PREVENTING HIV AND OTHER SEXUALLY TRANSMITTED DISEASES AMONG YOUNG TEENS pdf

1: Sexually Transmitted Disease Prevention: What Can You Do? | Family and Youth Services Bureau | AC

What are sexually transmitted diseases (STDs)? STDs are diseases that are passed from one person to another through sexual contact. These include chlamydia, gonorrhea, genital herpes, human papillomavirus (HPV), syphilis, and HIV.

Journal of Adolescent Health ;27 4: Keeping middle school students abstinent: Preventing adolescent pregnancy with social and cognitive skills. The challenge of changing drug and sex risk behaviors of runaway and homeless adolescents. Evaluation of a knowledge- and cognitive-behavioral skills-building intervention to prevent STDs and HIV infection in high school students. Peer counseling in a culturally specific adolescent pregnancy prevention program. Information-motivation-behavioral skills model-based HIV risk behavior change intervention for inner-city high school youth. Effects of 2 prevention programs on high-risk behaviors among African American youth: Effects of a skill-based intervention to encourage condom use among high risk heterosexually active adolescents. A replication study of Reducing the Risk, a theory-based sexuality curriculum for adolescents. Reductions in HIV risk-associated sexual behaviors among Black male adolescents: Effects of an AIDS prevention intervention. Testing the generality of intervention effects. The effect of tailoring a model HIV prevention program for local adolescent target audiences. An AIDS and pregnancy prevention middle school program. An HIV prevention program for adolescent mothers. Unprotected sex among African-American adolescents: Long-term outcomes of an abstinence-based, small-group pregnancy prevention program in New York City schools. Computerized HIV preventive intervention for adolescents: Outcomes of intensive AIDS education for male adolescent drug users in jail. Preventing HIV infection among adolescents: Evaluation of a school-based education program. McBride D, Gienapp A. Using randomized designs to evaluate client-centered programs to prevent adolescent pregnancy. The Effectiveness of Poder Latino: New England Research Institutes; Moberg D, Piper DL. The Healthy for Life Project: Sexual risk behavior outcomes. Group-based HIV risk reduction intervention for adolescent girls: The effectiveness of the reach for health community youth service learning program in reducing early and unprotected sex among urban middle school students. Effects of a replication of a multicomponent model for preventing adolescent pregnancy in three Kansas communities. Tapping youth as agents for change: Journal of Adolescent Health ;31 1: Philliber S, Allen J. Life Options and Community Service: Preventing pregnancy and improving health care access among teenagers: Reducing HIV sexual risk behaviors among runaway adolescents. Timing of HIV interventions on reductions in sexual risk among adolescents. Adolescent adjustment over six years in HIV-affected families. Reductions in HIV risk among runaway youth. Long-term effects of a middle school- and high school-based human immunodeficiency virus sexual risk prevention intervention. Arch Pediatr Adolesc Med ; Outcomes of a randomized, controlled community-level HIV prevention intervention for adolescents in low-income housing developments. The long-term impact of AIDS-preventive interventions for delinquent and abused adolescents. The role of condom motivation education in the reduction of new and reinfection rates of sexually transmitted diseases among inner-city female adolescents. Comparison of education versus behavioral skills training interventions in lowering sexual HIV-risk behavior of substance-dependent adolescents. A Randomized Controlled Trial. Randomized trial of a parent intervention: The complex business of adapting effective interventions to new populations: A randomized controlled trial testing an HIV prevention intervention for Latino youth. AIDS risk reduction among a multiethnic sample of urban high school students. Does Parental Involvement Make a Difference? Washington State Institute for Public Policy, A report on the postsecondary outcomes and cost-effectiveness of the QOP Program Increasing condom use among adolescents with coalition-based social marketing. Medical cost savings attributable to comprehensive sex education programs that delay coitus and increase condom use among adolescents in the U. Ohio State University, Perspect Sex Reprod Health ;34 5: Economic evaluation of a comprehensive teenage pregnancy prevention program: Am J Prev Med ;37 6S1: Tao G,

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Remafedi G. Economic evaluation of an HIV prevention intervention for gay and bisexual male adolescents. Economic evaluation of Safer Choices: Fam Plann Perspect ;20 4: With the assistance of a CDC librarian, the team searched for published studies in the following databases: In addition, we also reviewed references listed in all retrieved articles, published and unpublished reports provided by team members and elsewhere, and references from a search of an electronic database continuously updated and maintained by Prevention Research Synthesis PRS in the Division of HIV and AIDS Prevention at CDC. The teams considered studies for inclusion if they were: Portions of the search terms below in parentheses indicate allowances for variation of a keyword, such as the singular and plural versions.

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2: Sexually Transmitted Diseases | Healthy People

EveryBody[TM]: Preventing HIV and Other Sexually Transmitted Diseases among Young Teens. Schoeberlein, Deborah EveryBody is a curriculum that emphasizes prevention of human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) among early adolescents.

Links Introduction Many adolescents engage in sexual intercourse with multiple partners and without condoms. Among sexually experienced people, adolescents aged 15 to 19 years have some of the highest reported rates of STDs. In addition, particular groups of adolescents eg, males who have sex with males, injection drug users, and teens who have sex for drugs engage in even greater risk-taking behavior. Some of these programs have been effective at changing behavior, while others have not. This chapter presents data on adolescent sexual risk-taking behavior, reviews the studies measuring the impact of adolescent prevention programs, and identifies common characteristics of programs that have been effective in reducing sexual risk-taking behavior. It recommends a that these effective school and community programs be implemented more broadly, b that promising clinic programs and comprehensive community-wide campaigns be replicated and evaluated, and c that additional programs focusing on high-risk youth be implemented and evaluated. Adolescent Sexual Risk-Taking Behavior In many countries throughout the world, sexually transmitted disease and unplanned pregnancy have always occurred among adolescents. However, during the last century, and especially during the last few decades of that century, the onset of puberty and initiation of sexual intercourse occurred at decreasing ages in many industrialized countries, whereas the average age of marriage increased. Thus, many adolescents began having sexual intercourse with multiple sexual partners prior to marriage, and this, of course, facilitated STD and HIV transmission. In many countries, a significant proportion of young people initiate sexual activity by age Among students in grades across the U. These networks are often defined by ethnicity, class, geographic location, and other socially defined norms. Sometimes these networks do not connect with each other. Use of Condoms Condoms are recognized as an especially important form of contraception, because they are currently the only form of contraception that prevents the transmission of most STDs. However, condom use varies with urban area, age, ethnicity, gender, and involvement in other risk-taking behaviors, and this national average obscures wide variations in different groups. In young people, for example, condom use declines with age, and is higher among African-Americans than European-Americans. According to some estimates, both ulcerative and nonulcerative STDs increase HIV transmission risks as much as 3- to 5-fold. Similarly, female teenagers have the highest age-specific rate of gonorrhea, whereas male teenagers have the third highest rate. About half of all new HIV infections worldwide, or approximately 6, per day, occur among young people. Despite the challenges of determining at what ages HIV infection occurs, the U. Office of National AIDS Policy has estimated that half of all new HIV infections occur in people under 25 and that half of these occur among young people between the ages of 13 and Among adolescents aged , older adolescents, males, and members of racial minorities have the highest infection rates. Among both males and females, the risk category was often unidentified. Conclusions About Adolescent Risk and Implications for Programs Adolescents, in general, are at risk of contracting HIV through sexual transmission, because a large majority engage in sexual intercourse, have multiple partners over a period of time, and fail to consistently use a condom during every act of intercourse. On the other hand, in the United States, most of these adolescents are actually at relatively low risk, because they rarely, if ever, have sex with people who are HIV infected. In contrast, adolescents in countries where HIV infection is widespread are at much higher risk of contracting HIV through sexual intercourse, as are adolescents in low-prevalence countries who have unprotected intercourse with members of very high-risk groups eg, males who have sex with other males or injection drug users. In addition, there are some adolescents who engage in very frequent unprotected sex for drugs, and thereby greatly increase their risk, both by having frequent unprotected sex and by having sex with partners in high-risk groups. These high-risk groups are somewhat bounded by social

networks, but this may change. Finally, some adolescents are at risk of contracting HIV through sharing needles used to inject drugs. These patterns have important implications for educational programs. First, they suggest that there should be effective HIV education programs for all young people. Furthermore, they suggest that there should be additional, more focused programs targeting those groups of adolescents who are at higher risk of HIV infection. Educational programs for school-aged males should adequately address the risks of unprotected intercourse among males who may have sex with males, while programs for young women and female adolescents in the United States should address the special threat of unprotected heterosexual intercourse with injection drug users and the exchange of sex for drugs. Finally, programs should address drug use and needle sharing. Programs for some of those subgroups of young people who are particularly at risk eg, males who have sex with males, injection drug users, and racial minorities , are discussed in separate chapters. The remainder of this chapter reviews programs designed to reduce sexual risk-taking among adolescents in general in the United States. In addition, programs have tried to reach parents and their adolescent children in their homes, whereas others have used social marketing and media approaches. As long ago as the early s there was concern that young people were having premarital sex and that the rates of "venereal disease" VD were increasing. Believing that accurate information about VD would prevent youth from engaging in sex, some schools and community organizations implemented VD education programs. Schools responded far more dramatically when AIDS became a prominent problem in the latter part of the s. The advent of AIDS affected both the willingness of some schools to cover certain topics and the overall design of some programs. Because of this support, some sex and HIV education programs are implemented with relatively little controversy. On the other hand, there are sex and HIV education controversies in many other communities and entire states. Often these controversies focus on whether only abstinence should be taught in schools or whether condoms and other forms of contraception should also be discussed. In some communities, proponents of abstinence-only approaches are willing to discuss condoms and other forms of contraception, but only if their failure rates are emphasized. Other groups believe that condoms and contraception should be covered in a medically accurate manner. As a result of these controversies, an increasing number of states place restrictions on instruction about condoms and contraceptives, and a substantial proportion of schools limit instruction to abstinence. Other strategies can also facilitate the design and acceptance of more comprehensive programs. Condoms are widely available in schools in some of the largest U. By the end of , at least schools made condoms available to students. At the forefront of these efforts have been the innumerable county or community AIDS projects that have developed programs for youth. Sometimes these include educational programs in schools, but they also include various types of outreach efforts outside of schools. Sometimes they target some of the highest risk groups, such as street youth. Many family planning clinics have also given greater emphasis to HIV and STDs, have initiated policies of giving away free condoms, and have tried to become more friendly and attractive to males. Unfortunately, not many of these efforts have been studied nationwide. Impact of Education Programs Before examining the impact of these programs, two considerations should be made. First, these programs face a daunting challenge. A large number of forces encourage youth to engage in sexual activity, including unprotected sexual activity eg, changing hormones, emotional and physical needs and desires, desires to be an adult and to take risks, ambivalence about becoming pregnant or producing a pregnancy, peer pressures, norms promoting sexual risk-taking, and the omnipresent inaccurate portrayal of sex in the media. In addition, it is known that significant underlying factors, such as the many manifestations of poverty and family and community disorganization, are related to sexual risk-taking behavior, as is detachment from parents or school and lack of a belief in the future. Second, it should be understood that most kinds of educational instruction are evaluated by assessing the impact of instruction upon knowledge, not upon behavior outside of school. For example, history or civics classes are not evaluated by measuring their impact on voting, law breaking, or better citizenry. In contrast, when researchers evaluate the impact of sex or HIV instruction upon sexual or contraceptive behavior, they use dramatically more challenging criteria: Nevertheless, because of the need to identify programs that reduce

sexual risk-taking behavior, these more demanding criteria are used in research studies and in this review. There are more than 60 studies that have used experimental or quasi-experimental designs with sample sizes of at least to examine the behavioral impact of school and community education programs that specifically focus on the reduction of sexual risk-taking behavior among adolescents 18 years old or younger. However, it was possible to measure the impact upon behaviors that are logically related to HIV and STD infection rates: Abstinence Programs Abstinence programs focus upon the importance of abstinence from sexual intercourse, typically abstinence until marriage. Either these programs do not discuss condoms or contraception or they briefly discuss the failure of condoms and contraceptives to provide complete protection against STD and pregnancy. Thus, these programs are not well suited for those young adults at highest risk--gay males. To date, there are only three studies of abstinence programs that meet reasonable scientific criteria. Additional, rigorous evaluations of abstinence-only programs are currently under way. Sex and HIV Education Programs These programs differ from the abstinence-only programs in that they often emphasize abstinence as the safest choice and also encourage the use of condoms and other methods of contraception as ways to protect against STDs or pregnancy. This group includes a wide variety of programs, ranging from sex or AIDS education programs taught in school to programs taught in homeless shelters and detention centers. They reflect the considerable creativity and differing perspectives of these agencies. Studies of these programs strongly support the conclusion that sexuality and HIV education curricula do not increase sexual intercourse, either by reducing the age at first intercourse, increasing the frequency of intercourse, or increasing the number of sexual partners. Of the 28 evaluations of middle school, high school, or community sexuality or HIV education programs that measured the impact of the programs on the initiation of intercourse, nine studies found that their respective programs delayed the initiation of sex, 18 studies found that the programs had no significant impact one way or the other, and only one study found that the program hastened the onset of intercourse. Similarly, of 19 studies that measured the impact of programs upon the frequency of sex, five programs decreased the frequency, 13 had no significant impact, and only one increased the frequency. Finally, of 10 studies that measured impact on number of sexual partners, three programs reduced the number of partners, seven had no impact, and none increased the number of sexual partners. Thus, a multitude of studies clearly demonstrates that these programs that emphasize abstinence but also encourage condom and contraceptive use for sexually active youth do not increase sexual behavior and that some of these programs may actually decrease one or more sexual behaviors. Eighteen studies examined program impact upon condom use, and 10 of them found that the programs did increase some measure of condom use, whereas the remaining programs had no significant effect. Characteristics of Effective Curricula The Effective Program and Research Task Force of the National Campaign to Prevent Teen Pregnancy has reviewed the evidence for the effectiveness of programs in reducing sexual risk-taking behaviors, and has identified five programs with particularly strong evidence for success in delaying sex or increasing condom use. When these five curricula and other curricula having significant positive behavioral outcomes are compared with curricula without such positive behavioral results, the effective curricula share 10 characteristics, which may be linked to their success, whereas the ineffective curricula lack one or more of these characteristics. These programs focused narrowly on a small number of specific behavioral goals, such as delaying the initiation of intercourse or using condoms or other forms of contraception; relatively little time was spent addressing other sexuality issues, such as gender roles, dating, or parenthood. Nearly every activity was directed toward the behavioral goals. Effective programs were based on theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviors. Such approaches include social cognitive theory, 35 social influence theory, 36 social inoculation theory, 37 cognitive behavioral theory, 38,35 theory of reasoned action, 39 and theory of planned behavior. In addition, social influence theories address societal pressures on youth and the importance of helping young people understand those pressures and resist the negative ones. Thus, these programs strive to go far beyond the cognitive level; they focus on recognizing social influences, changing individual values, changing group norms and perceptions of those norms, and building social skills.

These theories help to specify which particular antecedents the interventions should strive to change eg, the beliefs, attitudes, norms, confidence, and skills related to sexual behavior to bring about voluntary change in sexual or contraceptive behavior. Thus, each activity was designed to change one or more antecedents specified by the particular theoretical model for the curriculum, and each important antecedent in the theoretical model was addressed by one or more activities. Although all of the effective curricula focused on antecedents specified by their adopted theories, some program developers actually surveyed students and empirically determined which possible antecedents best predicted desired behavior. Activities in their programs then focused on those particular antecedents. Effective programs gave a clear message about sexual activity and condom or contraceptive use and continually reinforced that message. This particular characteristic appeared to be one of the most important criteria that distinguished effective from ineffective curricula. The effective programs did not simply lay out the pros and cons of different sexual choices and implicitly let the students decide which was right for them; rather, most of the curriculum activities were directed toward convincing the students that abstaining from sex, using condoms consistently, or using other forms of contraception consistently was the right choice, and that unprotected sex was clearly an undesirable choice. To the extent possible, they tried to use group activities to change group norms about what was the expected behavior. Effective programs provided basic, accurate information about the risks of teen sexual activity and about methods of avoiding intercourse or using protection against pregnancy and STDs. Effective programs provided basic information that students needed to assess risks and avoid unprotected sex. Typically, this information was not detailed or comprehensive. For example, the curricula did not provide detailed information about all methods of contraception or different types of STDs.

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3: Sexual Behaviors | Adolescent and School Health | CDC

Sexually transmitted diseases (STD) as well as teen pregnancy are considered surrogate markers for HIV infection. Data from the North Carolina HIV/STD Prevention and Care Branch's HIV/STD Surveillance Report illustrate the scope of chlamydia and gonorrhea, STDs treatable with antibiotics, in adolescents.

More information Program overview The New Jersey Teen Prevention Education Program Teen PEP is a statewide sexual health promotion and peer education initiative that enables high school students to make healthy decisions. The collaborating partners work with interested high schools across New Jersey to institute the Teen PEP sexual health course that is consistent with the core curriculum content standards developed by the New Jersey Department of Education. The Teen PEP sexual health class is an elective or alternative health class that carefully selected high school juniors or seniors chose to enroll with parental approval. The students who enroll in the Teen PEP course become a cohesive team of trained peer educators who are knowledgeable, effective and capable sexual health advocates and role models. They attend the Teen PEP class daily or the equivalent where they receive the information about sexual health and the skills needed to facilitate innovative prevention outreach workshops on a variety of sexual health issues, including: Once peer educators master the information and skills needed to educate others, they conduct structured and scripted outreach workshops, under the supervision of their faculty advisors. These workshops focus on not only on sexual health information, but equally important, on enhancing the critical skills needed to promote teen sexual health, i. The students participating in Teen PEP sexual health outreach workshops are required to obtain parental consent prior to attending the workshops. The faculty who team-teach the Teen PEP course receive special training in the sexual health and coordination of activity-based learning. A minimum of two faculty at each Teen PEP school attend two three-day residential training sessions in their first year and two one-day advanced training workshop annually. Faculty advisor training is key to equip advisors with the skills needed to manage a successful Teen PEP program. The primary tasks addressed during the planning year include: Just prior to the second program year, the newly-selected Teen PEP peer educators and their Faculty advisors take part in a three-day retreat that marks the beginning of the Teen PEP school year. During this retreat peer educators and advisors participate in activities that are designed to assist them in developing a cohesive, working team that they need to become prior to embarking on the learning experiences that are part of the Teen PEP curriculum. The second program year is marked by the onset of the Teen PEP sexual health class that meets daily throughout the school year. Peer educators are enrolled in the Teen PEP course which is team-taught by faculty advisors. Peer educators are trained to conduct at least five outreach workshops annually, and one Family Night sexual health education session for parents. Program participants Stakeholder Team Each Teen PEP school has a diverse team of individuals that supports efforts to implement and institutionalize the program. Faculty Advisor Team In each program school a Faculty Advisor Team of two or three teachers or other qualified school personnel manages the day-to-day operation of the Teen PEP sexual health class. At least one advisor must have prior training in the area of teen sexual health. Should the Teen PEP course be offered as an alternate health course, one advisor must be a New Jersey certified health teacher. Faculty advisors complete a comprehensive training program prior to assignment to teaching the Teen PEP sexual health class; and utilize only materials, curricula and workshops that are part of the Teen PEP curriculum. Peer Educator Team Each school selects a diverse group of students, in the spring of their sophomore or junior year. Students are enthusiastic, responsible leaders who are representative of the student body of the school. Peer educators facilitate prevention outreach workshops for their peers, parents and community, and commit to being positive role models and sexual health advocates for youth. Outreach Audience At each Teen PEP school, peer educators conduct a series of at least five outreach workshops annually. These five workshops can be presented to any group of teens that the Teen PEP stakeholders and school administrators view as appropriate. However, one group of approximately 25 students at each school is

selected to participate in all five of the outreach workshops. Return to Top Participating schools Currently, there are over 50 public high schools and two youth-serving organizations representing 15 New Jersey counties that are active members of the Teen PEP network.

4: STDs (Sexually Transmitted Diseases)

Science and Success: Science Based Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections among Hispanics/Latinos Science and Success in Developing Countries: Holistic Programs That Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections.

Among other requirements, the policies must allow parents to object to and withdraw a child from an activity, class or program. The policies must also include a procedure for notifying parents at least two weeks before any activity, class or program with content involving human reproduction or sexual matters is provided to a child. Sex education, human reproduction education and human sexuality education curriculum and materials must be approved by the school board and available for parents to review. In addition, sets requirements for those who teach sex education, human reproduction education or human sexuality education. Arizona SB Amends existing law to allow school districts to provide sex education instruction unless a parent provides written permission for a student to opt out of instruction. Requires that school districts provide sex education that is medically accurate and age and developmentally appropriate in grades kindergarten through Education requirements also include information to support students in developing healthy relationships and skills such as communication, critical thinking, problem solving and decision making. Requires the Department of Education, among other things, to develop list of appropriate curricula and create rules for instructor qualifications. HB Amends existing law to allow school districts to provide sex education instruction unless a parent provides written permission for a student to opt out of instruction. Authorizes related alternative education. The bill includes that accurate, age-appropriate and culturally responsive STI prevention curricula shall be provided to schools. Georgia HB Requires age-appropriate sexual abuse and assault awareness and prevention education in kindergarten through grade Also provides that professional learning and in-service training may include programs on sexual abuse and assault awareness and prevention. Requires all public schools to implement sex education consistent with these requirements beginning in Allows written permission by parental or legal guardian to opt out of sexuality education. Allows the Department of Education to make modifications to ensure age-appropriate curricula in elementary school. Requires the Department to maintain a public list of curricula that meets requirements of law and to create standards for instructor qualifications. HB Amends existing sexuality health education law to specify additional requirements for information that helps students form healthy relationships and communication skills, as well as critical thinking, decision making and stress management skills, and encourages students to communicate with adults. Requires the Board of Education to collaborate with the Department to maintain a public list of curricula that meets requirements of law. Requires the Department to create standards for instructor qualifications. Kansas HB Requires parental consent for sexuality education and provides that sexuality education materials will be available for parental review. Also requires the boards of education of each school district to adopt policies and procedures related to sexuality education, including prohibiting the distribution of materials to any student whose parent has not consented. Provides that sexual health education should help students develop the relationship and communication skills to form healthy relationships free of violence, coercion, and intimidation. Requires the school to adopt a written policy ensuring parental or legal guardian notification of the comprehensive sexual health education and the right of the parent or legal guardian to withdraw his or her child from all or part of the instruction shall be adopted. SB Requires every city, town, regional school district, vocational school district or charter school with a curriculum on human sexuality to adopt a written policy ensuring parental or legal guardian notification of the comprehensive sexual health education provided by the school, the right of the parent to withdraw a student from instruction and the notification process to the school for withdrawal. Also stipulates that education should help students develop the relationship and communication skills to form healthy relationships free of violence, coercion, and intimidation. Provides that the department of elementary and secondary education shall establish

age-appropriate guidelines for child exploitation awareness education. Provides that factual information includes medical, psychiatric, psychological, empirical, and statistical statements. Mississippi HB Requires sex-related education to consist of medically accurate comprehensive instruction or program. Requires certain teaching components including the appropriate approaches to accessing health care services related to the human reproductive system, and health complications resulting from consensual or nonconsensual sexual activity and available resources for victims of rape, sexual assault or other instances of nonconsensual sexual activity. SB Revises the curriculum on sex-related education and requires the local school board of each school district to implement a program on personal responsibility education into the middle and high school curriculum. Requires that curriculum selected must have been deemed evidence based and medically accurate by the Mississippi State Department of Health. Stipulates that the curriculum must include information that abstinence from sexual activity is the only way to prevent unintended pregnancy. HB Revises the requirement and standards of curriculum to be used in public school districts for the teaching of sex education and removes the requirement that such program be abstinence only. Provides that the required policy to be adopted to implement sex education shall be comprehensive in nature and provide medically accurate, complete, age and developmentally appropriate information. HB Revises the curriculum on sex-related education and requires the local school board of each school district to implement a program on personal responsibility education into the middle and high school curriculum. SB Requires Mississippi school districts to adopt a sex education curriculum that includes medically accurate, complete, age and developmentally appropriate information and to provide information about the prevention of unintended pregnancy, sexually transmitted infections including HIV , dating violence, sexual assault, bullying and harassment. Stipulates that the curriculum shall promote and uphold the rights of young people to information in order to make healthy and responsible decisions about their sexual health. Missouri HB Amends laws related to sex education in schools. In addition to existing criteria of medically and factually accurate, requires that curricula must also be age appropriate and based on peer review. Adds stipulations to cover certain topics, including helping students develop critical thinking, decision making, and stress management skills in order to support healthy relationships. Specifies that curricula promote communication with parents. SB Creates the Teen Dating Violence Prevention Education Act to provide students with the knowledge, skills, and information to prevent and respond to teen dating violence. Authorizes school districts and charter schools to provide teen dating violence education as part of the sexual health and health education program in grades seven through 12 and to establish a related curriculum or materials. Also allows age appropriate instruction on domestic violence. Nebraska LR Designates an interim study be conducted to look at the link between academic achievement and risky health behaviors and to identify specific strategies in schools proven to simultaneously address and improve both academic achievement and health outcomes. Specifically looks at comprehensive sex education and how it can promote healthy attitudes on adolescent growth and positively affect adolescent behavior. New York AB Amends existing education law to add prevention of sexual abuse and assault to health education in all public schools. Requires instruction to be based on current practice and standards and to include recognizing, avoiding, refusing and reporting sexual abuse and assault. Establishes teacher training and standards for type of teacher who can instruct in elementary and secondary school. Requires that applicants teach information that is medically accurate and age appropriate and does not teach religion. Makes provisions for other components, which are not required but may not be contradicted by applicants, including instruction that: Authorizes the commissioner to determine certain topics of instruction to be optional for age-appropriate reasons. SB Establishes an age-appropriate sex education grant program through the Department of Health. Includes the legislative intent of the bill. SB Mandates comprehensive, medically accurate and age-appropriate sex education be taught in grades one through 12 in all public schools. Provides that the Commissioner of Education will create and establish a curriculum to accomplish such goal within one year of the effective date of this legislation. Allows boards of education to adopt their own curricula with approval of Commissioner of Education. AB Mandates comprehensive, medically accurate and age appropriate sex education be taught in

all public schools, grades one through twelve; provides that the commissioner of education will create and establish a curriculum to accomplish such goal within a specified timeframe. North Carolina HB 29 Repeals existing health education statute. Requires the same comprehensive health education and reproductive health education as existing law. Makes organizational to language of law. HB Amends the expertise required for review and acceptance of materials used in reproductive health and safety education and prohibits teaching about certain drugs as part of reproductive health and safety education. Prescribes that instruction shall stress abstinence but shall not exclude other instruction and materials on contraceptive methods and infection reduction measures, and that instruction shall be medically accurate and age-appropriate. Pending- Carryover; House Version: Oklahoma HB Provides that school districts may provide programs to students in grades 7 through 12 addressing sexual violence, domestic violence, dating violence and stalking awareness and prevention. The programs may address the issue of consent to sexual activity and educate students about the affirmative consent standard. Programs may be offered as a separate program or as a part of a sex education class or program. The program outline shall be made available to the public online through the school district website. No student shall be required to participate in the program if a parent or guardian objects in writing. HB Requires sex education curriculum to be medically accurate, factual information that is age-appropriate and designed to reduce risk factors and behavior associated with unintended pregnancy. Pennsylvania SB Requires public school districts to provide sexual health education. Instruction and materials must be age appropriate and all information presented must be medically accurate. Also stipulates certain content that the sexual health education must include, such as information on sexting and affirmative consent. Also requires school districts to publish on its website the title and author of health education materials used. Failed-Adjourned; Senate Version: Utah HB Requires the state board of education to establish curriculum with instruction in comprehensive human sexuality education which includes evidence-based information about topics such as human reproduction, all methods to prevent unintended pregnancy and sexually transmitted diseases and infections including HIV and AIDS and sexual or physical violence. Stipulates that this curriculum shall include instruction to help students develop skills to make healthy decisions and not making unwanted verbal, physical, and sexual advances. Also provides that the curriculum shall include the information on sexual abstinence as well as increasing the use of condoms and other contraceptives. Requires that the state instructional materials commission shall consult with parents, teachers, school nurses, and community members in evaluating instructional materials for comprehensive human sexuality curriculum that comply with this section. Washington SB Adds information on sexual assault and violence prevention and understanding consent to existing health education requirement. It should be medically accurate and the Department of Health Services or the Department of Education can be consulted to review curriculum for medical accuracy and teacher training. The information must be medically accurate, factual, and objective. In grade seven, information must be provided on the value of abstinence while also providing medically accurate information on other methods of preventing pregnancy and STIs. A school district that elects to offer comprehensive sex education earlier than grade seven may provide age-appropriate and medically accurate information. Curriculum content standards shall also be age-appropriate, culturally sensitive, and medically accurate according to published authorities upon which medical professionals generally rely. Creates the comprehensive human sexuality education grant program in the department of public health and environment. The purpose of the program is to provide funding to public schools and school districts to create and implement evidence based, medically accurate, culturally sensitive and age appropriate comprehensive human sexuality education programs. Medically accurate is defined as verified or supported by research conducted in compliance with accepted scientific methods and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the federal Centers for Disease Control and Prevention, the American Public Health Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists. Requires comprehensive sex education offered in grades six through 12 to include instruction on both abstinence and contraception for the prevention of

pregnancy and STDs. Requires course material and instruction replicate evidence-based programs or substantially incorporate elements of evidence-based programs. Requires the State Board of Education to make available sex education resource materials. Allows parents to opt out. Research-based includes information recognized as medically accurate and objective by leading professional organizations and agencies with relevant expertise in the field. Districts must have a program that has technically accurate information and curriculum. The department of health and senior services shall prepare public education and awareness plans and programs for the general public, and the department of elementary and secondary education shall prepare educational programs for public schools, regarding means of transmission and prevention and treatment of the HIV virus. Beginning with students in the sixth grade, materials and instructions shall also stress that STIs are serious, possible health hazards of sexual activity. The educational programs shall stress moral responsibility in and restraint from sexual activity and avoidance of controlled substance use whereby HIV can be transmitted. Students shall be presented with the latest medically factual and age-specific information regarding both the possible side effects and health benefits of all forms of contraception.

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5: Adolescents and STDs | Sexually Transmitted Diseases | CDC

Thus, they engage in sexual behaviors that place them at risk of sexually transmitted diseases (STDs), including HIV. Among sexually experienced people, adolescents aged 15 to 19 years have some of the highest reported rates of STDs.

The content here can be syndicated added to your web site. What are sexually transmitted diseases STDs? STDs are diseases that are passed from one person to another through sexual contact. Many of these STDs do not show symptoms for a long time. Even without symptoms, they can still be harmful and passed on during sex. How are STDs spread? Anyone who is sexually active can get an STD. How common are STDs? STDs are common, especially among young people. About half of these infections are in people between the ages of 15 and Young people are at greater risk of getting an STD for several reasons: Some young people do not get the recommended STD tests. Many young people are hesitant to talk openly and honestly with a doctor or nurse about their sex lives. Not having insurance or transportation can make it more difficult for young people to access STD testing. Some young people have more than one sex partner. What can I do to protect myself? The surest way to protect yourself against STDs is to not have sex. There are many things to consider before having sex. If you do decide to have sex, you and your partner should get tested for STDs beforehand. Make sure that you and your partner use a condom from start to finish every time you have oral, anal, or vaginal sex. Know where to get condoms and how to use them correctly. Mutual monogamy means that you and your partner both agree to only have sexual contact with each other. Before you have sex, talk with your partner about how you will prevent STDs and pregnancy. You should also talk to your partner ahead of time about what you will and will not do sexually. Make sure you get the health care you need. Girls and young women may have extra needs to protect their reproductive health. Talk to your doctor or nurse about regular cervical cancer screening, and chlamydia and gonorrhea testing. You may also want to discuss unintended pregnancy and birth control. The only way to know for sure if you have an STD is to get tested. You can get an STD from having sex with someone who has no symptoms. Just like you, that person might not even know he or she has an STD. Where can I get tested? There are places that offer teen-friendly, confidential, and free STD tests. Can STDs be treated? Your doctor can prescribe medicine to cure some STDs, like chlamydia and gonorrhea. If you are ever treated for an STD, be sure to finish all of your medicine, even if you feel better before you finish it all. Ask the doctor or nurse about testing and treatment for your partner, too. Otherwise, you may continue to pass the STD back and forth. For example, if left untreated, chlamydia and gonorrhea can make it difficultâ€”or even impossibleâ€”for a woman to get pregnant. What if my partner or I have an incurable STD? Although it may be uncomfortable to talk about your STD, open and honest conversation can help your partner make informed decisions to protect his or her health. If I have questions, who can answer them? If you have questions, talk to a parent or other trusted adult. After all, they were young once, too. Ask which STD tests and vaccines they recommend for you. Where can I get more information?

PREVENTING HIV AND OTHER SEXUALLY TRANSMITTED DISEASES AMONG YOUNG TEENS pdf

6: State Policies on Sex Education in Schools

This may be the warning for a new epidemic of HIV among young adults during the next 5 to 10 years. HIV infection and other sexually transmitted diseases.

Start Talking Be honest about how you feel. Talking with your teen about how to prevent STDs may not be easy for you. Try not to give your teen too much information at once. Remember, you have plenty of time to talk about preventing STDs. Give your teen time to think â€" she may come back later and ask questions. Make this the first conversation of many about preventing STDs. Conversation Tips Listen and ask questions. Show your teen that you are paying attention and trying to understand his thoughts and feelings. Repeat back what your teen says in your own words. What do you think about that? Talk while you are doing something together. For example, try talking with your teen about sex and STDs when you are driving in the car or cooking dinner. You can still show your teen that you are listening to him by nodding your head or repeating what he says. Get ideas from other parents. Ask other parents what they have done. You may be able to get helpful tips and ideas. Counseling to prevent STDs is recommended for all teens who are sexually active. Under the Affordable Care Act , the health care reform law passed in , health insurance plans must cover prevention counseling and screening for teens at risk of getting an STD. Depending on your insurance plan, your teen may be able to get STD counseling and screening at no cost to you. Previous section Conversation Tips 10 of 10 sections.

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7: HIV/STD Prevention

1 in 4 teens contract a sexually transmitted disease every year. Less than half of adults age 18 to 44 have ever been tested for an STD other than HIV/AIDS. Sources.

This site contains HIV prevention messages that may not be appropriate for all audiences. However, according to General Statute G. Before a comprehensive sexuality education program is adopted, the local board of education shall conduct a public hearing and make all instructional materials available for review by parents or legal guardians for at least 30 days before the public hearing and 30 days after the hearing. Additionally, in , youth housed in juvenile detention centers were surveyed as part of a YRBS special project, and found many at high risk for HIV transmission. The survey also revealed that Substantial morbidity and social problems among youth are the result of unsafe sex practices resulting in unintended pregnancies and STDs, including HIV infection. Nearly half of all new sexually transmitted diseases in NC occur in youth years old. The age range of 13 to 24 may better describe infections that likely occurred during adolescence because there could be significant delay between infection and subsequent testing and reporting. If left untreated, these bacteria can lead to infertility later in life. Chlamydia and gonorrhea are predominantly found in younger age groups. For males, the highest rates of chlamydia are consistently found in the age group, followed by those age For females the trend is reversed, with year olds having the highest rates, followed by year olds. In North Carolina, gonorrhea rates mirror the chlamydia trends with respect to age. For males, the highest rates are consistently found in the age group, followed by age group. Until recently, the trend for females was reversed, with year olds having the highest rates, followed by 20 to 22 year olds. In , the rate of gonorrhea was From to , the rate for 20 to 24 year old females exceeded the rate for 15 to 19 year olds. These numbers do not include those who are infected and unaware of their status, as chlamydia and gonorrhea are often asymptomatic showing no symptoms. The timeline begins with and highlights such milestones as the establishment of the first community-based AIDS service provider in the U. Various file formats are used on this page that may require download. If larger than 1mb, it will take longer to download. For instructions or more information, please visit our download page.

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8: Talk with Your Teen about Preventing STDs - www.enganchecubano.com

In fact, girls who experience sexual violence are up to three times more likely to be infected with HIV or other sexually transmitted diseases than those who do not.

Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates the influence of these factors. Social, economic, and behavioral factors that affect the spread of STDs include: Racial and ethnic disparities. Race and ethnicity in the United States are correlated with other determinants of health status, such as poverty, limited access to health care, fewer attempts to get medical treatment, and living in communities with high rates of STDs. STDs disproportionately affect disadvantaged people and people in social networks where high-risk sexual behavior is common, and either access to care or health-seeking behavior is compromised. Access to health care. Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling for STDs. Groups with the highest rates of STDs are often the same groups for whom access to or use of health services is most limited. Many studies document the association of substance abuse with STDs. Perhaps the most important social factors contributing to the spread of STDs in the United States are the stigma associated with STDs and the general discomfort of discussing intimate aspects of life, especially those related to sex. A person may have only 1 sex partner, but if that partner is a member of a risky sexual network, then the person is at higher risk for STDs than a similar individual from a lower-risk network. Each state must address system-level barriers to timely treatment of partners of persons infected with STDs, including the implementation of expedited partner therapy for the treatment of chlamydial and gonorrheal infections. Innovative communication strategies are critical for addressing issues of disparities, facilitating HPV vaccine uptake, and normalizing perceptions of sexual health and STD prevention, particularly as they help reduce health disparities. It is necessary to coordinate STD prevention efforts with the health care delivery system to leverage new developments provided by health reform legislation. References 1 King K, et al. Janus considers the HIV pandemic: Harnessing recent advances to enhance AIDS prevention. Am J Public Health. Sexually transmitted infections among U. Prevalence and incidence estimates, Sex Transm Dis ; 40 3: The estimated direct medical cost of selected sexually transmitted infections in the United States, Confronting sexually transmitted diseases. National Academies Press; Impaired fecundity in the United States: Sexually Transmitted Disease Surveillance Department of Health and Human Services; Monitoring socioeconomic inequalities in sexually transmitted infections, tuberculosis and violence: Geocoding and choice of area-based socioeconomic measures. Health insurance coverage, health-care-seeking behaviors, and genital chlamydia infection prevalence in sexually active young adults. Confronting racial and ethnic disparities in health care. Substance abuse and the spread of sexually transmitted diseases. Institute of Medicine; Crack, sex, and STDs. A social history of venereal disease in the United States since Oxford University Press;

9: HIV Transmission and Prevention in Adolescents

Check out our interactive infographic to see progress toward the Sexually Transmitted Diseases objectives and other Healthy People topic areas. STDs refer to more than 35 infectious organisms that are transmitted primarily through sexual activity. STD prevention is an essential primary care strategy.

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