2012 Call to Action

RESOURCE DOCUMENT

State Alliance for Adolescent Sexual Health in South Carolina

SAASH
STATE ALLIANCE FOR Adolescent Sexual Health in South Carolina

www.saashsc.org

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SAASH Members

SC Campaign to Prevent Teen Pregnancy

SC Contraceptive Access Campaign

SC Department of Alcohol and Other Drug Abuse Services

SC Department of Education

SC Department of Health and Environmental Control
Division of STD/HIV

SC HIV Planning Council

SC Institute for Medicine and Public Health

SC School Boards Association

Harriet Hancock LGBT Center

New Morning Foundation

University of South Carolina, Arnold School of Public Health

This Call to Action Resource Document outlines the state of adolescent sexual health in South Carolina. It also highlights concrete programmatic and policy actions that are needed to create an environment that supports the sexual health and well-being of our state's youth.

See our website for more information and ongoing action being taken: www.saashsc.org

Call to Action Resource Document

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STATE ALLIANCE FOR Adolescent Sexual Health in South Carolina

The State Alliance for Adolescent Sexual Health (SAASH)

The South Carolina State Alliance for Adolescent Sexual Health (SAASH) is an integrated statewide, youth-focused sexual and reproductive health coalition formed in 2008 to promote collaborative, effective partnerships among state health and education departments and other agencies and organizations.

This type of collaboration is vitally important because health and education disparities have an impact on South Carolina's young people. **Teen birth, sexually transmitted infection (STI)* and HIV rates among youth in South Carolina are consistently among the highest in the nation.** South Carolina high school students drop out of high school at a higher rate than the national average. Racial, ethnic, socio-economic, and gender disparities exist in both health and education across our state.

Health and education disparities often share similar root causes:

- Limited access to quality education and effective preventive health services
- Stigma and discrimination, including racism and homophobia
- Poverty and other socioeconomic factors
- Inadequate financial and personnel resources that can limit the potential of education and health promotion efforts
- Lack of supportive, evidence-based health and education policies
- Lack of implementation of existing evidence-based policies

The physical, mental, emotional, and academic well-being of adolescents is directly affected by negative sexual health outcomes such as teen pregnancy and sexually transmitted infections (STIs). However, the impact does not end there. Pregnancy, childbearing, and STIs among adolescents place undue burdens on South Carolina's education, health, welfare, and social service systems.

We know that adolescents who are at risk for **poor academic performance** are also at risk for **negative sexual health outcomes.** This fact underscores the need for sustained collaborative actions among education and health professionals, along with researchers, activists, policymakers and donors to promote the health and well-being of youth in South Carolina. **SAASH wants every young South Carolinian to reach her or his full potential.**

*The terms STD (sexually transmitted disease) and STI (sexually transmitted infection) are used interchangeably throughout this document.

The World Health Organization (WHO) defines sexual health as "a state of physical, mental, and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality… free of coercion, discrimination and violence."[1]

SAASH is committed to promoting sexual health among the youth of our state by:

- Providing accurate information to educators, health professionals, parents, students, school boards, policy makers, and communities across the state that can support evidence-based programs and policies;
- Advocating for sound public policies to ensure that youth across our state receive high quality, comprehensive education about sexual and reproductive health.

With the support of a wide range of stakeholders, the State Alliance for Adolescent Sexual Health can provide essential resources and technical assistance to districts and schools to improve student health and academic outcomes.

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[1] World Health Organization. Retrieved April, 2011 from http://www.who.int/topics/sexual_health/en/

The Comprehensive Health Education Act[1]

In 1988, the South Carolina legislature passed the Comprehensive Health Education Act (CHEA)[1], which requires sexual risk reduction education, including HIV/STI prevention education, for middle and high school students. The CHEA requires that middle and high school students receive health education instruction that includes reproductive health and STI prevention. In grade six, a minimum of 75 minutes per week for 36 weeks of health education, or the equivalent, is required. For grades seven and eight, a minimum of 250 minutes per week for nine weeks of health education, or the equivalent, is required. High school students must receive instruction in comprehensive health education, including 750 minutes of reproductive health and pregnancy prevention education at least once during the four years of grades nine through twelve.

This law mandates that abstinence and the risks associated with sexual activity outside of marriage must be strongly emphasized. Contraceptive information must be given in the context of future family planning. The CHEA also requires districts to maintain district-level Comprehensive Health Education Advisory Committees comprised of students, teachers, health professionals, clergy, parents, and community members. The Committees are responsible for reviewing and approving all HIV/STI and teen pregnancy prevention materials and curricula before this information is used in schools.

Although these requirements, established by law, exist in South Carolina, district and school comprehensive health education staff continue to need professional development to implement effective programs and practices to meet the goals of existing policies.

South Carolinians have spoken: **84% of registered voters in the state support comprehensive sexual health education** being taught in schools, emphasizing abstinence as the first and best option for young people. Most importantly, comprehensive sexual health education also teaches youth about the benefits and importance of using contraception to prevent pregnancy and to protect against sexually transmitted diseases.

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[1] Comprehensive Health Education Act, Chapter 32, Title 59, South Carolina Code of Laws, April 1988.Accessed February 15, 2012 at http://www.scstatehouse.gov/query.php?search=DOC&searchtext=comprehensive%20health%20education%20act&category=CODEOFLAWS&conid=6880046&result_pos=0&keyval=1151&numrows=10

[2] Oldendick, R. (2011). Summary of Findings for the South Carolina State Survey. Columbia, SC: USC Institute for Public Service and Policy Research.

Adolescents at Risk

"Adolescence is an age of opportunity. It is a dynamic and exciting time where physical development allows young people to create a new sense of self, while cognitive development brings enhanced capacity to examine problems from multiple perspectives, analyze and think deeply about the world, and invent new, innovative solutions.

Adolescence is generally defined as the period of life ranging from 10 to 24 years of age, which includes the more nuanced categories of youth for those 10 to 14 years, adolescents for those aged 15 to 19 years, and young adults as those aged 20 to 24 years.[1,2] During this period, social and moral development expand and young people are exposed to new ideas and new possibilities through parents and siblings, peers, teachers, doctors, religious leaders, media, and other personal, social, and environmental influences. Although there is great opportunity, there are also multifaceted endocrine, neural, and social changes during and after the pubertal transition that make adolescents extremely susceptible to impulsive and risky behavior, as well as psychological, physical, and emotional challenges.[3,4]

Adolescents find themselves in a unique position, ready to take on more responsibility, but not always certain how to manage the volatility and change within themselves and society. With support, care and involvement of parents, health care providers, other adults, schools, community services and other local and state-level systems, we can help ensure that our youth not only avoid the many risks that surround them but also gain the skills needed to navigate the circumstances and complexities of life to become well-equipped, successful adults."[5]

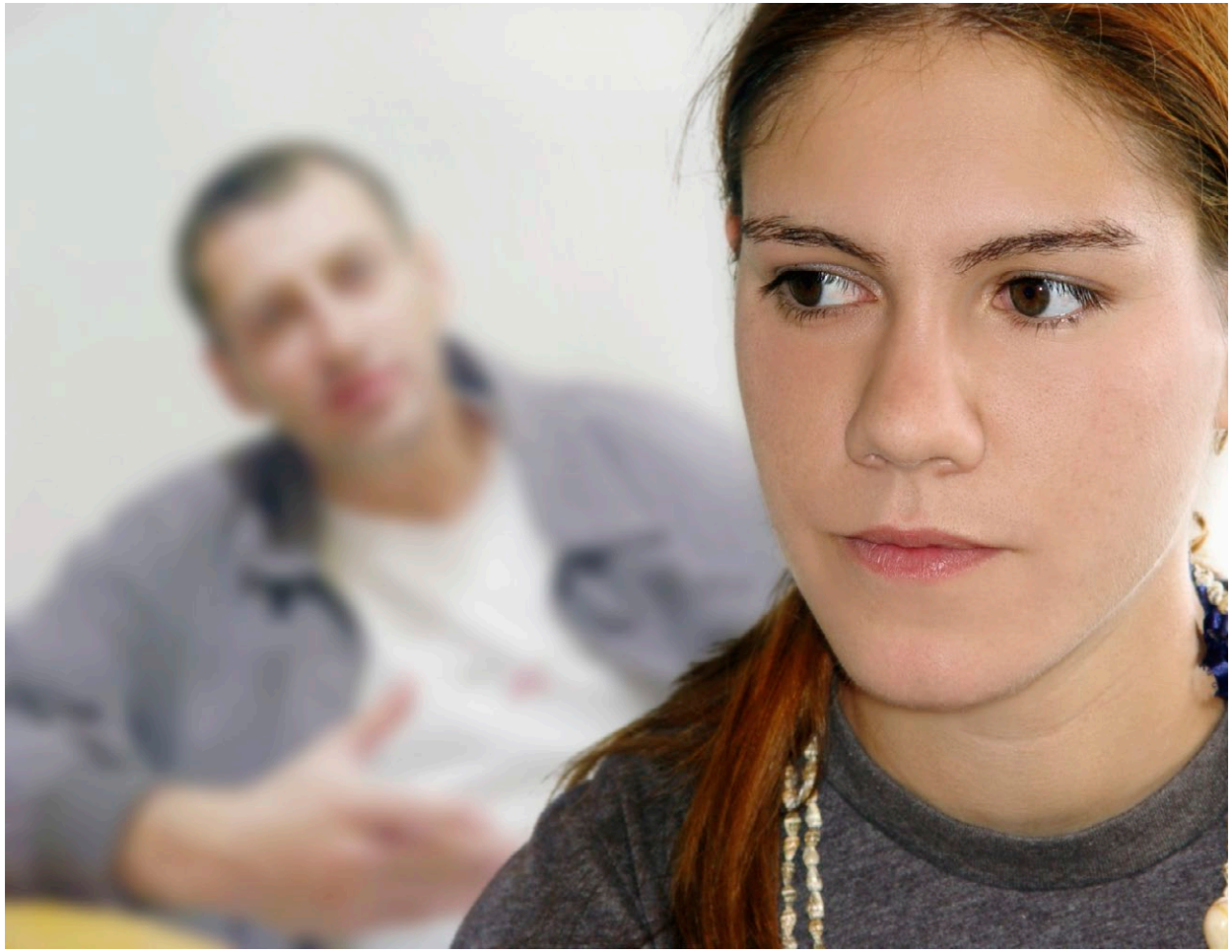
1. Association MCHP. (2005). *A conceptual framework for adolescent health.*Washington, D.C. Retrieved from http://www.amchp.org/MCH-Topics/A-G/Documents/conc-framework.pdf

2. Centers for Disease Control and Prevention (CDC). (2009, July 17). Sexual and reproductive health of persons aged 10 to 24 years-United States, 2002-2007. *Surveillance Summaries, MMWR.*58(no.ss-6).

3. National Research Council and Institute of Medicine (2007). *Challenges in Adolescent Health Care: Workshop Report.*Committee on Adolescent Healthcare Services and Models of Care for Treatment, Prevention, and Health Development, Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academies Press.

4. Patton, G.C., Viner, R. (2007). Pubertal Transitions in Health. Lancet, 369 (9567):1130-1139.

5. Association of Maternal and Child Health Programs. (2010). AMCHP White Paper Making the Case: A Comprehensive Systems Approach for Adolescent Health and Well-Being. Washington, DC. (Note: the entire quote is taken from this citation)



Sexual Risk Behavior

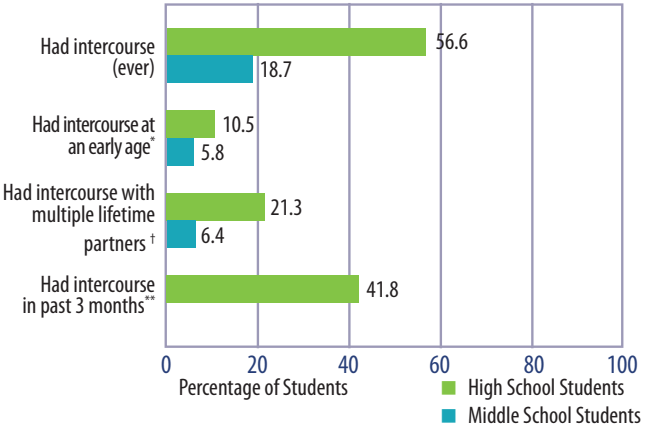
The Youth Risk Behavior Survey* (YRBS) is distributed to high school and middle school students in South Carolina every two years in order to assess students' self-reported risk behaviors. Risk behaviors measured include smoking/tobacco use, alcohol and other drug use, violence and injury, obesity-related behavior, and sexual activity.

Youth in South Carolina consistently report engaging in behaviors that put them at risk for serious health problems. In fact, compared to national YRBS data from 2011, from 2011 SC YRBS show that significantly more high school students in South Carolina reported engaging in risky sexual behaviors, including ever having had sexual intercouse, having sexual intercourse for the first time before age 13, and having engaged in sexual intercourse with four or more people *(Figure 1)*.[1-3]

The 2011 YRBS conducted in South Carolina showed that **almost one-fifth (19%)** of **middle school students** and **more than half (57%) of high school students** reported having engaged in sexual intercourse at least once in their lifetimes *(Figure 1)*.[2,3]

Between 1999 and 2011, the percentage of South Carolina high school students who reported ever having had intercourse decreased from 66% to 57%; those having engaged in intercourse in the past three months decreased significantly from 48% to 42%.[4] Despite this decline, this means that **more than a third of high school students in South Carolina are currently sexually active.** Additionally, the 2011 SC YRBS indicates that among those sexually active students who did not use a condom (56%), 36% reported using **no birth control method at all.**[4]

Figure 1: Sexual Risk Behaviors among SC Middle and High School Students, 2011[2,3]



Although condom use (defined as the percentage using condoms at last intercourse) had been increasing since 1991, there has been a significant reverse in recent years. From 2005-2011, condom use declined among sexually active high school students

from 67% to 58%.[4] This decline in condom use, combined with high rates of sexual activity, places South Carolina students at risk for negative consequences such as unintended pregnancies and sexually transmitted diseases, including HIV.

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* The best estimates of adolescent sexual behavior come from the Youth Risk Behavior Survey (YRBS), a nationwide surveying effort led by the CDC to monitor adolescents' health risks and behaviors.

1. South Carolina Campaign to Prevent Teen Pregnancy. (2011). Simply Stated: Sexual Risk Behaviors in South Carolina. Retrieved January 2012 from: http://www.teenpregnancysc.org/documents/Simply+Stated+-+Sexual+Risk+Behaviors+in+South+Carolina.pdf
2. YRBS 2011 SC High School Sexual Risk Behaviors factsheet. Retrieved 20February 2012 at http://www.ed.sc.gov/agency/os/Health-and-Nutrition/School-Health/documents/2011HS_SexualRisk.pdf.
3. YRBS 2011 SC Middle School Sexual Risk Behaviors factsheet. Retrieved 20 February 2012 athttp://www.ed.sc.gov/agency/os/Health-and-Nutrition/School-Health/documents/2011MS_SexualRisk.pdf.
4. Pluto D. 2012. Adolescent Sexual Risk Behaviors from the 2011 SC YRBS. Presented 15 January 2012, SC SAASH meeting, Columbia, SC.

Alcohol and Other Drug Use

Drug and alcohol use is a contributing factor to risky sexual behaviors. Genetic disposition, personality, and shifting factors in an adolescent's environment all affect his or her ability to negotiate situations where drugs and alcohol are involved. Importantly, the part of an adolescent's brain that is responsible for controlling impulses, making decisions, forming strategies, and planning behavior is not fully developed until a young person's early 20s.[1]

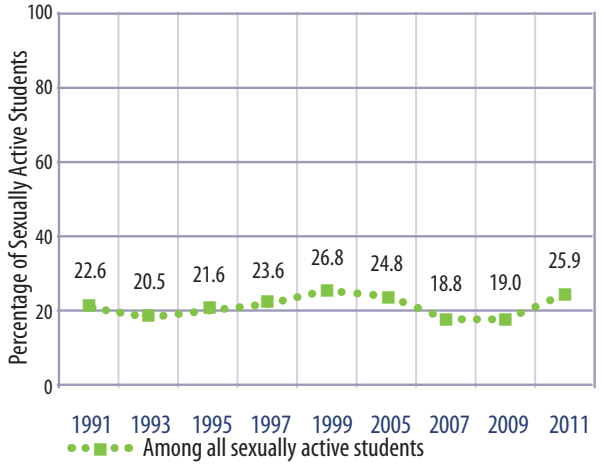
Drug use and underage drinking are major public health concerns, with alcohol being the most commonly used and abused drug among youth in the US.[2] Young people who drink are more likely than adults to be binge drinkers, and initiation of alcohol use at young ages has been linked to more problematic levels of use during teenage years and adulthood.[3]

According to the 2011 South Carolina YRBS, **71% of high school students in South Carolina have reported using alcohol at least once in their lives.**[4] The same survey found that almost 40% of South Carolina high school students had consumed at least one drink of alcohol in the last 30 days, and almost 22% had engaged in "episodic heavy drinking" (meaning they had five or more drinks of alcohol in a row, within a couple of hours) in the past 30 days.[4]

The 2011 YRBS survey also found that 44% of South Carolina high school students reported having tried marijuana—a dramatic increase from 27% in 1991.[4]

Additionally, according to the 2011 YRBS, 26% of sexually active high school students in South Carolina reported using alcohol or drugs before their last act of intercourse. This rate has not changed significantly since 1991 *(Figure 2)*.[4]

Figure 2: Percentage of SC High School Students Who Used Alcohol or Drugs before Last Intercourse, 1991-2011[5]



1. National Institute of Mental Health. N.D. The teen brain still under construction.Retrieved 10 January 2012 from http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/complete-index.shtml

2. Centers for Disease Control and Prevention. CDC Fact Sheet Alcohol and Public Health. (2010, July 20). Retrieved December 20, 2011 from http://www.cdc.gov/alcohol/fact-sheets/underage-drinking.htm

3. South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) South Carolina Strategic Prevention Framework State Incentive Grant Plan. January 2010 [Revised April 2010]. Retrieved 10 January 2012 from http://www.daodas.state.sc.us/documents/2012%20SC%20State%20Plan%20Draft%20Combined%20Attachments.pdf

4. YRBS 2011 SC High Schools Alcohol and other Drug use factsheet. Retrieved 20 February 2012 from http://www.ed.sc.gov/agency/os/Health-and-Nutrition/School-Health/documents/2011HS_ATOD.pdf.

5. Pluto D. 2012.Adolescent Sexual Risk Behaviors from the 2011 SC YRBS. Presented 15 January 2012, SC SAASH meeting, Columbia, SC.

Sexual Minority Youth

Young people who identify as lesbian, gay, bisexual, transgender, or who are questioning their sexual orientation or gender identity (LGBTQ) are collectively referred to as sexual minority youth. Due to the stigma surrounding their sexual orientation or gender identity, sexual minority youth often experience rejection, verbal harassment and/or physical assault from family members, schoolmates, and others in their community.[1-3] Approximately half of sexual minority youth reported experiencing a negative reaction from parents, and **26% were kicked out of their home** after disclosing their sexual orientation or gender identity to their families.[2] According to the National Network of Youth and Runaway Services, sexual minority youth constitute between 20%-40% of all homeless youth.[2]

Sexual minority youth report experiencing similar difficulties at school; **85% reported being verbally harassed** and 19% reported being physically assaulted at school in the past year.[3] Approximately 28% eventually drop out of school because of harassment based on their sexual orientation or gender identity.[3]

Unfortunately, due to the controversy surrounding the issues of sexual orientation and gender identity, inaccurate information is often given to youth in schools.[4] In South Carolina, according to the Comprehensive Health Education Act, classroom discussion about "alternate sexual lifestyles including, but not limited to homosexual relationships" may occur only "in the context of instruction concerning sexually transmitted diseases".[5] This rule perpetuates the stereotype of sexually transmitted diseases as the inevitable negative result for individuals with a homosexual orientation.[6]

Research has demonstrated that adolescents struggling with issues surrounding their sexual orientation or gender identity who do not receive appropriate health care services, accurate prevention information, or support from family, school, and community, are in jeopardy of serious emotional, mental, and physical difficulties. Sexual minority youth often turn to unsafe activities such as alcohol and drug use or high-risk sexual behaviors to cope with the stigma surrounding their sexual orientation. These behaviors place them at greater risk for addiction, unintended pregnancy, sexually transmitted diseases, and HIV/AIDS.[7-9]

1. Savin-Williams, R.C. Verbal and physical assault as stressors in the lives of lesbians, gay males, and bisexual youth: Association with school problems, running away, substance abuse, prostitution, and suicide. *J Consult ClinPsychol* 1994, 62: 261-269.

2. Ray, N. Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness. New York: National Gay and *Lesbian Task Force Policy Institute and the National Coalition for the Homeless.* 2006. Retrieved 14 February 2012 at http://www.thetaskforce.org/reports_and_research/homeless_youth

3. Gay, Lesbian, and Straight Education Network. *The 2009 National School Climate Survey: The School Related Experiences of Our Nation's Lesbian, Gay, Bisexual and Transgender Youth*. New York, NY: GLSEN, 2009.

4. Rienzo, B., Button, J., Wald, K. The politics of school-based programs which address sexual orientation. *J Sch Health* 1996, 66(1): 33-40.

5. Comprehensive Health Education Act, Chapter 32, Title 59, South Carolina Code of Laws, April 1988.Accessed February 15, 2012 at http://www.scstatehouse.gov/query.php?search=DOC&searchtext=comprehensive%20health%20education%20act&category=CODEOFLAWS&conid=6880046&result_pos=0&keyval=1151&numrows=10

6. Lindley, L., Reininger, B. Support for instruction about homosexuality in South Carolina public schools. J Sch Health 2001, 71(1): 17-22.

7. Garofalo, R., Wolf, R.C., Kessel, S., et al. The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics* 1998, 101(5): 895-902.

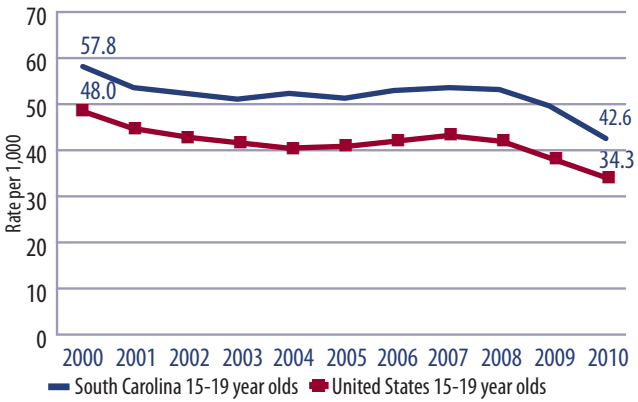
8. Centers for Disease Control and Prevention. Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12 – Youth Risk Behavior Surveillance, Selected Sites, United States, 2001-2009. *MMWR Early Release 2011*; 60, June 6: 1-133.

9. Willoughby, B., Doty, N. Victimization, family rejection, and outcomes of gay, lesbian, and bisexual young people: The role of negative GLB identity. *J GLBT Family Studies* 2010, 6: 403-424.

Teen Births

Over the last decade, there have been substantial declines in teen birth rates in South Carolina and across the nation. In 2010, the South Carolina teen birth rate for 15-19 year olds was approximately 43 births per 1,000 females, representing a 26% decrease from 2000.[1] Despite these declines, South Carolina's teen birth rate remains **far above the national average** *(Figure 3)*.[2] In fact, our state has the 12th highest teen birth rate in the United States.[1] Furthermore, teen birth rates in South Carolina exhibit significant disparities by age, race and ethnicity. Teen birth rates among older youth are much higher than those of their younger peers; Black and Hispanic teen birth rates continue to far exceed rates among their White counterparts.[1]

Figure 3: National and SC Birth Rate Trends among 15-19 Year Olds, 2000-2010[3]



Teen Birth Rate Trends

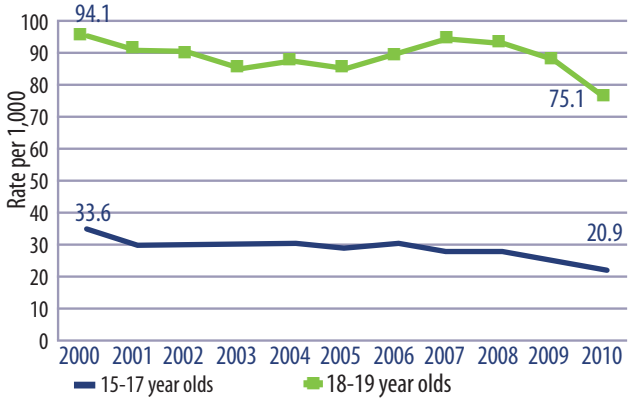
Disparities by Age[3]

Over the last decade, teen birth rates overall have decreased. However, a significant difference in the rates of birth among older (18-19 years) versus younger (15-17 years) teens persists. In 2010, the birth rate among younger teens was approximately 21 births per 1,000 females, while the birth rate among older teens was 75 births per 1,000 females. In fact, in South Carolina, **18 to 19 year olds made up 71% of all teen births in 2010.** Over the past decade, younger teens experienced a 38% decrease in birth rates, whereas the decrease was only 20% among older teens *(Figure 4).* This difference in birth rates by age group is not surprising, since the majority of teen pregnancy prevention efforts have focused on populations of school-age young people. Only in the last few years have older adolescents become a priority focus population for intentional, intensive prevention efforts.

Disparities by Race and Ethnicity[3]

In South Carolina, there also are stark contrasts by race and ethnicity. White youth have notably lower birth rates than Black and Hispanic youth. Although Hispanic 15-19 year

Figure 4: South Carolina Teen Birth Rate Trends by Age, 2000-2010[3]



old females represent a small portion (5%) of the total population in South Carolina, they represent a disproportionate share of births among 15-19 year old females (8%). African-American females make up 36% of South Carolina's population of 15 to 19 year old females, but account for nearly half (47%) of all births to teens in this age group.

1. South Carolina Campaign to Prevent Teen Pregnancy. (2012). Simply Stated: South Carolina Teen Birth Trends. Retrieved 10 January 2012 from http://www.teenpregnancysc.org/uploads/Simply%20Stated%20-%20Winning%20the%20Battle%20%20Teen%20Birth%20Data%202010%282%29.pdf
2. CDC. Vital Signs: Teen Pregnancy-United States, 1991–2009. MMWR 2011; 60 (Early Release, April, 2011).
3. SC Campaign to Prevent Teen Pregnancy (2012). 2000-2010: South Carolina 15-19 Year Old BirthTrends. Retrieved 10 January 2012 from http://www.teenpregnancysc.org/uploads/file/STATE%20South%20Carolina%202010%20TB%20data(1).pdf

Sexually Transmitted Infections (STIs) and HIV/AIDS

Estimates from the Centers for Disease Control and Prevention (CDC) demonstrate that although **young people between the ages of 15-24** years old represent only a quarter of the sexually active population, they **make up over half of the estimated 19 million new STD cases** that occur each year. [1]A recent national study found that one in four teenage girls between 14-19 years of age (3.2 million teenage girls) has experienced at least one STD in her lifetime.[2]

Sexually active youth and young adults are at higher risk for acquiring many common STDs due to a combination of cultural, behavioral and biological factors. When young people attempt to access quality STD prevention and care services, they often experience barriers such as transportation limitations, concerns about confidentiality, a lack of health insurance and concerns that facilities are not teen-friendly.[3]

South Carolina consistently ranks among the top ten states in the US for the highest case rates of AIDS, chlamydia and gonorrhea.[4] High STI prevalence rates may place sexually active youth/young adults living in South Carolina at greater risk for acquiring an STI due, in part, to simple geography.

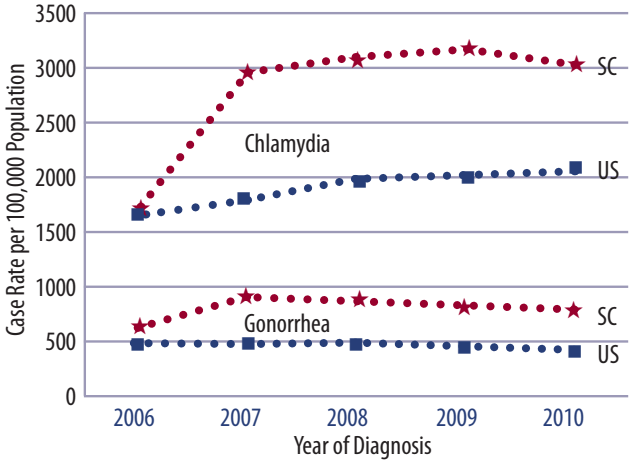
Chlamydia and Gonorrhea

Chlamydia is the most commonly reported notifiable STI in the US, and gonorrhea is the second most common. In 2010, as in previous years, adolescents ages 15-19 had the highest chlamydia and gonorrhea rates nationally, followed by young adults ages 20-24.[5] In the same year, chlamydia and gonorrhea case rates among 15-24 year olds living in South Carolina were higher than national chlamydia and gonorrhea case rates among that same age group *(See Figure 5)*.[6]

On average, there are **68 cases of chlamydia or gonorrhea reported among SC adolescents and/or young adults each day.**[6] In 2010, South Carolina ranked 4th for gonorrhea case rates per 100,000 population, and 5th for chlamydia rates among all states, the District of Columbia and US dependent areas.[7]

Untreated STIs like chlamydia and gonorrhea can cause emotional and economic burdens and can lead to long-term reproductive health consequences in women such as Pelvic Inflammatory Disease (PID). PID can cause chronic pelvic pain, ectopic (tubal) pregnancy and even damage to the fallopian tubes that can result in infertility. Each year, approximately 24,000 women in the US become infertile as a result of untreated STIs.[8] Although screening

Figure 5. US and SC Chlamydia and Gonorrhea rates among adolescents ages 15-19 (2006-2010)[15]



can reduce the incidence of PID by as much as 60%, screening is often underutilized, because the majority of chlamydia and gonorrhea infections in females have few or no symptoms.[9]

Geographical, behavioral risk, age and racial health disparities

The South has the highest number of young adults/adolescents living with AIDS in the US.[10]

In 2009, (the latest year for comparison), South Carolina ranked 9th among all US states, the District of Columbia and US dependent areas in AIDS case rates at 15.6 per 100,000 population.[11] And in 2010, **one in five newly reported HIV/AIDS cases in SC was among young persons under 25 years old.**[12]

According to the CDC, although the annual number of new HIV infections remained stable from 2006 through 2009, there was an estimated 21% increase in HIV incidence for people ages 13-29 years. Much of this increase was caused by a 34% increase in new HIV infections among young men who have sex with men (MSM). Teens who identify as lesbian, gay, bisexual, transgender or are questioning their gender and sexual identity (LGBTQ) may find themselves at greater risk for sexually transmitted infections.[13] Many MSM and LGBTQ teens may not be utilizing risk reduction measures due, in part, because of the stigmatizing and negative manner in which they are portrayed.

Young MSM of all races are heavily impacted by HIV, however, young African American MSM bear the brunt of the epidemic. From 2006 to 2009, young African American MSM were the only group to experience a statistically significant increase in new infections. CDC estimates that new HIV infections among young African American MSM increased 48% (from 4,400 HIV infections in 2006 to 6,500 infections in 2009)."[14]

In South Carolina, 82% of HIV cases among African Americans aged 15-24 years were attributed to sexual contact among men who have

sex with men, compared to 14% of Caucasians among the same age group.[15]

African Americans bear the brunt of the STD/HIV epidemic in South Carolina. These racial health disparities are apparent among adolescent/young adult populations as well. **Of the newly reported HIV/AIDS cases in 2010 among young persons under 25 years of age, 82% were African American.** Also in 2010, African Americans ages 15-19 in SC had chlamydia case rates three times that of their Caucasian peer group. In 2010, African Americans in South Carolina ages 15-19 had gonorrhea case rates **seven times that of Caucasians in the same age group.**[15]

Hispanics account for 3% of those living with HIV, but they comprise 5% of newly reported cases. While these numbers are small compared to other racial/ethnic groups, proportionally, this is an emerging disparity that needs to be monitored. It is also an excellent opportunity to implement science-based prevention interventions that target the growing Hispanic population in South Carolina.[15]

1. Weinstock, H., Berman, S., Cates, W. Jr. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspect Sex Reprod Health.* 2004:36(1):6-10.

2. Forhan, S.E. (2008) Prevalence of Sexually Transmitted Infections and Bacterial VaginosisAmong Female Adolescents in the United States: Data From the National Health and Nutrition Examination Survey (NHANES)2003-2004. 2008 National STD Prevention Conference.

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8. Scholes, D., Stergachis A., Heidrich, F.E., Andrilla, H., Holmes, K.K., Stamm, W.E. Prevention of pelvic inflammatory disease by screening for cervical chlamydial infection. *N Engl J Med.* 1996, 34(21):1362-6.

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10. Southern States Manifesto: Update 2008 HIV/AIDS and Sexually Transmitted Diseases in the South. Retrieved 10 July 2011 from http://southernaidscoalition.org/policy/southern_states_manifesto_2008.pdf.

11. South Carolina 2011 STD/HIV Surveillance Report, STD/HIV Division, *AIDS Cases, Case Rates and Rankings by State and Metropolitan Statistical Area,* P. 6

12. South Carolina 2011 STD/HIV Surveillance, STD/HIV Division.

13. Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2010. Atlanta: US

14. Department of Health and Human Services; 2011. Retrieved 20 November 2011 from http://www.cdc.gov/std/stats.

15. Prejean J, Song R, Hernandez A, Ziebell R, Green T, et al. (2011) Estimated HIV Incidence in the United States, 2006-2009. PLoS ONE 6(8):e17502.doi:10.1371/journal.pone.0017502.

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Sexual Violence

Sexual violence (SV) is any sexual act that is perpetrated against someone's will. SV encompasses a range of offenses, including a nonconsensual sex act (i.e., rape), an attempted nonconsensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment).[1]

Males are more likely than females to be perpetrators of sexual violence. In South Carolina, women and girls accounted for 86% of sexual violence victims, while men and boys accounted for 14% of all victims.[2]

Important risk factors for SV include alcohol and drug use, and societal norms that support male superiority and sexual entitlement as well as those that maintain women's inferiority and sexual submissiveness.[3]

Statistics on sexual violence vastly underestimate the true extent of the problem. For example, in 2009 in South Carolina, 729 victims under 18 years of age reported their abuse to law enforcement. However, the rape crisis centers in the state served 2,792 new direct victims under 18 years old, almost four times the amount reported to law enforcement.[2] Many victims do not report being assaulted to anyone, for a multitude of reasons; the stigma related to sexual violence often keeps victims silent.

Sexual Violence among Adolescents

Youth are at particular risk for sexual violence. **In South Carolina from 2004 to 2008, young people were five and a half times more likely to experience sexual violence than adults.** Girls ages 15 to 17 were most likely to be victims of sexual violence, followed closely by girls ages 10 to 14.[4] In 2009, more than 50% of victims served by South Carolina's rape crisis centers were under 18 years old.[4]

According to the 2011 SC YRBS, **12% of high school students** have experienced dating violence in the past year, and **11% have been forced to have sex** at some point in their lives.[5]

Sexual violence has serious consequences on adolescent sexual health. These include chronic pain, HIV and other sexually transmitted diseases, and unintended pregnancy. Victims often experience anger and stress, sometimes leading to depression and suicide. Victims are more likely to smoke, abuse alcohol, use drugs and engage in risky sexual activity.[1]

Reporting Sexual Abuse and Sexual Activity of Minors[6]

Medical providers and other mandated reporters in South Carolina are required to report suspected child abuse and neglect to the Department of Social Services if the alleged perpetrator is a family member, and to law enforcement in other cases. These reports were developed to protect minors under 18 in the event of sexual abuse, coercion, or assault. **It is important to understand** however, **that sexual activity and sexual abuse are not synonymous.** It should not be assumed that adolescents who are sexually active are, by definition, being abused. Many adolescents have consensual sexual relationships. Since minors under the age of 16 cannot legally consent to sexual activity, some interpret any sexual activity in this population to be subject to abuse reporting laws. Differences in interpretation of the law result in inconsistencies in reporting and enforcement across the state.

The American Academy of Family Physicians supports the stance that laws should not interfere with either an adolescent's access to confidential health care or a parent's ability to provide health supervision to his or her child, consistent with the medical and ethical responsibilities held by adolescent health professionals.

It is critical that adolescents who are sexually active receive appropriate and confidential health care and counseling. Many adolescents avoid accessing medical care for family planning and STI and HIV testing due to fear that their consensual sexual activity may be reported to law enforcement. A continuation of this pattern could lead to an increase in teen pregnancy, STI, and HIV among youth throughout our state.

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Low Educational Achievement

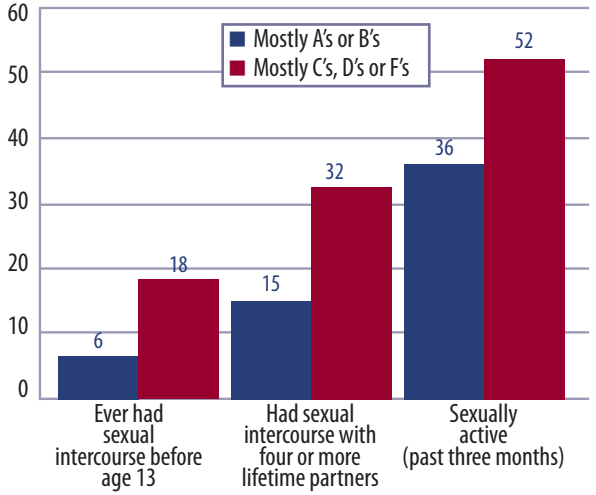
Health and education disparities are interrelated, especially among adolescents. Not only is good health related to academic success, but lower education levels predict higher levels of health risk behaviors, including violence and early sexual initiation.[1] Students who drop out of high school are more likely to engage in health risk behaviors, have limited or poor academic achievement, and be of low socioeconomic status.[2] **Helping teens get involved and stay in school can reduce the likelihood that they will engage in risky behaviors,** and can increase the number of young people in South Carolina who will have the opportunity to complete their education and achieve their goals.

Academic Achievement

Adolescents need to feel a connection to their school to succeed academically and engage in healthy behaviors.[3] In fact, the strongest protective factor in terms of reducing risky behaviors in adolescents is a feeling of connectedness to school.[3] Teens who are engaged in school are more likely to delay sexual activity and are less likely to become pregnant in their teens, while students who are not engaged in school are more likely to engage in risky sexual behavior.[4]

Data from the 2011 South Carolina Youth Risk Behavior Survey (YRBS) show that **high school students with higher grades are less likely to engage in sexual risk behaviors than their classmates with lower grades.** As *Figure 6* shows, South Carolina students with higher grades are less likely to have had sexual intercourse before age 13, had intercourse with four or more lifetime partners or have been sexually active during the past three months.[5]

Figure 6: Correlations between Sexual Risk Behaviors and Academic Performance, High School Students, South Carolina 2011[5]



Dropping Out of School

The South Carolina Department of Education reports that there were 6,265 dropouts among grades 9-12 between 2009 and 2010, a dropout rate of 2.9%.[6]

Although adolescent dropout rates are currently on the decline from previous years, **South Carolina continues to have one of the lowest graduation rates in the country.** Only 59% of South Carolina students entering the 9th grade in the 2003 to 2004 school year graduated within four years, compared to 74% nationally.[7] High school completion leads to increased economic opportunities and college entrance/completion, which, in turn, leads to even more economic and health benefits.[8]

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Calls to Action

The stark realities highlighted in this document demonstrate the need to TAKE ACTION to improve the sexual health of adolescents in the state of South Carolina. SAASH is committed to the work that needs to be done, and we call on each of you to also take action and work to advance the health and well-being of young people throughout the state.

SCHOOLS

- Provide quality, age-appropriate, comprehensive health education that includes reproductive health, family life education, and the prevention of teen pregnancy, HIV/STDs, and sexual violence, as outlined by the Comprehensive Health Education Act (CHEA).
- Assess and monitor the implementation of the Comprehensive Health Education Act for grades K-12.
- Require that teachers responsible for providing instruction in reproductive and sexual health subject areas receive relevant professional development.
- Require primary certification in Health Education for those instructors teaching health education in schools.
- Require that members of local school boards and the local comprehensive health education advisory committees receive training on their roles and responsibilities related to the implementation of CHEA, including the selection of evidence-based, medically accurate sexual risk reduction materials.
- Provide access to support services and programs such as mentoring, counseling, tutoring, and alcohol and other drug prevention efforts, including those that support pregnant and parenting teens, in an effort to prevent drop out among at-risk youth.
- Ensure a positive school climate that supports academic achievement, effective risk prevention efforts, and positive youth development to increase a sense of school-connectedness for all youth, including sexual minority youth.
- Support the use of social media to foster discussions about respectful and healthy relationships.
- Incorporate sexual violence prevention into anti-bullying interventions and campaigns in an effort to transform our community into one of zero-tolerance for sexual violence.
- Continue to report suspected cases of incest, sexual coercion or sexual assault of minors under 16.

HEALTH CARE PROVIDERS

- Increase the number of teen friendly clinics or integrated teen health services within existing clinics to improve access to testing and screening services for youth.
- Ensure adolescent access to condoms and all forms of birth control, both for STI and pregnancy prevention.
- Utilize and promote use of technology-based prevention strategies to provide health education messages to youth that raise awareness of risk and increase linkages to care and support services.
- Adhere to age- and risk-specific STD/HIV testing guidelines developed by the Centers for Disease Control and Prevention (CDC) as outlined below:

  HIV testing:
  - Performed as a routine part of care for all adolescents and young adults ages 13 and older.
  - All patients seeking treatment for STDs should be screened for HIV.

  Chlamydia and Gonorrhea testing:
  - All sexually active females 25 years of age and younger
  - Women with new or multiple partners; and
  - Sexually active men who have sex with men
- Support the integration of training programs that specifically address prevention of STDs and sexual violence.
- Develop and implement "No Wrong Door" policies within state and local agencies, where teens and their families have multiple portals of entry and access to services through the mental health, social services, education and juvenile justice systems. This ensures that every doorway is the "right door" to access services, regardless of the presenting problem.
- Support diversity training among health care providers.
- Continue to report suspected cases of incest, sexual coercion or sexual assault of minors under 16.

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Calls to Action

POLICY MAKERS

- Engage in uniform implementation and monitoring of quality, medically accurate, evidence-based sex education programs, according to the Comprehensive Health Education Act.
- Support required certification and/or professional development for teachers who provide instruction in reproductive and sexual health subject areas.
- Support "No Wrong Door" policies within state and local agencies, where teens and their families have multiple portals of entry and access to services through the mental health, social services, education and juvenile justice systems. This ensures that every doorway is the "right door" to access services, regardless of the presenting problem.
- Convene a task force, including parents and family members, legislators, judges, law enforcement, health care providers, school administrators and the Departments of Social Services and Health, to make recommendations and clarify reporting standards of the sexual activity of minors.
- Support prevention programs aimed at adolescents, especially efforts to prevent alcohol and other drug abuse, bullying, sexual violence, and discrimination based on sexual identity and/or orientation.

PARENTS

- Engage in honest and open dialogue about sexual health and responsibility.
- Advocate for full implementation of the Comprehensive Health Education Act.
- Promote the use of social media to counter negative sexual stereotypes, sexual violence, and bullying among youth.
- Support violence prevention programs, including bystander prevention strategies, in an effort to empower youth to intervene with peers to prevent sexual violence from occurring.
- Support recommended STD/HIV testing and screening guidelines as outlined by the Centers for Disease Control and Prevention (CDC).

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