Sex Education Policies and Adolescent Pregnancy in the United States and North Carolina

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I. Introduction: Explanation of and rationale for the project

For my presentation at the United Nations' Commission on the Status of Women (CSW) in February, I will present about sex education policies and rates of adolescent pregnancy and STIs in the United States (U.S.) and North Carolina and two organizations, the Adolescent Pregnancy Prevention Campaign of North Carolina (APPCNC) and El Pueblo, Inc., that are working to reduce rates of adolescent pregnancy and inform adolescents about their sexual and reproductive health.[1] In my presentation, I will pay specific attention to Latinas in North Carolina because North Carolina has one of the fastest growing rates of Latina/os in the nation and it is crucial to understand the needs of the Latina community and the barriers that women and girls face in terms of access to sexual and reproductive education and healthcare. This paper, therefore, will focus on national and local trends, policies, and implications in relation to sex education, adolescent pregnancy, and STIs and describe two local organizations' efforts to address North Carolina's rate of adolescent pregnancy, adapt sex education programs to North Carolina's recently mandated Healthy Youth Act, and educate adolescents to become active participants in decisions surrounding their sexual and reproductive health.

This topic is important to me as a doula, which is a woman who provides emotional, physical, and informational support to pregnant women and their partners throughout the pregnancy and birthing process, and as a woman who has worked with the Latina community in Chapel Hill, Carrboro, and El Paso, Texas as a doula, ESL tutor, and volunteer for campus organizations that organize working and housing rights workshops on behalf of Latina/o immigrants. While issues of sexual and reproductive health apply to those of all gender identities, they are particularly pertinent to young girls because if girls do not receive education

[1] Opinions vary widely about age ranges for adolescents. For the purposes of this paper and in accordance with the research I have conducted, adolescents will refer to those between the ages of ten and nineteen.

about or have access to resources concerning their sexual and reproductive health, it is harder for them to make informed decisions because their choice is already constrained by the oppression they face on the basis of their gender. It is important to research and provide information about these topics nationally and locally because the U.S. has some of the highest rates of adolescent pregnancy and adolescent incidences of STIs in comparison to other industrialized countries and I believe that comprehensive sexuality education is a key factor in helping adolescents, particularly girls, be informed about and exercise their sexual and reproductive rights. Both the U.S. and North Carolina have a growing population of Latina/os – by 2025 nearly 25% of adolescents in the U.S. will be Latina/o – and I also believe it is crucial that Latina/os have access to affordable, accessible, and linguistically understandable sexual and reproductive healthcare, education, and resources (Vexler and Suellentrop 7).

Access to education and information that informs women and girls about their sexual and reproductive health is mentioned multiple times in the United Nations' Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), specifically in relation to women's access to healthcare services and education, information, and counseling about family planning.[2] Article 16.1(e) specifically states that women should have the ability to "declare freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights," which explains why exposure to accurate, accessible information and resources regarding sexual and reproductive health is crucial, particularly to women, so that they can exert autonomy over reproductive processes (Convention on the Elimination of All Forms of Discrimination Against Women). To understand why girls' and women's access to sexual and reproductive health information is crucial to their ability to make autonomous decisions regarding relationships,

[2] The articles to which I refer include Article 10(h), 12.1, and 14.2(b).

childbearing, and personal well-being in the U.S. and North Carolina, I will begin by discussing federal programs and policies that have shaped the wide use of abstinence-only education in U.S. public school districts over the past thirty years. I will also describe regional trends in sexuality education and implications of these policies on rates of adolescent pregnancy and STIs. I will devote the next portion of the paper to sex education policies and adolescent pregnancy rates in North Carolina, with a specific focus on barriers that Latina immigrants face accessing information. After establishing the need for resources and support in North Carolina to address girls' access to sexual and reproductive health information, I will then share my experiences working with APPCNC and El Pueblo, Inc. and contrast their approaches to connecting adolescents to information and resources. I will conclude by providing national and local policy and programmatic recommendations based on qualitative information from teens and parents captured in various research studies and my own conclusions.

II. National Perspective: The United States

Despite the fact that the effectiveness of abstinence-only sex education programs has not been scientifically proven, study surveys consistently show that the majority of parents desire for their children to receive comprehensive sexuality education, and national organizations such as the American Medical Association, the American Academy of Pediatrics, and the National Academy of Sciences have recommended that schools teach comprehensive sexuality education, the U.S. government has provided funding solely to abstinence-only education programs for the past thirty years (Landry, Kaeser, and Richards 280; Landry, Darroch, Singh, and Higgins 261; Dailard 9). There have been no federally-funded programs that support comprehensive sexuality education during this time period, however, even though nine out of ten teachers believe that children should be taught about contraception, 81% of parents desire for education programs to

cover the topics of pregnancy and STI prevention, and two in five teens want access to more information about where to get and how to use birth control and how to handle peer pressure to have sex (Dailard 10, 12).

Congress's passage of the Adolescent Family Life Act (AFLA), also known as the "chastity law," as well as the creation of the Maternal and Child Health's Services Block Grant program in 1981 initiated a cascade of federally-funded programs that endorsed abstinence-only education. The original intent of the AFLA was to create a counseling and service network that encouraged "self-discipline and other prudent approaches to the problem of adolescent premarital sexual relations" and that provided contraceptives only to adolescents who had already had a child or were trying to prevent subsequent births (qtd. in Landry, Kaeser, and Richards 281). Even though this system never emerged, the AFLA marked the beginning of promoting abstinence-only education in public school districts across the U.S. The policy awarded grants to programs that taught abstinence as the only means of preventing pregnancy and sexually transmitted infections (STIs) and to those that prohibited discussion of contraceptives, except to mention their failure rates.

The Maternal and Child Health Services Block Grant also played a key role in upholding abstinence-only education and restricting discussion of contraceptives. The Block Grant falls under Title V of the Social Security Act and is a "public health program that reaches across economic lines to improve the health of all mothers and children" through capacity-building, education, outreach, trainings, screenings, prevention, and promotion ("Maternal and Child Health Bureau"). While the program provides hundreds of millions of dollars each year to state programs that work to provide poor women and children with access to resources and information, it, too, provides funding to abstinence-only programs that are only permitted to

discuss contraceptives' failure rates. Each of these served as a strong foundation for continued funding of abstinence-only education through policies like Section 510 of the Social Security Act.

Congress created Section 510 of Title V of the Social Security Act in 1996. The purpose of Section 510 was to continue to support abstinence-only education programs as part of overall welfare reform (Landry, Kaeser, and Richards 280). Section 510 provides funding to programs that teach abstinence as the only certain means of avoiding out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems ("Separate Program for Abstinence Education"). Section 510 not only endorses programs that teach the "social, psychological, and health gains to be realized by abstaining from sexual activity," but also those that teach that sexual activity outside of marriage is psychologically and physically harmful and that a mutually faithful monogamous relationship in the context of marriage is "the expected standard of human sexual activity" ("Separate Program for Abstinence Education"). Discussion of contraceptives is also prohibited under Section 510 and about $50 million per year is allocated to programs that adhere to these criteria.

These federal laws translate to the state level through school districts' sexuality education policies, which may be comprehensive, abstinence-plus, or abstinence-only. A comprehensive policy includes information about both abstinence and contraceptives as part of a larger program to inform and prepare adolescents to make healthy decisions about their sexual health (Landry, Kaeser, and Richards 283). An abstinence-plus policy is one in which abstinence is taught as the preferred option, but educators are allowed to discuss contraceptives as effective means of preventing unwanted and unintended pregnancy and the transmission of STIs (Landry, Kaeser, and Richards 283). As mentioned previously, abstinence-only policies are those that teach

abstinence as the only option for unmarried people and discuss contraceptives solely in terms of their failure rates (Landry, Kaeser, and Richards 283). In 1998, the Alan Guttmacher Institute, which is an organization that promotes sexual and reproductive health in the U.S. through research, policy, and public education, completed an extensive study of sexuality education policies in U.S. public school districts. The study captured responses from 825 public school district superintendents and their representatives who completed a mailed questionnaire on sexuality education policies for grades seven through twelve. The study revealed that, among all U.S. school districts, 69% have a policy to teach sexuality education and the remaining 31% leave policy decisions to be made by individual schools or teachers within the district (Landry, Kaeser, and Richards 282). It also found that among all U.S. school districts, including those with no policy, 10% have a comprehensive sexuality education policy, 34% have an abstinence-plus policy, 23% have an abstinence-only policy, and 33% have no policy (Landry, Kaeser, and Richards 283). Districts in the South were five times more likely than those in the Northeast to have abstinence-only policies (Landry, Kaeser, Richards 280). Overall, this study found that while there has been a move towards more abstinence-based education policies in the U.S., two-thirds of districts do allow some discussion of contraceptives to occur (Landry, Kaeser, and Richards 285). One in three districts still prohibits the distribution of positive materials about contraception, however (Landry, Kaeser, and Richards 280).

The effects of these restrictions on sexuality education are evident in the U.S.'s rates of adolescent pregnancy, unintended pregnancy, STIs, and HIV. Interconnected factors such as gender, race, socioeconomic status, geographical location, and social and/or familial expectations influence and may limit adolescents' access to education, information, and resources about sexual and reproductive health. The U.S. has one of the highest adolescent pregnancy rates in

the industrialized world and over half of all pregnancies in the U.S. are unintended (Scales, 11; "Sexual and Reproductive Health of Young People"). In 2006, 750,000 women younger than twenty became pregnant, a rate of 71.5 pregnancies per 1,000 women aged fifteen to nineteen, which accounted for 7% of all pregnancies that year (Kost, K., L. Henshaw, and L. Carlin 2). About one in three girls in the U.S. becomes pregnant by the age of twenty and 78% of those pregnancies are unplanned (Scales 11). Adolescent parents are twice as likely to have been assaulted or abused in comparison to their non-parenting peers and face specific social and economic challenges and stigma once they have children ("Young Families"). Seventy percent of adolescent parents do not finish high school and thirty percent have another child within two years ("Young Families"). The children of adolescent parents are also more likely to face health problems and become adolescent parents ("Young Families").

U.S. adolescents also face higher rates of STIs than adolescents in industrialized nations that foster greater acceptance of sexual relations among adolescents and enhanced access to and education about contraceptives (Landry, Darroch, Singh, and Higgins 262). Every year, about 4 million new STIs occur among teenagers in the U.S., with rates of gonorrhea (636.8 cases per 100,000 girls), and chlamydia (3,275.8 cases per 100,000 girls), being highest among girls between the ages of fifteen and nineteen (CDC *National Profile*). Human papillomavirus (HPV) is also an important sexual and reproductive health concern for women and girls; about twenty-five percent of girls aged fifteen to nineteen had an infection between 2003 and 2004 ("Sexual and Reproductive Health of Young People"). While the majority of HIV diagnoses in 2006 occurred among those between the ages of twenty and twenty-four and males, information about the transmission of HIV and encouragement of the use of condoms to protect against STIs and HIV should still be heavily influenced in education programs for adolescents ("Sexual and

Reproductive Health of Young People"). Rates of adolescent pregnancy, STIs, HPV, and HIV are highest among women of color, which illustrates the gender, racial, and socioeconomic factors that restrict women from gaining access to sexual and reproductive health information and the need for programs to address the needs of women of color more specifically ("Sexual and Reproductive Health of Young People").

The aforementioned policies and statistics illustrate that federal policies do not necessarily reflect the opinions of teachers, parents, and teens, who desire to have more comprehensive information about sexual and reproductive health included in education programs. U.S. rates of adolescent pregnancy and STIs also clearly reflect that adolescents are not being provided with the comprehensive sexuality information that would help them decide when and if to have sex and how to protect themselves against unintended or unwanted pregnancy and STIs if they choose to have sex. Even though studies consistently demonstrate that abstinence-only education programs are not effective in delaying the onset of sexual intercourse and the Obama administration cut $170 million of funding geared towards abstinence-only programs in 2009, state-level policies vary widely in regards to sexuality education and it takes time, advocacy, and support to change decades-old policies and programs, as well as deeply embedded gender, racial, and socioeconomic inequalities (Doubossarskaia). National statistics and trends translate to the local level in North Carolina, in which rates of adolescent pregnancy are high, specifically among Latinas, but the passage of the Healthy Youth Act in 2009 presents an important opportunity for North Carolina's public schools and sexuality educators to provide adolescents with access to comprehensive information and for advocacy organizations like APPCNC and El Pueblo, Inc. to play an important role in adapting the new law to educational contexts.

III. Local Perspective: North Carolina

Between 1995 and 2009, North Carolina law had left the decision about whether to provide comprehensive or abstinence-only until marriage education to local school districts. North Carolina continued to have the ninth highest adolescent pregnancy rate in the U.S. throughout the 1990s and 2000s. Studies began cropping up during the 2000s that highlighted the ineffectiveness of abstinence-only education programs and the efficacy of evidence-based, scientifically-proven programs in preventing and curbing rates of adolescent pregnancy. Surveys distributed to North Carolina parents by APPCNC and the University of North Carolina at Chapel Hill (UNC) Gillings School of Global Public Health in 2008 also revealed that 91.8% of North Carolina parents of public school children thought that sexuality education should be taught in schools, reflecting national trends in parental opinions about sexuality education (APPCNC 1). Due to national and local demands and realities, therefore, the North Carolina General Assembly passed the Healthy Youth Act in 2009.

The primary sponsors of this legislation included Representative Alma S. Adams, Representative Bob England, Representative Susan C. Fisher, and Representative Winkie Wilkins (APPCNC 1). The Healthy Youth Act requires schools to offer Reproductive Health and Safety Education for adolescents in 7th, 8th, and 9th grade, but parents are able to withdraw their children from instruction if they do not want their children to receive it (APPCNC 6). In addition to promoting the benefits of abstinence to adolescents, the law also requires educators to address three facets of reproductive health and safety, which include how to prevent the transmission of STIs, Federal Drug Administration (FDA) approved contraceptive methods, and sexual assault and abuse risk reduction (APPCNC 7). Schools may demonstrate proper use of condoms, but cannot distribute them on school property (APPCNC 8). Schools are also allowed

to discuss sexual orientation, but only in relation to medically accurate STI prevention and transmission, tolerance, and anti-bullying (APPCNC 8). Instruction materials should not only be based on peer reviewed scientific research, but also provide factually accurate biological and reproductive information and encourage opportunities for parent-child interaction (APPCNC 7). Schools are expected to adhere to the requirements of the Healthy Youth Act for the 2010-2011 school year (APPCNC 6).

The Healthy Youth Act is a critical piece of legislation for North Carolina because of its historically high rates of adolescent pregnancy and because it seeks to provide adolescents with more comprehensive, factual information about sex, STIs, contraceptives, healthy relationships, and relationship violence. Over 19,000 North Carolinians between the ages of ten and nineteen get pregnant each year and about 30% of adolescent pregnancies occur in girls who have already had a baby ("About Teen Pregnancy;" "Collaborate"). Adolescent pregnancy rates in North Carolina are highest among minorities (74.3 pregnancies per 1,000 girls) and specifically so among Latinas, which will be addressed in the next section (Finley). Rates of chlamydia (2,260 per 100,000) and gonorrhea (786.1 per 100,000) were highest among adolescents and adults between the ages of fifteen and twenty-four in North Carolina as of 2008 (CDC *Rates)*. North Carolina's adolescent pregnancy rate fell to its lowest in 2009, however, making it the 14th highest in the nation and illustrating the importance of endorsing and providing comprehensive sexuality education programs (Finley). While I do not agree with the Healthy Youth Act's strict focus on heterosexual relationships and marriage as the expected standards of behavior, especially due to declines in marriage nationally, and believe that LGBTQ youth are left out of this legislation, I still believe this law is a positive step towards the comprehensive sex education

that teachers, parents, and adolescents desire and that has been proven to work in reducing rates of adolescent pregnancy and STIs.

Latina/os living in North Carolina are also an extremely important group to consider in light of sexuality education policies and programs. North Carolina has the fastest growing rate of Latina/os in the U.S. and about 7.7% of its population is comprised of Latina/os, the majority of whom are from Mexico, but also from Cuba, Puerto Rico, and other Central and South American countries, and live in the eastern, metro, and military areas of the state ("North Carolina;" Talmi, Schryer, Billings, and Gordon 2; Wang, Keir, and Link 11). Latinas not only face the highest adolescent pregnancy rate in North Carolina at 118.4 pregnancies per 1,000 girls, which is two times the state's overall rate, but a myriad of other factors with which new immigrants must contend, such as language barriers and lack of access to transportation and healthcare services, that also influence high pregnancy rates ("Hispanic Outreach"). Even though Latina pregnancy and birth rates have declined over the past two decades, 51% of Latinas get pregnant at least once before the age of twenty and Latina adolescents have had the highest birth rate among all racial and ethnic groups in the U.S. since 1995 (Vexler and Suellentrop 3). Additionally, between 1991 and 2002, adolescent pregnancy rates for girls between the ages of fifteen and nineteen decreased by about 25% in North Carolina, but rose by 55% among Latina adolescents (Talmi, Schryer, Billings, and Gordon 2).

According to a five-county needs assessment conducted in North Carolina by Ipas, a reproductive rights organization committed to ending abortion-related deaths and disabilities, Latinas identified high rates of unintended adolescent pregnancy, STIs, and domestic violence as key issues in their communities (Talmi, Schryer, Billings, and Gordon 1). This study captured the opinions and experiences of twenty Latinas heavily involved in reproductive health and the

Latina/o community through qualitative interviews conducted by a graduate student in UNC's School of Social Work. The interviewees provided critical information about barriers to information and care that Latinas face, including lack of experience seeing medical care providers in their country of origin, misconceptions about contraceptives and their costs, lack of access to reliable transportation, isolation and fear as newly arrived and potentially undocumented immigrants, language barriers and interpreter selectivity in terms of what is translated to women, and cultural norms and expectations surrounding motherhood. In terms of adolescent pregnancy, the Latinas in this study described it as a complex issue that is influenced by Latina/o youth's lack of hope for and limited opportunities in the future, particularly as undocumented immigrants, the perceived citizenship and economic benefits of having a child in the U.S., lack of comprehensive sex education in schools, cultural expectations surrounding motherhood and family, and limitations on the discussion of sexuality in the home.

The observations of these informants demonstrate that the factors shaping rates of adolescent pregnancy and STIs in North Carolina are multifaceted and require various approaches to provide adolescents with the information and resources they need to make informed decisions about their sexual and reproductive health. In the next section, I will discuss my experiences working with and shadowing two organizations, APPCNC and El Pueblo, Inc., and contrast their approaches to reducing adolescent pregnancy and equipping adolescents with the sexual and reproductive health information they need to know.

IV. Organizational Approaches: APPCNC and El Pueblo, Inc.

The Adolescent Pregnancy Prevention Campaign of North Carolina (APPCNC) was founded in 1985. Originally formed as a coalition in Charlotte to connect people to pregnancy prevention resources during a time in which North Carolina's adolescent pregnancy rate

fluctuated from the 2nd to the 4th highest in the U.S., it is now located in Durham and is the only nonprofit in North Carolina specifically focused on reducing adolescent pregnancy (Kay Phillips). Its mission is "to support North Carolina's communities in preventing adolescent pregnancy through advocacy, collaboration, and education" and it works closely with the state and the Centers for Disease Control and Prevention (CDC) to make this mission a reality ("About Us"). While the organization's name has changed over the years, its mission has not and it has become a model for other programs in the U.S. working to prevent adolescent pregnancy through its array of programmatic initiatives that reach service providers, health educators, parents, and adolescents (Kay Phillips).

APPCNC regularly provides trainings to service providers and health educators in curricula that are evidence-based and scientifically proven to reduce rates of adolescent pregnancy, STIs, and HIV. These curricula include "Making Proud Choices," "Making a Difference," "¡Cuidate!," and "Safer Choices." The staff in charge of teen health and prevention programs presents these curricula to health educators from across the state, walking them through the materials interactively and providing opportunities for educators to practice and simulate answering questions that are specific to each educators' context. APPCNC also provides trainings in the areas of advocacy, organizational sustainability, cultural competency, and on how to cater programs to LGBTQ youth and the Latina/o community ("Professional Development"). APPCNC's commitment to education is evident through less formalized trainings and informational sessions like those that they provided after the Healthy Youth Act was mandated. APPCNC played a pivotal role informing communities about the recently mandated Healthy Youth Act and made at least fifty presentations throughout North Carolina about how to adapt educational programs to the new law between January and May 2010. It also

maintains yearly statistics about adolescent pregnancy rates in North Carolina that are accessible online and in APPCNC's office library.

APPCNC has gained national recognition for its BrdsNBz Text Message Warm Line, which began on February 1, 2009 (Hoffman). The purpose of this text messaging service is to provide safe, medically accurate, and nonjudgmental answers to teens' questions about their sexual health ("About BrdsNBz"). Adolescents text their questions to APPCNC and a trained staff member responds to them within twenty-four hours. When responding to questions, staff members are not supposed to provide medical advice, advocate for abortion, or use sarcasm, should refer questions to medical clinics or care providers if necessary, and should read text messages twice before responding kindly and reasonably (Hoffman). This is the first service of its kind in the U.S. and was featured in the New York Times in May 2009. In a personal interview, APPCNC's Executive Director told me that once this article was published, APPCNC began receiving about one-hundred text messages per day (Kay Phillips). She said that it is now down to between three and ten text messages per day (Kay Phillips). While the service has limitations in terms of how much information and counseling APPCNC staff can provide to curious or scared adolescents, it attempts to reach adolescents through a technological device to which they are always connected and may encourage them to seek additional advice or support.

APPCNC also connects to adolescents through its Teen Health Now program and by providing outreach and support to Latina/o adolescents and adolescent parents. APPCNC's Teen Health Now program is comprised of high school and college students from throughout North Carolina who care about sexual health issues and education ("Teen Health Now"). Students in this program work as advocates in conjunction with their peers, community leaders, and legislators to represent North Carolina at the state and national level ("Teen Health Now").

Members of Teen Health Now lobby in both Raleigh and Washington, D.C., participate in community forums and media interviews, blog about their experiences and adolescent sexual health issues, and organize school awareness events about the work that they are doing ("Teen Health Now"). APPCNC supports the Latina/o community through its part-time Hispanic Outreach Coordinator and organization of its annual Hispanic Symposium, which brings together individuals involved in education, healthcare, and social services to discuss issues facing the Latina/o community ("Hispanic Outreach"). It also supports adolescent parents by connecting them to education and resources, such as Adolescent Parenting Programs, which help diminish chances of a second pregnancy and increase the likelihood that adolescent parents will remain in high school ("Young Families").

While APPCNC is concerned with providing access to education and resources that will reduce adolescent pregnancy in North Carolina and focuses somewhat on the Latina/o community, the role of El Pueblo, Inc. is to strengthen the Latina/o community through "leadership development, proactive and direct advocacy, education, and promotion of cross-cultural understanding in partnerships at the local, state, and national levels" ("Our Mission at El Pueblo, Inc."). El Pueblo, Inc. is located in Raleigh and has been serving North Carolina's communities through its focus on advocacy and public policy since 1995. The initial idea for El Pueblo, Inc. began in May 1994 when a group of thirty people organized a Latin American Festival in Chapel Hill, a tradition that has continued since then with El Pueblo's annual Fiesta del Pueblo ("History of El Pueblo, Inc."). El Pueblo Inc.'s core programs fall into the realms of advocacy, culture, health, public safety, and youth. Within these areas, the staff at El Pueblo, Inc. work to inform and strengthen the Latina/o community by providing opportunities for

Latina/os to learn about and participate in leadership trainings related to immigration, healthcare, violence awareness and prevention, sexual and reproductive health, and cultural enrichment.

While El Pueblo, Inc. has a broad programmatic spectrum, it has three programs that specifically focus on Latinas' sexual and reproductive health. These include Our Rights Have No Borders, Comunidad Sana, and Mujer Sana. The main program with which I worked was Our Rights Have No Borders; Comunidad Sana and Mujer Sana provide critical information about breast and gynecological cancers that are common among Latinas through informal community *charlas* (chats). Our Rights Have No Borders began in 2009 as a reproductive health program for Latina/o youth living in Chatham, Durham, Orange, and Wake counties with the mission of "training Latin@ youth on sexual and reproductive health as well as building a movement of Latina youth activists that focus on these topics" ("Our Rights Have No Borders"). El Pueblo, Inc. trains Latina/o youth between the ages of eleven and twenty-two about sexual and reproductive health issues, preparing them to serve as peer educators and advocates at the local and national level ("Our Rights Have No Borders"). The program was created collaboratively by El Pueblo, Inc., Ipas, and students in UNC's Gillings School of Global Public Health. The topics that are discussed during the ten-week training include sexual and reproductive rights as part of human rights, anatomy, gender identity and sexual orientation, contraception, violence attention and prevention, the importance of preventing STIs, unplanned pregnancies in adolescents, and how to maintain healthy relationships ("Our Rights Have No Borders"). Adolescents also participate in weekend retreats that allow them to delve deeper into the themes of advocacy, peer to peer education, and media representation. Once Latina/o youth have gone through the ten-week program, they attend conferences at the state and national level and serve as peer educators in their communities to put what they have learned into practice.

This program is free to interested youth and El Pueblo provides monetary incentives for participants to complete it. It is intended not only to instill Latina/o youth with the skills to facilitate discussions about and advocate for their sexual and reproductive health, but also to seep into other issues that are pertinent to the Latina/o community, such as immigration reform and healthcare access (Carol Osorio Hodgman). According to the program coordinator, the majority of participants are female and Mexican, but more males are beginning to attend the trainings, which she sees as an extremely positive addition to the program (Carol Osorio Hodgman). This program approaches sexual and reproductive health differently than APPCNC in a few fundamental ways, however, and I will devote the next section to explaining what these differences are.

As organizations, APPCNC and El Pueblo, Inc. are each concerned with sexual and reproductive health, education, and advocacy, but APPCNC is primarily focused on lowering rates of adolescent pregnancy, while El Pueblo, Inc. directs its efforts to informing and solidifying North Carolina's Latina/o community through multiple programs. APPCNC's programs are based on rigorous scientific evaluation and peer review, while El Pueblo, Inc.'s are created more from community input and collaborations. For example, the Our Rights Have No Borders program does not have a specific evaluation process; students complete a pre and post-test to evaluate the knowledge they have gained, but there is no formal evaluation process with the goal of achieving scientifically measurable results. Both APPCNC and El Pueblo, Inc. approach sexual and reproductive health through the framework of human rights, but El Pueblo, Inc. is unique in its inclusion of sexual orientation and gender identity in its training modules. While APPCNC convenes trainings on how to work with the Latina/o community and LGBTQ youth, most state-approved programs for which it provides trainings to educators are allowed,

but not required to include sexual orientation in the context of STIs, anti-bullying, and tolerance under the Healthy Youth Act. Even though the frameworks through which APPCNC and El Pueblo, Inc. operate differ, these organizations complement one another through their strong emphases on adolescent pregnancy prevention and Latina/o empowerment. Their combined efforts are crucial to improving adolescents' and Latina/os' sexual and reproductive health in North Carolina and the U.S.

V. Conclusion and Recommendations

In both the U.S. and North Carolina, the effects of federally and state funded abstinence-only education policies are evident through high rates of adolescent pregnancy and STIs. Multiple scientific studies have shown the efficacy of comprehensive sexuality education programs in lowering rates of adolescent pregnancy, STIs, and age of sexual initiation and laws like North Carolina's Healthy Youth Act demonstrate that some movement is being made towards policies that include medically accurate information about contraceptives, STIs, and relationship violence. North Carolina organizations like APPCNC and El Pueblo, Inc. provide critical local, state, and national support to adolescents, parents, and educators through their interactive programs that are dedicated to enhancing adolescents' sexual and reproductive health. I believe that the future of adolescents' sexual and reproductive health truly lies in providing comprehensive sex education and resources and that there are key ways to make this possible.

Adolescents should serve as stakeholders in the development of pregnancy and STI education and prevention programs because they are dealing directly and daily with the issues that are discussed in trainings as adolescents. While adolescent pregnancy and reproductive health issues are often framed solely as girls' and women's issues, they are very much boys' and men's issues, as well, because it's not just girls and women that are sorting through the social

and economic effects of unintended and/or unwanted pregnancies, STIs, or incidences of sexual trauma or assault. Boys and men should be encouraged, therefore, to participate in programs that teach them about sexual and reproductive health, gender stereotypes and expectations, relationship violence, and healthy relationships. Programs should be more inclusive of Latina/o youth and LGBTQ individuals so that these communities do not feel further marginalized and so that children feel comfortable making decisions about their sexual orientation as it develops. The media's images and messages are extremely pervasive and influential, particularly in its representations of sex and adolescent pregnancy, and programs should also equip adolescents with the skills to analyze and negotiate these depictions. Because multiple qualitative studies have shown the discomfort both adolescents and parents experience discussing sexual and reproductive health issues with one another, yet the desire to do so, programs should also be developed that encourage continued parent-child interaction. Due to both the evidence and demand for educational programs that include comprehensive information about abstinence and contraceptives, individuals should remain aware of local and state policies, lobby for desired changes, and push for policies and programs that will provide adolescents with the information that they need and want to know about to make informed, sound decisions about their sexual and reproductive health.

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