conjugation). It was necessary to retitle this lesson “The Importance of Communication” to accurately convey the lesson’s purpose. Similar challenges arose in all the lessons, as we struggled to ensure they maintained the originally intended meaning and impact cross-culturally.

The manual was distributed to hundreds of sexuality educators via SIECUS’ National Network of Sexuality Educators of Color, the National Latina Health Network,

y los comportamientos que las personas necesitaban seguir para reducir su riesgo<sup>7</sup>. Algunos de los conceptos y principios incluidos en la primera edición de *Teaching Safer Sex* son considerados ahora estándares en todos los esfuerzos de prevención, por ejemplo, hacer que los/as participantes contribuyan activamente en el aprendizaje sobre las prácticas sexuales seguras.

En 1998, Peggy Brick escribió una nueva edición de *Teaching Safer Sex* como respuesta a las inquietudes expresadas por el *Institute of Medicine*<sup>8</sup> respecto a que el único enfoque de la educación para las prácticas sexuales más seguras era la prevención del VIH. El manual *The New Teaching Safer Sex*<sup>9</sup> les recordó a los/as educadores y a los/as jóvenes no olvidarse de las muchas otras bacterias, hongos, parásitos y virus causantes de un número todavía mayor de casos al año de infecciones de transmisión sexual. (Y también trató el tema de los beneficios del condón en la prevención del embarazo imprevisto). La nueva edición integró el *Transtheoretical Model of Behavior Change*<sup>10</sup> y agregó lecciones nuevas y ampliadas. Por ejemplo, se incluían muchas variantes derivadas de una lección que aparecía en el manual original, titulado *Don’t Pass It Along*<sup>11</sup>.

### CÓMO ENSEÑAR LAS PRÁCTICAS SEXUALES MÁS SEGURAS EN ESPAÑOL

Al principio de este año, en un esfuerzo por llegar a una audiencia nueva con las lecciones populares de *Teaching Safer Sex*, Planned Parenthood of Greater Northern New Jersey o PPGNNJ colaboró con la Fundación Mexicana para la Planeación Familiar (MexFam) en la producción en español de *El Nuevo Enseñando el Sexo Seguro*<sup>12</sup>. Financiado por *teenwire.com*, el sitio web de Planned Parenthood para jóvenes (disponible en inglés y en español), el nuevo manual continúa involucrando activamente a los/as jóvenes, permitiéndoles que se enfoquen en el conocimiento, las actitudes y las habilidades necesarias para realizar las prácticas sexuales más seguras, pero esta vez en español. Las lecciones se revisaron para reflejar las investigaciones corrientes acerca de las infecciones de transmisión sexual y su prevención, así como nueva información sobre los anticonceptivos. Fue revisado con cuidado por prominentes educadores de la sexualidad de diferentes nacionalidades hispanoparlantes para asegurar que los mensajes del manual pudieran transmitirse a un amplio espectro de latinos en los Estados Unidos y en otros países. Al revisar *Enseñando el Sexo Seguro*, Elizabeth Amaya Fernández, la Directora de Youth Initiatives para la National Latina Health Network comentó:

and MexFam. In late 2003, we began training bilingual sexuality educators to use the lessons of the manual.

### THE CONDOM LINEUP

The “Condom Lineup” activity is part of the popular “Condom Comfort” lesson. It appears in English and Spanish as taken from *The New Teaching Safer Sex* and *El Nuevo Enseñando el Sexo Seguro*. Over the years, the activity has become one of the fundamental methods of teaching people the steps necessary to use a condom. In the activity, participants receive a card that describes one of the steps for using a condom (e.g., roll condom on, leave room at the tip, etc.), and line up in the correct order, as other participants observe and discuss their placement. The lesson is helpful for teaching participants to reduce their user error, thereby lessening the gap between perfect use (98%) and typical use (85%) rates of effectiveness.<sup>13</sup>

Educators across the country and overseas commented on their experiences using the now famous “Condom Lineup.”

*We use an extended list—from “twinkle in the eye” to “the last goodbye.” We also ask participants to think about what might really happen rather than what should happen, and then to remove those cards. Then we have an opportunity to create situations and skills that improve the situation.*

Drue Brenner

Planned Parenthood of South Central New York

*We use the condom lineup as a game that parents and teens play together, to de-sensitize them to talking about condom use. Parents have reported that it’s a less anxiety-provoking way to discuss condom use.*

Karen Eastman, PhD

UCLA/RAND Center for  
Adolescent Health Promotion

*I often have students do the activity without talking to demonstrate how difficult managing your sexuality can be without communication.*

Melissa Meyer, LPN

Planned Parenthood Cincinnati Region

1. The Centers for Disease Control, “Pneumocystis Pneumonia—Los Angeles,” *Morbidity and Mortality Weekly Report* 30 (1981), 250–52.
2. National Institutes of Health, “In Their Own Words...NIH Researchers Recall the Early Years of AIDS,” 2001. Accessed at (acceso conseguido en) <http://aidshistory.nih.gov> on October 31, 2003 (en el 31 de octubre, 2003).
3. Ibid.
4. Planned Parenthood of Bergen County later joined with two other New Jersey Planned Parenthood affiliates to form today’s Planned Parenthood of Greater Northern New Jersey. (Más luego Planned Parenthood de Bergen County se unió con dos otras afiliaciones de Planned Parenthood de Nueva Jersey, para formar el Planned Parenthood de Greater Northern New Jersey de hoy.)

*“¡Por fin, las mejores estrategias para enseñar prácticas sexuales más seguras con lecciones en español! Los materiales de fácil uso de este manual son divertidos, pertinentes y adaptables a las diversas comunidades latinas”.*

Numerosos retos transculturales surgieron durante la traducción del manual. Las expresiones idiomáticas en inglés que a menudo se dan por entendidas, carecían del impacto deseado al traducirlas al español. Por ejemplo, la traducción del título de la lección “*Talk is a Four-Letter Word: Use It!*” no mantuvo el sentido en español porque la palabra “hablar” es realmente una palabra de seis letras y no de cuatro (sin tomar en cuenta su conjugación). Era necesario cambiar el título de esta lección a “*La importancia de la Comunicación*” para poder transmitir precisamente el propósito de la lección. Se presentaron retos similares en todas las lecciones, mientras luchamos para asegurarnos que se conservara el significado y el impacto transcultural que originalmente estaba previsto.

El manual se distribuyó a cientos de educadores de la sexualidad por medio de *The National Network of Sexuality Educators of Color* del Consejo de Información y Educación de la Sexualidad de los Estados Unidos (*Sexuality Information and Education Council of the United States* o SIECUS), la *National Latina Health Network* y *MexFam*. A finales del 2003, empezamos a capacitar a educadores de la sexualidad bilingües para impartir las lecciones del manual.

### LA ALINEACIÓN DEL CONDÓN

La actividad “Alineación del Condón” es parte de la popular lección “Comodidad del Condón” y aparece en inglés y en español en *The New Teaching Safer Sex* y *El Nuevo Enseñando el Sexo Seguro*. Al paso de los años, la actividad ha llegado a ser uno de los métodos fundamentales para enseñar los pasos necesarios para utilizar un condón. En la actividad, los/as participantes reciben una tarjeta que describe uno de los pasos para utilizar el condón (por ejemplo, enrollar el condón casi hasta la punta, dejar un espacio sin enrollar en la punta, etc.), y las van colocando en el orden correcto, mientras que otros/as participantes observan y analizan el orden de los pasos. La lección es útil para enseñar a los/as participantes a reducir errores al usar el condón, disminuyendo la discrepancia entre los índices de eficacia del uso perfecto (98%) y del uso típico (85%)<sup>13</sup>.

Los/as educadores de todo el país y del extranjero comentaron sus experiencias con la ya famosa actividad “Alineación del Condón”.

5. P. Brick, et al., *Teaching Safer Sex*. (Hackensack, NJ: Planned Parenthood of Bergen County, 1989).
6. Ibid.
7. Ibid.
8. Institute of Medicine, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. (Washington, D.C.: National Academy Press, 1997).
9. P. Brick, et al., *The NEW Teaching Safer Sex*. (Morristown, NJ: Planned Parenthood of Greater Northern New Jersey, 1998).
10. Prochaska, et. al., "In Search of How People Change: Applications to Addictive Behaviors," *American Psychologist* 47, 1102-1114.
11. "Don't Pass It Along" lessons are very interactive and demonstrate how quickly a sexually transmitted infection can spread among a group of people, even with just one "infected" participant. (Las lecciones de "No la Pases" son muy interactivas y demuestran que rápido una infección de transmisión sexual se puede esparcir entre un grupo de personas, aún con sólo un participante infectado.)
12. P. Brick, with translations by (traducido por) A. Balina Valiente, *El Nuevo Enseñando el Sexo Seguro*. (Morristown, NJ: Planned Parenthood of Greater Northern New Jersey, 2003).
13. R.A. Hatcher, *A Pocket Guide to Managing Contraception*. (Dawsonville, GA: The Bridging the Gap Foundation, 2003).

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Lizbeth Cruz, Sexual Health Educator (Educatora de salud sexual), *CFLE*, PPGNNJ, 1150 Dickinson Street, Second Floor, Elizabeth, NJ 07207. Telephone (Teléfono): 908/353-6701.

Jescenia Oviedo, Sexual Health Educator (Educatora de salud sexual), *CFLE*, PPGNNJ, 129 Park Avenue, Plainfield, NJ 07060. Telephone (Teléfono): 908-756-3765, extension (extensión) 30.

*Utilizamos una lista grande, desde "un guiño del ojo" hasta "el último adiós". También pedimos a los participantes que piensen en lo que pudiera realmente suceder, en vez de pensar en lo que debe suceder, y entonces quitar esas tarjetas. Así tenemos la oportunidad de crear situaciones y generar habilidades que mejoran la situación.*

*Drue Brenner  
Planned Parenthood of South Central  
New York*

*Utilizamos la alineación del condón como un juego que padres y jóvenes juegan juntos, para romper el hielo y ayudarles a hablar acerca del uso del condón. Los padres nos han informado que es una forma que genera menos tensión al hablar sobre el uso del condón.*

*Karen Eastman, Ph.D.  
UCLA/RAND Center for Adolescent  
Health Promotion*

*A menudo yo pido que los estudiantes hagan la actividad sin hablar para demostrar qué tan difícil puede ser manejar su sexualidad sin modos de comunicación.*

*Melissa Meyer, LPN  
Planned Parenthood Cincinnati Region*

*The New Teaching Safer Sex and El Nuevo Enseñando el Sexo Seguro are both available from the Center for Family Life Education at Planned Parenthood of Greater Northern New Jersey. In addition to The Condom Lineup lesson that appears on the following pages, these manuals also feature valuable lessons on Sexual Transmitted Diseases, HIV/AIDS, abstinence, outercourse, communication, and safer sex issue for gay, lesbian, and bisexual youth.*

*For more information: Center for Family Life Education, Planned Parenthood of Greater Northern New Jersey, 973/539-9580 ext. 120.*

## THE CONDOM LINEUP

### A Lesson in Both English and Spanish

Planned Parenthood of Greater Northern New Jersey  
Morristown, New Jersey

#### THE CONDOM LINEUP

##### OBJECTIVES:

Participants will:

- Feel comfortable discussing correct condom use.
- Discuss factors that influence effective condom usage.

##### RATIONALE:

All too often education about condom use fails to address the many factors essential for correct and consistent use. Often, admonitions are given without adequate explanation and people are left with questions that discourage compliance. The popular “Condom Lineup” and follow-up discussion address the most common questions.

##### MATERIALS:

- Condoms, male and female
- Pamphlets that describe how to use a condom
- Nineteen pieces of cardboard, labeled (in proper sequence, the cards are):
  1. Decide to have sexual intercourse
  2. Talk about safer sex
  3. Buy/get condoms
  4. Check expiration date
  5. Arousal
  6. Erection
  7. Open package carefully
  8. Inspect condom
  9. Place a drop of lube on the inside tip of the condom
  10. Hold condom at tip leaving space at the end
  11. Place condom on tip of erect penis
  12. Roll down to base of the penis
  13. Smooth out air bubbles
  14. Vaginal, oral, or anal intercourse
  15. Ejaculation
  16. Before loss of erection, grasp base of penis and withdraw
  17. Remove condom and dispose of safely
  18. Savor the afterglow
  19. Repeat as necessary

#### LA ALINEACIÓN DEL CONDÓN

##### OBJETIVOS:

Los(as) participantes:

- tendrán una mayor confianza al hablar acerca del uso correcto del condón.
- abordarán los factores que influyen en el uso eficaz del condón.

##### JUSTIFICACIÓN:

Con demasiada frecuencia la educación sobre el uso del condón no aborda los muchos factores esenciales para su uso correcto y consistente. A menudo se hacen advertencias sin dar explicaciones apropiadas, una situación que provoca que la gente se quede con dudas que desalientan su uso adecuado. En esta lección, a través del popular ejercicio de “La Identificación del Condón” y la discusión de seguimiento correspondiente, se abordan las preguntas más comunes al respecto.

##### MATERIALES:

- Condones, masculino y femenino
- Folletos que describe como usar el condón.
- Diecinueve pedazos de cartulina (más o menos del tamaño de una hoja) para utilizarlos como
  1. Decidir tener relaciones sexuales
  2. Hablar sobre el sexo seguro
  3. Comprar/conseguir condones
  4. Revisar la fecha de caducidad o vencimiento
  5. Excitación
  6. Erección
  7. Abrir el paquete con cuidado
  8. Revisar el condón
  9. Colocar una gota de lubricante en la parte interior de la punta del condón
  10. Sostener el condón por la punta dejando un espacio vacío en el extremo
  11. Colocar el condón sobre la punta del pene erecto
  12. Desenrollar el condón hasta llegar a la base del pene
  13. Eliminar cualquier burbuja de aire
  14. Relaciones sexuales vaginales, orales o anales
  15. Eyaculación
  16. Antes de la pérdida de la erección, sujetar el pene por su base y retirarse
  17. Quitarse el condón y desecharlo adecuadamente
  18. Disfrutar el momento posterior a la relación sexual.
  19. Repetir según sea necesario

## PROCEDURE:

1. Introduce “The Condom Lineup” by telling participants that they will have the opportunity to show-off what they know about condom use.
2. Shuffle condom cards so that they are not in the proper order, and distribute to participants. Each participant will have one card, unless it is a small group, in which case participants can receive more than one.
3. Explain that the cards, when placed in the correct order, show steps to use condoms effectively.
4. Instruct the participants to hold the cards and line themselves up shoulder to shoulder with each other, in the correct order, from left to right. If there are more cards than participants, ask participants to tape them in the correct order on the wall.
5. After the participants have agreed on the sequence, ask the whole group whether the position of cards should be changed.
6. Once everyone is in agreement, have each participant hold their card up and read it aloud.
7. Use a variety of discussion questions to clarify important points. Some questions might include:
  - When should the expiration date be checked?
  - Erection and ejaculation are on the list, but what female responses are missing?
  - Why should you open the package carefully?
  - Why should space be left at the end?
  - What do you do if the condom is put on the tip of the penis inside out by mistake?
  - Why should the air bubble be smoothed out?
  - How does alcohol or other drug use affect condom use?
8. Ask what the differences are, if any, if the steps are between two men? Two women? Involve oral sex?
9. Note that some couples choose to use the female condom. Demonstrate how the female condom works. (Clear directions come with the purchase of the female condom.)
10. Conclude with a demonstration of how the latex condom works, or continue with discussion or role-play about the importance of communication for successful condom use.

*Adapted from (adaptado por) P. Brick, The New Teaching Safer Sex. Morristown, NJ: Planned Parenthood of Greater Northern New Jersey (PPGNNJ), 1998. For more information on (para más información sobre) The New Teaching Safer Sex, contact (contacte) PPGNNJ at (a) 973/539-9580, ext. 120, or send an e-mail message to (o envíe un mensaje por e-mail a) Bill.Taverner@ppfa.org.*

## PROCEDIMIENTO:

1. Introduzca el ejercicio de “La Alineación del Condón” diciéndole a los participantes que tendrán la oportunidad de presumir todo lo que saben acerca del uso del condón.
2. Baraje las tarjetas de condones de modo que queden en desorden y distribúyalas entre los(as) participantes. Cada participante deberá recibir una tarjeta, a menos que se trate de un grupo pequeño, en cuyo caso se le puede dar más de una tarjeta a cada participante.
3. Explíquelo al grupo que, si se colocan en el orden correcto, las tarjetas muestran los pasos para el uso eficaz del condón.
4. Pídale a los(as) participantes que sostengan las tarjetas y se alineen hombro con hombro, en el orden correcto, de izquierda a derecha. Si existen más tarjetas que participantes, pídale que las peguen sobre la pared en el orden correcto.
5. Una vez que los participantes se hayan puesto de acuerdo en lo que respecta a la secuencia, pregúntele al grupo en su conjunto si debería cambiarse el orden de las tarjetas.
6. Una vez que todo el grupo esté de acuerdo, pídale a cada participante que sostenga su tarjeta y la lea en voz alta.
7. Use una variedad de preguntas de discusión para aclarar los puntos importantes.
  - ¿En qué momento debe revisarse la fecha de caducidad o vencimiento?
  - En la lista se incluye la erección y eyaculación, ¿pero qué respuestas femeninas faltan?
  - ¿Por qué es necesario abrir el paquete con cuidado?
  - ¿Por qué es necesario dejar un espacio vacío en el extremo?
  - ¿Qué hay que hacer si por error colocamos el condón al revés sobre la punta del pene?
  - ¿Por qué es necesario eliminar cualquier burbuja de aire atrapada en el condón?
  - ¿Cómo se afecta el uso del condón cuando se usa alcohol o otras drogas?
8. ¿Pregunte cuáles serían las diferencias, en caso de existir, en caso de que los pasos fueran entre dos hombres? ¿fueran entre dos mujeres? ¿incluyeran sexo oral?
9. Haga notar que algunas parejas optan por usar el condón femenino. Demuestre cómo funciona el condón femenino. (Junto con la compra del condón se reciben instrucciones claras para su uso).
10. Concluye con una demostración de como funciona el condón de látex, o continua con una discusión o desempeña un papel, sobre la importancia de la comunicación para usar el condón con éxito.

# VOICES FOR CALIFORNIA VIEWS ON TEEN PREGNANCY FROM DIFFERENT ETHNIC GROUPS

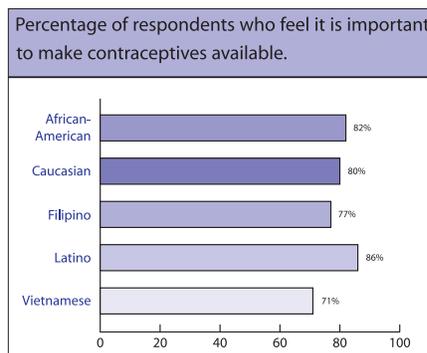
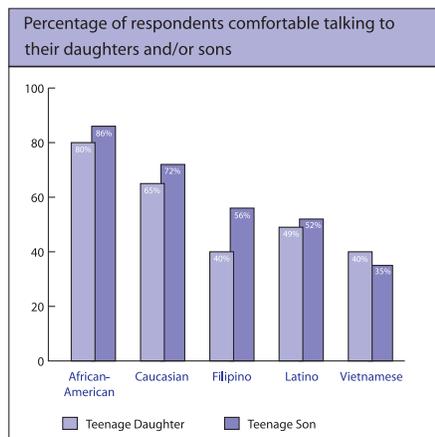
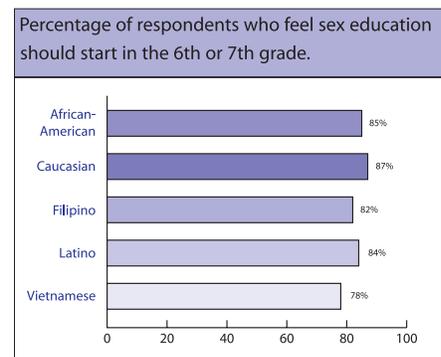
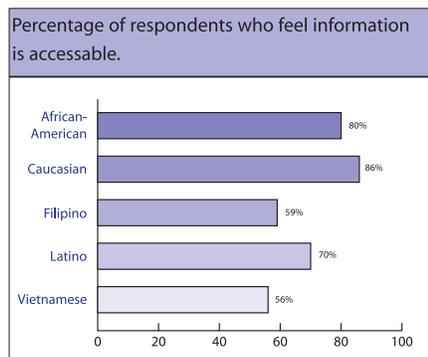
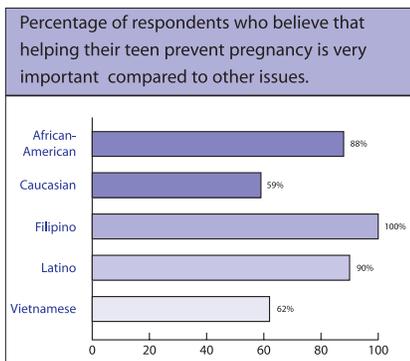
## Get Real About Teen Pregnancy Los Angeles, California

**E**ditor's Note: Get Real About Teen Pregnancy is a state-wide public education campaign in California. The campaign is run by Ogilvy Public Relations Worldwide and supported by a grant from the California Wellness Foundation.

In late 2002, the campaign commissioned a public opinion poll of more than 1,300 adults in California representing several different ethnic backgrounds. The poll was designed to assess attitudes and opinions regarding teen pregnancy and related issues.

The research focused on adults representing various ethnic backgrounds including African-American, Caucasian, Filipino, Latino, and Vietnamese. These groups were chosen based on their percentage in the overall population and rates of teen pregnancy in each community.

The following charts are reprinted from *Voices For California: Findings in Brief*, a report published in April 2003. They provide a good example of how opinions about teen pregnancy vary throughout different communities. To read the report in its entirety or find more information, visit the campaign's web site at [www.letsgetreal.org](http://www.letsgetreal.org).



# GAY-BOY TALK: DISCOURSE FOR STOPPING HIV INFECTIONS AMONG YOUNG GAY MEN

Matt G. Mutchler, PhD with George Ayala, PsyD;  
Patrick Hebert, MFA; and Ray Fernandez, BA

AIDS Project Los Angeles  
Los Angeles, CA

The perceived need to “intervene” with young gay men has been heightened by the HIV/AIDS epidemic and the risk of HIV exposure. However, constantly being cast as a population in need of public health intervention can have a stigmatizing effect. Individual-level, behavioral interventions reinforce the stigma because they define risk as existing inside a person rather than as a by-product of cultural or social contexts. We call instead for a different programmatic approach.

The purpose of this article is to discuss the importance of influencing discourse about homosexuality at the social and cultural levels in HIV-prevention efforts targeting young gay men. The discussion is based on *Sexual Stories*, a study which sought to understand the interpersonal, social, and cultural contexts in which behavioral risk for HIV infection occurs among young gay men. In this study, researchers conducted forty in-depth, semi-structured interviews with white and Latino gay men between the ages of 18 and 24. Findings from these interviews reveal that sexual risk behaviors occurred mainly in two social situations: primary relationships of presumed monogamy, and sexual coercion. Young gay men also reported receiving little to no gay-relevant sex education prior to engaging in sexual risk behaviors.<sup>1</sup>

Based on the findings reported by young gay men regarding their safer sex and HIV-risk behaviors, we suggest employing a discourse conceptualized as ‘gay-boy talk’ as a strategy for addressing factors that place young gay men at risk for HIV and for building on their strengths and protective behaviors. By introducing positive ideas about homosexuality into the verbal exchanges between young gay men and by normalizing discussion about sex and sexual desire, young gay men can both create and disseminate ethics for becoming sexually active adults.

## CURRENT APPROACHES

Sexual politics have shaped AIDS education efforts since the beginning of the crisis in the early 1980's.<sup>2, 3</sup> One approach to HIV prevention advocates eroticizing safer-sex in an attempt to minimize the spread of HIV with realistic, sex positive campaigns. The moralist approach to education blames gays for “their” disease, espouses heterosexist ideologies about a marriage as the only proper place for sex

(while prohibiting gays from getting married), and preaches celibacy and procreation-only models for sex. This strain of thinking is wedded to the abstinence-only-until-marriage programs that are currently receiving strong federal support and funding, despite the fact that none have met scientific tests for proven effectiveness.<sup>4</sup>

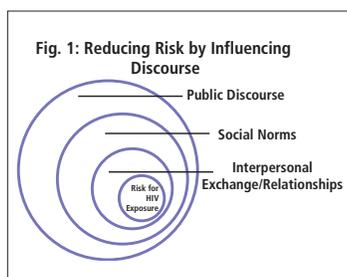
Sexuality education policies in the schools only target heterosexual adolescents despite the fact that gay adolescents are vastly over-represented in HIV rates. No peer-reviewed, published study of school-based sexuality education has looked at the impact of abstinence-only programs on young gay men, yet one has shown that HIV instruction that is gay- and lesbian-sensitive does significantly reduce HIV risk behaviors among gay and lesbian adolescents.<sup>5</sup> In addition, there are public health models for HIV-prevention programs at the community-intervention level that have been shown to be effective for young gay men. These models share common elements. They are: peer driven; explicit about gay sex and condom usage; culturally relevant; ongoing; and conducted in safe, non-homophobic spaces. These models are also specifically tailored to the issues of gay youth including their perceptions of HIV risk.<sup>6</sup> Effective community-level models can be extremely difficult to fund and such interventions may not be effective for hard-to-reach gay youth.<sup>7</sup> Still, the establishment of multiple safe and supportive spaces for young gay men is a critical element of HIV-prevention campaigns for this target population.

Innovative thinking is required to complement effective community-level models and to create safe and supportive cultural spaces wherever gay youth grow up. Multiple safer-sex messages must be meaningful to young gay men and account for the complexities of their lives. Talking with young gay men about sex, including negotiating safety and saying no to unwanted sex, could lead to more self-initiated talk among them about how best to manage the kind of sex they actually want. Moreover, simply making it okay to be gay (whatever that might mean to an individual) could help a young man overcome negative feelings about intimacy with other men. It is important to promote open and factual talk among peers about sex and issues that undermine the health and wellness of gay men.

## THE GAY-BOY TALK MODEL

'Gay-boy talk' can be thought of as a form of verbal exchange or social discourse that addresses the sexual health concerns of young gay men by countering negative discourses with more positive ideas about homosexuality.

Social discourse comprises specialized language, ideas, and social outcomes that are tied to social power and social location.<sup>8</sup> We believe that social discourse influences social norms, interpersonal relationships, and ultimately individual risk behaviors for HIV exposure (see Figure 1). Dominant social discourses about gay youth are currently guided by culturally pervasive homophobic ideas (i.e., homosexuality is wrong). Alternate discourses could encourage gay boys to pass on 'gay-boy talk' much as girls pass on 'girl-talk' about pregnancy, marriage, and rape.<sup>9</sup>



'Gay-boy talk' should address multiple issues that shape the sexual development of young gay men. For instance, 'gay-boy talk' might encourage discussions about dating and relationships centering on questions such as: What is

a relationship? What is a steady partner? What kind of sex makes sense with my current partner? What is safer sex in a relationship? How do gay men treat each other in relationships? What role do trust and protection play? In addition, young gay men need opportunities to talk about what kind of sex they enjoy, and how to prepare for sex, including anal sex, before it happens the first time. 'Gay-boy talk' takes into consideration the risk of HIV exposure as an integrated feature of sexual relationships. Trust can be recast in the context of taking risks to communicate openly about complex and difficult feelings and desires. 'Gay-boy talk' can be and is used by young gay men to communicate with their partners about pleasure and desire, HIV status, rules for safety with each other, sexual histories, and sex that might happen outside of their primary relationships. It should also address sexual coercion and rape so that young men can define and identify such interactions when they occur. 'Gay-boy talk' can impart tools for avoiding these situations and for handling them when they arise.

'Gay-boy talk' can also be used as a tool to influence the sometimes fragile logic that young gay men employ when having sex. For instance, many young gay men believe they are protected against exposure to HIV if they are in an exclusive relationship with a boyfriend. However, presumed monogamy in gay relationships, without communication or contingency planning, can heighten the risk for HIV exposure when used as a risk-reduction strategy. In order to address presumptions about monogamy in primary relationships with

young gay men, the lives and relationships of young gay men, in all of their intricacies, need to be normalized, acknowledged, and respected. Current HIV interventions targeting young gay men do not always sensitively address sex (including anal sex) between boyfriends, because they do not always acknowledge the seriousness and importance of boyfriend-relationships and the sex young gay men choose to have.

It is also important to remember that young gay men are motivated by more than their desire for sex. HIV-prevention approaches should therefore seek to honor and celebrate the many facets of gay youth's lives as well as the larger social relationships in which they are embedded. Conventional HIV-risk behavior evaluation forms may not capture the fullness of the lives young gay men are leading. When providers respect the ways gay boys are talking to each other, instead of seeing them as 'empty' vessels who need the public health vocabulary of prevention, they can develop more effective programs. As providers, researchers, educators, and parents we should not "put a condom" on the conversation.

In fact, peers, parents, and teachers can all play vital roles in this effort to foster discussions about the safer-sex needs of gay youth. Sex education policies and curricula should be expanded to include explicit information about some of the challenges that gay youth face as sexual minorities, gay men's relationships with primary partner, gay and lesbian organizational resources, and the use of condoms for anal sex. Simply asking young gay men about their relationships, sharing resources for gay-related services, supporting young gay men to be active in social justice issues, or introducing them to mentors who can talk about the importance of safer sex for gay men could lead to more self-initiated talk amongst them about how best to manage the kind of sex they actually want.

## USING THE GAY-BOY TALK CONCEPT

The findings from the *Sexual Stories* project suggest important implications for education policies targeting gay youth. Too often, public health officials seek a "magic-bullet" intervention to target "at-risk" populations and change their behaviors. We believe that training curricula for targeting gay youth are critical components of our efforts to reduce HIV risk among young gay men. Yet, it is also important to build on their own resiliencies and to involve young gay men in the 'gay-boy talk' that will lead to social and cultural change and, ultimately, to their own behavioral changes.<sup>10</sup>

AIDS Project Los Angeles (APLA) is currently using this concept along with the Mpowerment training guidelines to implement an HIV-prevention program with gay youth. The Mpowerment model has been shown to be effective in reducing rates of unprotected anal intercourse

among young gay men.<sup>11</sup> APLA is adapting the model to the particular needs of young, working-class, urban gay men of color in Los Angeles. The young men in our program face numerous other salient issues in their lives beyond HIV. These include poverty, family violence, and urban gay life. They also have desires and dreams like becoming fashion designers or mystery novel writers. Having knowledge of, and being connected to these issues is the best entrance into discussions about safer sex with our clients. We can then begin to more effectively analyze and address the factors that contribute to their understandings of safe and unsafe sex as well as larger feelings of safety or risk in their lives, homes, and neighborhoods.

### EXAMPLES OF GAY BOY TALK

Such an approach to sexual health education is driven by a philosophy of building on gay youth's existing 'gay-boy talk' in their daily lives, rather than relying solely on educational events. For example, the Mpowerment program at APLA faced an incident in which one of the boys in the program was considering suicide as a result of tensions in his family surrounding being gay. Several of the young men in the program responded by effectively employing 'gay-boy talk' as a powerful strategy for managing a high-risk circumstance. They advised him and shared tactics for negotiating the perils of home life.



IMAGE 1

The picture above is a self-portrait of an Mpowerment participant representing himself during a workshop. The image functions as self-generated 'gay-boy talk' that visually conveys beauty, agency, vulnerability, and playfulness. With such images, young gay men talk to themselves and each other, while talking back to a larger society that is often indifferent or even hostile. This kind of 'gay-boy talk' imagery can be used in outreach materials such as flyers and websites, community events such as readings and exhibitions, and simply to affirm the creativity and

resilience of young gay men. In fact at APLA, such images have been so successful at "talking" with young gay men that dozens of potential clients have asked to participate in the program because it would allow them to make their own representations.

The Mpowerment project at APLA draws on existing safer-sex training and materials but only in the service of activating young gay men's imaginations and sense of belonging. For instance, one of the first 'interventions' of the program involved asking the young men to take pictures of themselves, talk about their lives, and create a flyer for the program.



IMAGE 2



IMAGE 3

The flyer (see Image 2) depicts images of young gay men 'gay-boy talking' in non-verbal ways that illustrate their connection to each other and their own unique ways of being in the world. The flyer also incorporates a cartoon character named 'Flamer' designed by a client in consultation with his peers (see Image 3). This is one example of the ways in which 'gay-boy talk' can be culturally coded through fashion, gesture, and physical camaraderie. This simple flyer allows the guys to see themselves as an integral part of the

program's process. This kind of inter-subjective programming can model and affirm the power of 'gay-boy talk.'

### MOVING FORWARD

'Gay-boy talk,' then, is a means for creating and disseminating ethical principles for becoming sexually active adults. Through 'gay-boy talk,' young gay men can reinforce collective practices that support communication, intimacy, pleasure, consensual sex, protection, trust, and healthy boundaries. Conversely, they can actively reject the imposed sexual silences, shame, disempowerment, and violence that heighten the risk for HIV. 'Gay-boy talk' is an HIV-prevention strategy that operates at the cultural level, moving us away from a singular focus on individual behavioral risk. Fostering 'gay-boy talk' can help in our work against future HIV infections among young gay men.

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### NEW RESOURCE FROM NMHA

The National Mental Health Association (NMHA) recently developed "What Does Gay Mean?," an anti-bullying, educational initiative, to raise awareness of anti-gay prejudice and its mental health impact, and to improve understanding and respect. This project grew out of concern for the mental health of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth who face daily taunting, bullying, and acts of violence in their schools, homes, and communities. As a result, these youth are at increased risk for depression, anxiety disorders, and suicide.

*What Does Gay Mean: Talking to Kids about Sexual Orientation and Prejudice* is a brochure developed by the project designed to help parents play a more proactive role in what their children learn about sexual orientation. In 2004, NMHA will develop a brochure for Latino parents.

For more information: National Mental Health Association, 2001 N. Beauregard Street, 12th Floor, Alexandria, VA 22311, phone: 703/684-7722, fax: 703/684-5968, web site: [www.nmha.org](http://www.nmha.org).

# SIECUS FACT SHEET

## SEXUALITY AND YOUTH IN COMMUNITIES OF COLOR

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**Y**oung people in communities of color face disproportionate rates of unintended pregnancy and sexually transmitted diseases, including HIV.

The reasons for these disparities are rooted in the complex social, economic, and political landscape of our nation and are difficult to understand completely. Still, the Centers for Disease Control and Prevention (CDC) suggest several important factors including the distribution of poverty, availability and quality of health care, the level of drug use in some communities, multiple sexual partners, and sexual networks with high STD prevalence.

This fact sheet provides information about many issues affecting the health of young people in communities of color including sexual behavior, contraceptive use, STDs, HIV, unintended pregnancy, and knowledge and beliefs about sexual health. Understanding all of these issues can help professionals design culturally competent sexuality education and prevention programs.

Throughout this fact sheet references to racial/ethnic groups vary. These variations reflect the terms used in the original research.

### SEXUAL BEHAVIOR

#### *Data from the Youth Risk*

#### *Behavior Surveillance System (YRBS)<sup>1</sup>*

- 60.8 percent of Black students (68.8 percent of male and 53.4 percent of female); 48.4 percent of Hispanic students (53 percent of male and 44 percent of female); and 43.2 percent of White students (41.1 percent of male and 41.3 percent of female) reported having had sexual intercourse.
- 16.3 percent of Black students (25.7 percent of male and 7.6 percent of female); 7.6 percent of Hispanic students (11.4 percent of male and 4.1 percent of female); and 4.7 percent of White students (6.2 percent of male and 3.3 percent of female) reported having initiated sexual intercourse before the age of 13.
- 45.6 of Black students (52.3 percent of male and 39.5 percent of female); 35.9 percent of Hispanic students (37.3 percent of male and 34.5 percent of female); and 31.3 percent of White students (30.0 percent of male and 32.3 percent of female) reported being currently sexually active, defined as having had sexual intercourse in the three months prior to the survey.
- 26.6 percent of Black students (38.7 percent of male and 15.6 percent of female); 14.9 percent of Hispanic students (20.6 percent of male and 9.5 percent of female); and 12 percent of White students (12.8 percent of male and 11.1 percent of female) reported having had sexual intercourse with four or more partners.
- Among currently sexually active students, 17.8 percent of Black students, 24.1 percent of Hispanic students, and 27.8 percent of White students reported using alcohol or drugs during last intercourse.

#### *Data from the National Survey of Adolescents and Young Adults<sup>2</sup>*

- 68 percent of White adolescents and young adults (ages 15 to 24), 69 percent of African-American adolescents and young adults, 67 percent of Latino adolescents and young adults, and 57 percent of Asian adolescents and young adults reported having had sexual intercourse.
- 61 percent of White adolescents and young adults (ages 15 to 24), 41 percent of African-American adolescents and young adults, 47 percent of Latino adolescents and young adults, and 40 percent of Asian adolescents and young adults reported having engaged in oral sex.
- 89 percent of White adolescents and young adults (ages 15 to 24), 59 percent of African-American adolescents and young adults, and 75 percent of Latino adolescents and young adults who had engaged in sexual intercourse reported having engaged in oral sex.
- 14 percent of White adolescents and young adults (ages 15 to 24), 8 percent of African-American adolescents and young adults, and 9 percent of Latino adolescents and young adults who had not engaged in sexual intercourse reported having engaged in oral sex.
- 77 percent of White adolescents and young adults (ages 15 to 24), 76 percent of African-American adolescents and young adults, 74 percent of Latino adolescents and young adults, and 67 percent of Asian adolescents and young adults reported having “been with someone in an intimate or sexual way (including but not limited to intercourse).”

## ATTITUDES ABOUT SEXUAL BEHAVIOR

### Data from the National Survey of Adolescents and Young Adults<sup>3</sup>

- 60 percent of White adolescents (ages 15 to 17), 36 percent of African-American adolescents, and 36 percent of Latino adolescents agree that “once you have had sex it is harder to say no the next time.”
- 60 percent of White adolescents (ages 15 to 17), 59 percent of African-American adolescents, and 56 percent of

Latino adolescents agree that “there is pressure to have sex by a certain age.”

- 51 percent of White adolescents (ages 15 to 17), 30 percent of African-American adolescents, and 32 percent of Latino adolescents agree that “oral sex is not as big of a deal as sexual intercourse.”
- 61 percent of White adolescents (ages 15 to 17), 68 percent of African-American adolescents, and 67 percent of Latino adolescents agree that “waiting to have sex is a nice idea but nobody really does.”

## HIV/STD KNOWLEDGE, ATTITUDES, AND RISK BEHAVIORS AMONG HMONG-AMERICAN ADOLESCENTS

A study in *the Journal of Sex Education and Therapy* examined self-reported HIV/STD knowledge, attitudes, and risk behaviors among Hmong-American adolescents.

The Hmong are native to southern China and Southeast Asia. It is estimated that 150,000 Hmong now live in the United States. Much of the information available about HIV/STD groups all Asians, including the Hmong, together despite differences in language, religion, and customs. Therefore, little information is available on HIV/STD knowledge, attitudes, and risk factors specific to the Hmong community.

For this study, researchers surveyed 299 Hmong-American students, ages 12–21, who took part in a culturally specific HIV/STD prevention program offered by public junior and senior high schools in St. Paul, MN, during the 1993–94 and 1994–95 school years. Approximately 20 percent of the Hmong-American students in these schools chose to participate in these programs. The study found:

- 87 percent of participants responded correctly when asked if “people can get a sexually transmitted disease by having sex.”
- 80 percent of participants responded correctly when asked if “you can get AIDS if you use the same toilet seat or phone as someone who has AIDS.”
- 48 percent of participants responded correctly when asked if “one way to prevent the spread of HIV is to have sex with only one partner.”
- 71 percent of participants responded correctly when asked if “Hmong people don’t have to practice safer sex because it is very difficult for them to get HIV.”
- 50 percent of participants responded correctly when asked if “you eat a lot of hot peppers, you will not get AIDS.”
- 30 percent of participants responded correctly when asked if “in Laos, there is a tree that can keep you from

catching the AIDS virus if you make tea from the leaves and drink the tea.”

### ATTITUDES TOWARD HIV/STD

- 87 percent of participants expressed the desired attitude in response to the statement “It is smart to use a condom when having sex.”
- 67 percent of participants expressed the desired attitude in response to the statement “It’s okay for teenagers to refuse to have sex.”
- 62 percent of participants expressed the desired attitude in response to the statement “It’s okay for teenagers to have sex without a condom if they both say they’re virgins.”
- 54 percent of participants expressed the desired attitude in response to the statement “I do not want to get tested for HIV because the Hmong community would find out.”
- 47 percent of participants expressed the desired attitude in response to the statement “Condoms are quite disgusting and I wouldn’t want to touch one.”
- 44 percent of participants expressed the desired attitude in response to the statement “Hmong people whose ancestors were ‘bad’ are in great danger of getting AIDS.”

### AIDS RISK BEHAVIORS

- 7 percent of participants reported having engaged in sexual intercourse. Of these, 63 percent reported always using a condom during sexual intercourse and 75 percent reported having had only one sexual partner.
- 77 percent of participants reported knowing how to use a condom.

B. E. Robinson, et al., “HIV/STD Knowledge, Attitudes, and Risk Behaviors in Hmong-American Adolescents: An Unstudied Population,” *Journal of Sex Education and Therapy*, 24, nos. 1&2, 1999, 37–46.

## CONTRACEPTIVE USE

### *Data from the YRBS<sup>4</sup>*

- Among currently sexually active\* students, 67.1 percent of Black students, 56.8 percent of Hispanic students, and 53.5 percent of White students reported using condoms during last intercourse.
- Among currently sexually active\* students, 7.9 percent of Black students, 9.6 percent of Hispanic students, and 23.4 percent of White students reported that either they or their partner used birth control pills before last intercourse.

\*“Currently sexually active” was defined as having had sexual intercourse in the three months prior to the survey.

### *Data from the National Survey of Adolescents and Young Adults<sup>5</sup>*

- 62 percent of White adolescents and young adults (ages 15 to 24), 59 percent of African-American adolescents and young adults, 52 percent of Latino adolescents and young adults, and 62 percent of Asian adolescents and young adults who had engaged in sexual intercourse reported *using birth control or protection all of the time*.\*
- 6 percent of White adolescents and young adults (ages 15 to 24), 4 percent of African-American adolescents and young adults, 10 percent of Latino adolescents and young adults, and 8 percent of Asian adolescents and young adults who had engaged in sexual intercourse reported *never using birth control or protection*.\*
- 90 percent of White adolescents and young adults (ages 15 to 24), 93 percent of Black adolescents and young adults, 89 percent of Latino adolescents and young adults, and 85 percent of Asian adolescents and young adults who had engaged in sexual intercourse reported *ever using condoms*.\*
- 58 percent of White adolescents and young adults (ages 15 to 24), 72 percent of Black adolescents and young adults, 55 percent of Latino adolescents and young adults, and 57 percent of Asian adolescents and young adults who had engaged in sexual intercourse reported *having used condoms regularly*.\*
- 56 percent of White adolescents and young adults (ages 15 to 24), 67 percent of Black adolescents and young adults, 52 percent of Latino adolescents and young adults, and 62 percent of Asian adolescents and young adults who had engaged in sexual intercourse reported *having used a condom the last time they had sexual intercourse*.\*
- 67 percent of White adolescents and young adults (ages 15 to 24), 53 percent of Black adolescents and young adults, 53 percent of Latino adolescents and young adults,

and 46 percent of Asian adolescents and young adults who had engaged in sexual intercourse reported *ever using the birth control pill*.\*

- 41 percent of White adolescents and young adults (ages 15 to 24), 48 percent of Black adolescents and young adults, 42 percent of Latino adolescents and young adults, and 45 percent of Asian adolescents and young adults, who had engaged in sexual intercourse reported *ever using withdrawal or “pulling out.”*\*
- 6 percent of White adolescents and young adults (ages 15 to 24), 5 percent of Black adolescents and young adults, 11 percent of Latino adolescents and young adults, and 13 percent of Asian adolescents and young adults who had engaged in sexual intercourse reported *ever using the rhythm or calendar method*.\*

\*emphasis added

## ATTITUDES ABOUT “SAFER-SEX” AND CONTRACEPTION

### *Data from the National Survey of Adolescents and Young Adults<sup>6</sup>*

- 85 percent of White adolescents (ages 15 to 17), 92 percent of African-American adolescents, and 84 percent of Latino adolescents consider sex with a condom to be a form of safer sex.
- 77 percent of White adolescents (ages 15 to 17), 58 percent of African-American adolescents, and 62 percent of Latino adolescents consider sex using other kinds of birth control to be a form of safer sex.
- 18 percent of White adolescents (ages 15 to 17), 32 percent of African-American adolescents, and 27 percent of Latino adolescents consider “pulling out” to be a form of safer sex.
- 24 percent of White adolescents (ages 15 to 17), 32 percent of African-American adolescents, and 27 percent of Latino adolescents consider “sex during the ‘safe’ times of the month” to be a form of safer sex.
- 46 percent of White adolescents (ages 15 to 17), 22 percent of African-American adolescents, and 27 percent of Latino adolescents consider oral sex to be a form of safer sex.
- 92 percent of White adolescents (ages 15 to 17), 71 percent of African-American adolescents, and 73 percent of Latino adolescents agree that “sex without a condom isn’t worth the risk.”
- 34 percent of White adolescents (ages 15 to 17), 28 percent of African-American adolescents, and 39 percent of Latino adolescents agree that “it is hard to bring up the topic of condoms.”

## UNPROTECTED SEX AND ASSOCIATED RISK FACTORS AMONG YOUNG ASIAN AND PACIFIC ISLANDER MEN WHO HAVE SEX WITH MEN

*AIDS Education and Prevention* featured a study that focused on young Asian and Pacific Islander men who have sex with men (API MSMs). Researchers recruited 253 young API MSMs (ages 15–25) who reported having same-gender sexual intercourse\* within the 12 months preceding the study. Participants were selected from gay-identified venues in Seattle and San Diego. The study found:

### SEXUAL PARTNERS

- 88 percent of participants reported having at least one sexual partner in the three months preceding the study.
- Of these, 41 percent reported having only one sexual partner; 23 percent reported having two sexual partners; and 24 percent reported having three or more sexual partners in the three months preceding the study.

### PATTERNS OF SEXUAL BEHAVIOR

- 60 percent of the participants who reported having sexual intercourse\* in the three months preceding the study specified having anal intercourse.
- Of these, 48 percent reported having used condoms every time they had anal intercourse; 44 percent reported

having anal intercourse without condoms with at least one man; and 8 percent reported having anal intercourse without condoms with two or more men.

### MAIN PARTNER VERSUS NON-MAIN PARTNER

Participants were also asked to categorize their experiences with “main” or “non-main” partners. Researchers defined a main partner as a “steady boyfriend or lover.”

- 60 percent of participants reported having anal intercourse with a main partner, and 43 percent of participants reported having anal intercourse with a non-main partner in the three months preceding the study.
- 49 percent of participants reported having unprotected anal intercourse with a main partner, and 25 percent of participants reported having unprotected anal intercourse with a non-main partner in the three months preceding the study.

\* *Sexual intercourse was defined as oral and anal intercourse, as well as any physical contact leading to orgasm.*

Kyung-Hee Choi, et al., “Unprotected Sex and Associated Risk Factors among Young Asian and Pacific Islander Men Who Have Sex with Men,” *AIDS Education and Prevention*, 14, no. 6, December 2002, 472–81.

- 59 percent of White adolescents (ages 15 to 17), 60 percent of African-American adolescents, and 65 percent of Latino adolescents agree that “condoms break a lot.”
- 51 percent of White adolescents (ages 15 to 17), 29 percent of African-American adolescents, and 43 percent of Latino adolescents agree that “buying condoms is embarrassing.”
- 85 percent of White adolescents (ages 15 to 17), 89 percent of African-American adolescents, and 89 percent of Latino adolescents agree that if a partner suggested using a condom they would feel “like the person cared about me.”
- 87 percent of White adolescents (ages 15 to 17), 89 percent of African-American adolescents, and 89 percent of Latino adolescents agree that if a partner suggested using a condom they would feel “relieved.”
- 86 percent of White adolescents (ages 15 to 17), 98 percent of African-American adolescents, and 91 percent of Latino adolescents agree that if a partner suggested using a condom they would feel “like the person respected me.”
- 14 percent of White adolescents (ages 15 to 17), 9 percent of African-American adolescents, and 11 percent of Latino adolescents agree that if a partner suggested using a condom they would feel “insulted.”

- 52 percent of White adolescents (ages 15 to 17), 58 percent of African-American adolescents, and 58 percent of Latino adolescents agree that if a partner suggested using a condom they would feel “suspicious or worried about the person’s past sexual history.”
- 46 percent of White adolescents (ages 15 to 17), 54 percent of African-American adolescents, and 56 percent of Latino adolescents agree that if a partner suggested using a condom they would feel “like the person was suspicious or worried about my past sexual history.”

### SEXUALLY TRANSMITTED DISEASES

#### *Data from the Sexually Transmitted Disease Surveillance 2003<sup>7</sup>*

- In 2002, Black women ages 15 to 19 years had a gonorrhea rate of 3,307.7 cases per 100,000 females. This rate was 17 times greater than the rate among white females of the same age (196.1). In 2002, Black men ages 15 to 19 had a gonorrhea rate of 1680.1 cases per 100,000 males. This rate was 45 times greater than the rate among White males of the same age (37.7).

- In 2002, the gonorrhea rate among White, non-Hispanic adolescents ages 15 to 19 was 115.0 per 100,000 compared to 2,484.9 among Black, non-Hispanic adolescents, 214.7 among Hispanic adolescents, 66.8 among Asian or Pacific Islander adolescents, and 393.1 among American Indian/Alaska Native adolescents.
- In 2002, the chlamydia rate among White, non-Hispanic adolescents ages 15 to 19 was 713.2 per 100,000 compared to 5,032.2 among Black, non-Hispanic adolescents, 1,578.6 among Hispanic adolescents, 507.6 among Asian or Pacific Islander adolescents, and 2,659.6 among American Indian/Alaska Native adolescents.
- In 2002, the syphilis rate among White, non-Hispanic adolescents 15 to 19 was 0.3 per 100,000 compared to 8.6 among Black, non-Hispanic adolescents, 1.9 among Hispanic adolescents, 0.2 among Asian or Pacific Islander adolescents, and 0.5 among American Indian/Alaska Native adolescents.

#### ***Data from the Division of HIV/AIDS Prevention<sup>8</sup>***

- 2,825 cases of HIV infection among male adolescents ages 13 to 19 were reported to the Centers for Disease Control and Prevention through December 2001. Of these, 872 were White, non-Hispanic; 1,654 Black, non-Hispanic; 249 Hispanic; 8 Asian/Pacific Islander; and 20 American Indian/Alaska Native.
- 3,762 cases of HIV infection among female adolescents ages 13 to 19 were reported to Centers for Disease Control and Prevention through December 2001. Of these 739 were White, non-Hispanic; 2,716 Black, non-Hispanic; 256 Hispanic; 9 Asian/Pacific Islander; and 23 American Indian/Alaska Native.

### **ATTITUDES ABOUT SEXUALLY TRANSMITTED DISEASES**

#### ***Data from the National Survey of Adolescents and Young Adults<sup>9</sup>***

- 12 percent of White adolescents (ages 15 to 17), 11 percent of African-American adolescents, and 12 percent of Latino adolescents agree that “unless you have sex with a lot of people STDs are not something you have to worry about.”
- 17 percent of White adolescents (ages 15 to 17), 30 percent of African-American adolescents, and 22 percent of Latino adolescents agree that “STDs can only be spread when symptoms are present.”
- 27 percent of White adolescents (ages 15 to 17), 16 percent of African-American adolescents, and 28 percent of Latino adolescents agree that “if someone I was dating had an STD, I would know it.”

- 9 percent of White adolescents (ages 15 to 17), 11 percent of African-American adolescents, and 18 percent of Latino adolescents agree that “STDs are a nuisance but they do not have any serious health effects.”
- 55 percent of White adolescents (ages 15 to 17), 41 percent of African-American adolescents, and 45 percent of Latino adolescents agree that “it is hard to bring up the topic of STDs with a partner.”

### **ADOLESCENT PREGNANCY**

#### ***Data from the YRBS<sup>10</sup>***

- Among currently sexually active students, 11.4 percent of Black students, 5.7 percent of Hispanic students, and 3.3 percent of White students reported having been pregnant or having gotten someone pregnant.
- Among currently sexually active students, 11.9 percent of Black female students, 4 percent of Hispanic female students, and 6.2 percent of White female students reported having been pregnant.

#### ***Data from the National Vital Statistics Report<sup>11</sup>***

- In 2002, 39.4 per 1,000 White adolescents (ages 15 to 19) gave birth, compared to 66.6 per 1,000 Black adolescents, 53.8 per 1,000 American-Indian adolescents, and 18.3 per 1,000 Asian or Pacific Islander adolescents.
- In 2002, 83.4 per 1,000 Hispanic adolescents (ages 15 to 19) gave birth, compared to 63.0 per 1,000 “other Hispanic” adolescents, and 35.5 per 1,000 “non-Hispanic” adolescents.

### **BIRTH RATES DECLINE**

#### ***Data from the National Vital Statistics Report<sup>12</sup>***

- In 2002, 83.4 per 1,000 Hispanic adolescents (ages 15 to 19) gave birth compared to 104.6 per 1,000 in 1991.
- In 2002, 68.3 per 1,000 non-Hispanic Black adolescents (ages 15 to 19) gave birth compared to 118.2 per 1,000 in 1991.
- In 2002, 53.8 per 1,000 American-Indian adolescents (ages 15 to 19) gave birth compared to 84.1 per 1,000 in 1991.
- In 2002, 28.5 per 1,000 non-Hispanic White adolescents (ages 15 to 19) gave birth compared to 43.4 per 1,000 in 1991.
- In 2002, 18.3 per 1,000 Asian or Pacific Islander adolescents (ages 15 to 19) gave birth compared to 27.3 per 1,000 in 1991.

## WHERE YOUNG PEOPLE LEARN ABOUT SEXUALITY

### *Data from the YRBS<sup>13</sup>*

- 91.1 percent of White students, 86.1 percent of Black students, and 80.5 percent of Hispanic students reported having received education about AIDS or HIV infection in school.

### *Data from the National Survey of Adolescents and Young Adults<sup>14</sup>*

- 37 percent of White adolescents (ages 15 to 17), 60 percent of African-American adolescents, and 42 percent of Latino adolescents reported learning “a lot” about sexual health issues from their parents.
- 47 percent of White adolescents (ages 15 to 17), 33 percent of African-American adolescents, and 42 percent of Latino adolescents reported learning “a lot” about sexual health issues from their friends.
- 25 percent of White adolescents (ages 15 to 17), 45 percent of African-American adolescents, and 30 percent of Latino adolescents reported learning “a lot” about sexual health issues from doctors or other healthcare providers.
- 29 percent of White adolescents (ages 15 to 17), 47 percent of African-American adolescents, and 45 percent of Latino adolescents reported learning “a lot” about sexual health issues from TV, movies, magazines, or the Internet.
- 51 percent of White adolescents (ages 15 to 17), 70 percent of African-American adolescents, and 66 percent of Latino adolescents reported learning “a lot” about sexual health issues from sex education classes.

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Feature articles are usually 2,000–4,000 words. Book and audiovisual reviews are typically 200–600 words.

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