The Hidden Epidemic of STDs and HIV Among African American Adolescents: How parents and faith-based organizations can play an effective role in prevention and education

Schenita A. Davis
The University of North Carolina at Chapel Hill

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Abstract

Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV) are of epidemic proportions among the adolescent population. The seriousness of STDs and HIV prevalence among this population is hidden from public view because most Americans are reluctant to discuss sexual health issues openly. Although sex education classes are taught in the school setting, information is often limited. Reproduction and relationships are discussed in an unclear way because many believe that if adolescents know too much about sexual activity then they will practice it. Barriers to effective STD prevention are found in government, private and public sectors, and political factors and social norms. To implement positive changes with these barriers still present, programs that focus on STD and HIV prevention should integrate more parental involvement. Programs should inform and educate parents about STDs and HIV and equip them with effective communication skills to speak openly with their teens on sexual behaviors. Faith-based organizations can also be essential in targeting African American parents and adolescents. The church has historically been an influential component of the black family. It is imperative that young people have access to the knowledge and resources that will enable them to protect themselves and their partners against HIV and other sexually transmitted infections.
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Sexually transmitted diseases (STDs) and Human Immunodeficiency Virus (HIV) are an unacknowledged epidemic of tremendous health and economic consequence to the United States. The prevalence of STDs and HIV are often absent from public debate because Americans are reluctant to discuss sexual health issues openly (Butler, Eng, 2002).

Adolescents, in general and African American adolescents, specifically, have been identified as being at an increased risk for sexually transmitted diseases and HIV. Public Health initiatives should focus on prevention and education for this group and implement ways in which to overcome the barriers of communicating about sexuality. Sexuality encompasses more than sexual behavior, it affects the physical and the mental as well as spiritual aspects of an individual.

This paper examines the impact of STDs and HIV on adolescents; discusses factors associated with increased risk of these diseases among adolescents, particularly among African American adolescents. Further, this paper explores interventions aimed at reducing STDs and HIV; discusses the importance of parental involvement in sex education among African American adolescents and explores the potential role of faith-based organizations and the church in sex education within the African American community.

**Impact among adolescents**

In the United States, approximately 12 million new cases of sexually transmitted diseases occur annually, 3 million of them occurring among teenagers. By the 12th grade, nearly 70% of adolescents have had sexual intercourse, and approximately one-quarter of all students have had sex with four or more partners (Eng & Butler, 2002).

Chlamydia is more common among teens than among older men and women. Teens also have a higher prevalence rate of gonorrhea than do sexually active men and women aged 20-24.
Minority adolescents in particular have significantly higher STD rates than do other adolescent groups. Approximately 24-30% of gonorrhea cases in 1981-91 were among adolescents; highest rates were among 15-19 year old black females (Buzi, 2002).

Chlamydia is common among all races and ethnic groups, but prevalence is higher in racial and ethnic minorities. The CDC reports that the prevalence of chlamydia among African Americans is higher in women than in men. Among male and female teens, ages 15 to 19, prevalence was approximately 12 percent for African Americans, six percent for Mexican Americans, and nearly four percent for whites (Tracking the Hidden Epidemics, CDC, 2000).

In 2001, 75% of the total number of gonorrhea cases reported to the CDC occurred among African Americans. Reported rates of gonorrhea among African Americans in 2001 was 782.3 cases per 100,000 population compared to 29.4 cases per 100,000 population among non-Hispanic whites. In 2001, African American females age 15 to 19 had a gonorrhea rate of 3,495.2 cases per 100,000 females. A rate that is 18 times greater than among non-Hispanic white females of similar age, where the rate was 193.2 cases per 100,000. African American men 15-19 years of age had a gonorrhea rate of 1,794.1 cases per 100,000 males, which was 46 times higher than the rate among 15 to 19 year old white males (CDC, STD Surveillance 2001).

African American youth are disproportionately affected by HIV/AIDS, STDs and unintended pregnancy. African American adolescents 13-19 accounted for 1,919 AIDS cases (55% females) and 3,517 HIV infections (62% females). AIDS is the fourth leading cause of death among African Americans ages 35 to 44. This is a group likely to have contracted HIV as adolescents (African American Adolescents, 2002).
Human Papillomavirus (HPV) and Genital Herpes are also common sexually transmitted infections in the United States. It is estimated that 20 million people in the United States are currently infected with human papillomavirus. Some studies show that up to 15% of sexually active teenage women are infected with HPV, many with the type of HPV that is linked to cervical cancer. Genital herpes also continues to increase, spreading across all social, economic, racial, and ethnic boundaries, but most dramatically affecting teens and young adults (Today's STD Epidemic, 2002).

Although syphilis is not a disease that highly presents in the adolescent population, it does highly affect African Americans in general. In 2001, 62.5% of all cases of primary and secondary syphilis reported to CDC occurred among African Americans. National statistics show that the rates among African American adolescents age 15-19 were higher compared to other racial groups (CDC, STD Surveillance 2001). Based on these rates, it is evident that sexual behavior among adolescents is a public health problem that must be addressed. Although this paper targets minority adolescents, interventions are relevant for all adolescents regardless of sex and race.

Factors associated with the increased risk of STDs

Why is the risk of STD infections so high in adolescents? Compared with adults, adolescents are at a higher risk of acquiring STDs because they frequently have unprotected sex, are biologically more susceptible to infection, and lack access to medical services. Adolescents’ perception of risk, social problems, and a minors right to consent also play an important role in the risk factors associated with the higher rates for this population.
Adolescents are more likely to have multiple partners and short-term relationships, which leads to frequent unprotected sex (Adolescent Health, US 2000). The CDC data indicate an increase in reported condom use at last intercourse from 38% to 51% among females and from 56% to 63% among males for those in grades 9-12 between 1991 and 1997. Despite an increase in the usage of condoms by adolescents, consistent condom use is reported by less than half of all sexually active adolescents (Condom use by adolescents, 2001).

Adolescents are biologically more susceptible to infection. These biologic factors are more of an issue with adolescent females. In teenage girls the mucous membranes of the vagina may still be immature for three to four years after their period starts, this immaturity can increase the chances of sexually transmitted infections. Cervical ectopy and columnar epithelium of the pubertal cervix also increases susceptibility of sexually transmitted diseases (Braverman, 2000).

Barriers to health care are another risk factor that place adolescents at an increased risk. Lack of finances, adequate insurance coverage, knowledge of free resources, and transportation may potentially serve as barriers to evaluation and treatment of STDs. These barriers, over time greatly increase the prevalence of STDs (Butler, Eng, 2002).

Adolescents' perceptions of relationship dynamics play an integral role in explaining adolescents' frequency of unprotected vaginal sex with casual and steady sex partners. Most adolescents lack psychosexual maturation. There is a misunderstanding of relationships and an inability to maintain emotional intimacy at such a young age. Adolescents' perception of oral sex is also very misleading. Many teens believe that oral sex is safer and that sexually transmitted infections cannot be transmitted through oral or anal sex. Teens view oral sex as a bargain- you don’t get pregnant, you can’t get an STD, you’re still a virgin, you’re in control, and you can have oral sex with someone you’re not as intimate with (Remez, 2000).
According to a survey conducted by *Seventeen* magazine in 1999, 723 males and females aged 15 to 19 were approached in malls, 49% considered oral sex to be “not as big a deal as sexual intercourse,” and 40% said it did not count as “sex. In a study by North Carolina State University, 24 percent of teens consider anal sex abstinent behavior and half of all teens do not consider oral sex to be sexual behavior (Remez, 2000). There is definitely a shift in what constitutes sex and the beliefs of what is safe sexual behavior.

However, despite the disbeliefs, virtually all STDs that can be transmitted through intercourse can also be spread orally. Teens find it completely devastating when they have symptoms of a sore throat and find out that they actually have gonorrhea of the throat. Many adolescents have not completely developed the ability to fully consider the future and future consequences to present actions. Thus, many have an extremely low perception of the risk of sexual behaviors.

Social and societal issues highly impact higher rates for sexually transmitted infections. Adolescents are faced with peer pressure, self-esteem issues, and family conflicts that may have a negative affect on their social behaviors. In a study on urban adolescents, risky sexual behaviors and behavioral and emotional problems are strongly linked to STD acquisition and recurrent infections. Among adolescents reporting prior infection, depression may be the most important risk factor for recurrent STDs (Jackson-Walker, Nitz, 1996).

The media also greatly influences risky sexual behavior. Television, movies, music videos, and the internet rarely depict sexual behavior in the context of marriage or long-term relationships. Music videos portray women as sex symbols and give an image that sexual activities are the norm. More than one-half of the programming on TV has sexual content. More than one-half of high school boys and girls in a national survey said they learned about birth
control and preventing pregnancies from television; 40% learned about these topics from magazines (Satcher, 2001).

A minor's right to consent to confidential services assures that adolescents receive health care that is essential for their well being. Mandatory parental notification laws appear to have the unintended effects of increasing health risks to adolescents. The issues surrounding confidentiality for minors and parental notification laws have various standards for disclosure of information.

In North Carolina, as well as many other states, minors can independently seek healthcare for contraception, treatment for STDs, and prenatal care. They can consent to services for prevention, diagnosis and treatment of these conditions. According to law, the physician cannot notify the minors’ parent about the request for treatment except in unusual circumstances such as a threat to a minor’s life or health or with consent of minor to contact parent (Dellinger, Davis, 2001).

Although minors can give consent to these services, healthcare providers must assess whether or not they can give valid consent. The minor must demonstrate competency and sufficient ability to understand a situation and make a choice in the light of that understanding (Dellinger, Davis, 2001). In 1992, the American Medical Association’s National Coalition on Adolescent Health stated that: “Adolescents are more likely to seek health services on a timely basis if they are assured about the confidential nature of the health visit, particularly for problems that are sensitive in nature (Minors’ Right to Consent, 2003)”

In Wisconsin a group of sexually active girls were surveyed and 59 percent said they would stop, discontinue, or delay using reproductive health services if their parents were informed that they were seeking these services (Naral Pro-Choice American Foundation, 2003). Of the girls
that reported they would stop using the services, 99 percent said they would continue to engage in sexual activities regardless of access to contraceptives. In another study of adolescents, fifty percent of adolescents reported that they would seek care for sexually transmitted diseases if treatment were confidential. In this same study only fifteen percent of adolescents reported that they would seek treatment if parental consent and notification were required (Naral, 2003).

As the prevalence of sexually transmitted diseases continues to increase in the adolescent population, it is imperative that confidential health services are available for teens. The American Public Health Association urges “that contraceptive services be made available to minors in a confidential, nonjudgmental atmosphere, and that efforts be made to clarify or change laws regarding parental consent in those states where the legality of providing such services is now in doubt…and strongly opposes policies requiring parental consent or notification as a qualification of minors for initial or continued receipt of prescription contraceptives (Naral, 2003).”

In a study on the prevalence of STDs in teens with moderate risk behaviors, sexually active adolescent females ages 14-19 were interviewed in four adolescent health clinics. The data collected assessed demographic information, sexual and reproductive history, STD knowledge and history, contraceptive practices, drug and alcohol use, and information on current and past sexual partners. Results indicated that the prevalence of STDs was high in the adolescent female population. This was also true even for the adolescents that reported having only one sexual encounter. The author concluded that screening and education should target the entire adolescent population and not solely look at individual risk alone (Miller, 2000).

Although adolescents in general have high rates of STDs, statistics show that African American adolescents have higher rates. Some say that African Americans have higher rates
because of economic status, lack of access to healthcare, and lack of trust in the healthcare system (Hughes, 2000). Traditionally blacks have been poorer and have little or no access to quality health care.

A major issue is a lack of trust in the STD statistics for African Americans. Although public and private health care providers are required by law to report sexually transmitted diseases completely and accurately, public health departments are more likely to consistently report communicable diseases than private offices. Since minorities are more likely to utilize public health departments, the belief is that STDs among Blacks are over reported and white cases are underreported (Hughes, 2000).

Dr. Helene Gayle, director of the CDCs national center for HIV, STD, and TB prevention, says in an interview with Zondra Hughes, that although there may be some over reporting of STDs among Blacks, this does not justify the higher levels of sexually transmitted infections. Dr. Gayle also believes that social variables, including the disruption of the family, have an affect on the increase of STD cases among Blacks. She states:

“There are a variety of reasons as to why Blacks are more inflicted with sexually transmitted diseases. We have less access to treatment centers, less information about sexually transmitted diseases, and sometimes we [involve ourselves] with a network of people who may continue to infect one another and not know it. Another social reason is that the disruption of family often leads to multiple sex partners (Hughes, 2000, p. 9)”

Rochelle N. Shain, professor of obstetrics and gynecology at the University of Texas, says in an interview with Zondra Hughes, that the problem is not race, but poverty. She says that protection against STDs is not priority for poorer people. But their primary concern is finding out where their next meal is coming from. Poorer people usually do not go to the doctor until something is hurting them and they often share medications. These factors cause disease to stay in the community for longer periods of time (Hughes, 2000).
Interventions and Program Initiatives

Sexuality education is a lifelong process of obtaining information and forming beliefs, values, and attitudes. It encompasses reproductive health, relationship dynamics, body image, gender roles, and sexual development. Sexuality education classes have become a part of school curricula in many parts of the United States and also a component of community-based programs that target pregnancy prevention, violence reduction, substance abuse prevention, youth development, or reproductive health services. Abstinence-only programs and comprehensive education have also been implemented to decrease the prevalence of unintended pregnancies and sexually transmitted infections among teens.

Ninety-five percent of all youth between the ages of 15 and 17 are enrolled in school. Therefore school health programs can be an efficient method to educate adolescents on healthy sexual behavior (Center for Disease Control, 1996). The primary goal of school-based sexuality education is to assist young people in building a foundation as they mature into sexually healthy adults. The content of sexuality education in the schools varies depending on the age of the students, as well as the community.

Studies have provided information about what is being taught in the schools. The Centers for Disease Control’s Division of Adolescent and School Health has published School Health Education Profiles (SHEP) that summarizes results from thirty-five state surveys and thirteen local surveys conducted among school principals and health education coordinators. SHEP found that 97% of sex education courses required by states included HIV prevention, 94% gave information about STD prevention and 85% included information about pregnancy prevention (Sexuality Information and Education Council of the United States [SIECUS], 2001).
Among the schools that had HIV education as a requirement, 99% taught about HIV infection and transmission, 76% taught about condom efficacy, and 48% taught about how to use condoms correctly. Additionally, 96% taught skills to help students resist social pressures, 97% taught decision-making skills and 90% taught communication skills (SIECUS, 2001).

Since 1988, the Center for Disease Control has provided financial and technical assistance to state and local educational agencies to assist schools in implementing effective HIV education and prevention programs for youth. As a result of these efforts, school-based HIV education is widely implemented in the United States. Between 1987 and 1994 HIV education in schools increased from 13 states to 39 states. The public and policy makers agree that HIV education is important (CDC, 1996).

In 1996 a survey reported that 95% of United States residents believe that HIV/AIDS information should be provided in school. In 1994, CDC conducted the School Health Policies and Programs Study. They analyzed data from the Health Education component and found that although programs have been widely implemented in the U.S., improvement in these programs is needed (CDC, 1996).

Since AIDS is a fatal disease and education may be linked to information about becoming infected through sexual contact, the topic can be controversial. Some fear that talking about sex will encourage youth to engage in sexual activity. However, there is no evidence that school-based programs for sexuality or STD/HIV education promote sexual activity (Butler, Eng, 2002).

To decrease and/or eliminate controversy, the CDC recommends that school systems obtain participation from the community on school health policies and programs. These policies and programs should also be consistent with the morals and values of the community (CDC, 1996). Adolescence is a critical period for developing and adopting healthy behaviors. Schools are one
of the few venues available that can reach this population in large numbers. Multilevel youth development programs have also been proven to prevent health risk behaviors in adolescents.

Focusing on increasing social and psychological skills, rather than targeting specific behaviors can protect against a number of health risks, including STDs and HIV. Studies show that implementing youth development programs at an early age have a lasting impact as children grow into adulthood (Ethier, Lawrence, 2002). These programs affect the individual holistically. The broad spectrum of psychological, social, and behavioral competencies increases attachment to school, improve career opportunities, increase adult interaction, and provides structure (Satcher, 2001). Teaching children and youth these significant life skills enables them to have healthier lifestyles and make positive decisions in life.

Some program initiatives focus primarily on abstinence. President George W. Bush hopes to increase abstinence program initiatives from $60 million in 1998, to $135 million during 2003. Abstinence is one social issue that the new Republican Congress is eager to focus on. The campaign promises to spend as much on abstinence as on teen family-planning programs (Rosenberg, 2002).

Abstinence-only education teaches that abstinence from sexual intercourse before marriage is the only acceptable behavior. These programs teach only one set of values as morally correct for all students (The Dangers of Abstinence-only, 2002). However, abstinence only programs have not demonstrated successful outcomes with regard to delayed initiation of sexual intercourse or the use of safer sex practices (Sexuality Education for Children and Adolescents, 2001). In September of 1995 the Office of Technology Assessment examined the effectiveness of prevention programs and also found that there is no scientific evidence that abstinence-only programs delay the onset of sexual intercourse (CDC, 1997).
Abstinence-only programs limit information about sex and omit potentially life-sustaining knowledge about methods of prevention. Studies show that more than half of teenagers between the ages of 15 and 19 are sexually active. Statistics also show that 93% of American men and 80% of American women between ages 18 and 59 were not virgins on their wedding night (The Dangers of Abstinence-only, 2002). This proves that programs should offer abstinence education along with other methods to protect adolescents from STDs and HIV.

Comprehensive education programs show a delay in the initiation of sexual activity. Comprehensive programs offer abstinence as the best solution along with a discussion of STDs and HIV prevention and the use of contraceptives for sexually active teens. The Office of Technology Assessment reports that programs that include discussions of abstinence and contraception in combination with topics, such as resistance skills, do not lead to an earlier onset of sexual activities, and in some cases the incidence of sexual intercourse was lowered (CDC, 1997). Comprehensive education provides instructions on relationship dynamics. It establishes an understanding of the relationship between personal behavior and health.

AIDS education is more effective when students at appropriate ages are more knowledgeable about sexually transmitted diseases, drug abuse, and community health. There is also a greater impact when they develop such qualities as decision-making, refusal skills, self-efficacy, self-esteem, and communication skills (Sexuality Education for Children and Adolescents, 2001). Studies have demonstrated that comprehensive education programs have a positive effect on sexual behaviors in adolescence. Such programs increase awareness, delay onset of sex, reduce the frequency of sex and increase contraception (The Dangers of Abstinence-only, 2002).

Parents, teachers, and students continuously support these various sex education classes. A 2000 study by the Kaiser Family Foundation found that a majority of all parents, teachers,
principals, and students want some form of sex education in the schools; they support teaching high school student’s topics such as birth control options and safer sex. For middle and junior high school students, supporters are more divided, only half or more favor teaching all aspects of sexuality education (SIECUS, 2001).

The public also supports comprehensive sexuality education. A survey conducted by Peter D. Hart Research Associates, Inc., for the Children’s Research and Education Institute in 1999 found that 66% of registered voters supported sexuality education in elementary school, 22% had negative views, and 12% were neutral. In a recent Phi Delta Kappa/Gallup Poll, The Public’s Attitudes toward the Publics Schools, found that 87% of Americans agreed that sexuality education should be included in school curricula (SIECUS, 2001).

Numerous national and government organization advocate comprehensive sexuality education. The National Institutes of Health, the Institute of Medicine, the U.S. Centers for Disease Control and Prevention, the White House Office on National AIDS Policy, and the Surgeon General’s office all publicly support programs that provide information on abstinence, contraception, and condom use. Other supporters include the American Medical Association, the American Academy of Pediatric, the American College of Obstetrics and Gynecology, and the Society for Adolescent Medicine.

Parental Involvement

There are some organizations that do not support sex education programs, including the use of abstinence-only curriculum. The Minnesota Family Council is one group that opposes the guidelines put forth by the Sex Information and Education Council of the United States. They think that these programs are relativistic, undermine parental authority, and encourage sexual activity by young people (Pro-Family News, 1996). Since the topic of sex education is so
controversial and opinions are numerous, parents have been identified as a target population for prevention and education initiatives. Parents do not need consent to speak to their children about sex. They have free will to enforce their own values and morals into their children’s life. Parents also serve as an immediate source for accurate and detailed information pertaining to sexuality and sexual behavior.

Prevention of STDs begins with an understanding of the methods of transmission, common symptoms, and current treatment (Brevet, Wiggins, 2002). Parents should be targeted to provide this information so that they, in turn, can educate their children. Parents need to be educated and well informed of the affect of STDs and HIV among the adolescent population. Parents also need to learn how to communicate with their adolescent on these facts and other sexuality issues. Parents and caregivers face formidable challenges in parenting. Even the most well informed parents find it difficult to know what information to discuss with their children and at what age is appropriate to discuss sexuality issues.

Many parents are unaware of or in denial about their children’s sexual experiences. In a study of mothers and their teenagers, it was found that 70% of the mothers believed their sons were virgins, but only 44% actually were. In this same study, 82% of mothers thought their daughters were virgins, and only 70% actually were (Heft, Kurth, DeCarlo, 1997).

To proceed successfully to effective parent-child communication, parents must first recognize and implement changes to communication barriers. Most of today’s parents did not talk to their parents about sexuality. Sex is a topic that wasn’t openly discussed at the dinner table. You simply do not engage in it until you are married. Another barrier to communication is the fear that talking about sex will increase curiosity. Speaking openly about sexual intercourse gives the message that it is permissible to engage in sexual activities. Open communication about birth
control is said to be giving a green light to have intercourse. Numerous studies provide evidence that communicating about sexuality and sexual intercourse does not increase or promote sexual activities (SIECUS, 2001).

Parents do not have any experience to guide communication with their teens on sex. Programs should target parental involvement. They should implement role-playing and effective communication skills to promote an increase in parent-child communication and to tear down the barriers to communication (Heft, Kurth, & DeCarlo, 1997).

Peer education among parents has been proven beneficial in terms of talking to teens. Parent volunteers are trained to conduct workshops and open discussions with parents and/or guardians in a variety of community settings. This interaction significantly enhances parents’ ability to initiate discussions about sex with their children. Participants in peer education reported that they were more likely to talk to their children if they felt knowledgeable on the subject (Heft, Kurth, & DeCarlo, 1997).

Parenting and communicating classes often attract more parents than classes specifically addressing HIV, especially in religious communities. Involving churches and health care providers in a collaborative effort to educate parents has been shown to be effective. Scheduling meetings during the evenings and providing culturally sensitive presenters in the parents’ language is a positive factor in implementing parent-focused programs (Heft, Kurth, & DeCarlo, 1997).

Parent-child communication should be a focus of STD/HIV prevention efforts. Family members, children, and adults should all be involved in educating about sexuality, values, and family life. Parents and youth should also be involved in the planning, implementation, and delivery phases of program interventions (Heft, Kurth, & DeCarlo, 1997).
In a study to determine the effect of parental influence on adolescent sexual behavior in high-poverty settings, African American children aged 9 to 17 were surveyed. The objectives were to determine whether communication and monitoring children’s social behavior would reduce the initiation of risky sexual behaviors and prevent the adverse affect of unprotected sex. The study concluded that interventions with parents and guardians to increase communication and monitoring about sexual risks are promising health promotion strategies for high-risk adolescents and should be highly considered in prevention and education programs (Romer, Stanton, Galbraith, Feigelman, Black, Li, 1999).

The news media often devote considerable space to citing negative statistics to document the severity of the health disparities among blacks. Little time is spent focusing on the solutions to these problems, leaving many to believe that there is no hope. Strategies must be identified that can effectively strengthen African American families and build on and reinforce their strengths. Five assets of African American families have been identified: strong achievement orientation, strong work orientation, flexible family roles, strong kinship bonds, and strong religious orientation (Hill, 2001).

Although prevention messages are important, one message does not fit all populations. Public health practitioners must make themselves aware of the identified assets of African American families, as well as other racial and ethnic groups. Those who implement programs should also be aware of the impact of culture and cultural norms of their target population. It is not reasonable to take an intervention that has been successful for young, middle class adults and expect the same success for adolescent males and females with high-risk behaviors. When you take into the account that strong religious orientation is an asset for African Americans, the church would be a valuable setting for education and prevention.
The role of faith-based organizations

Faith-based organizations have the potential to be extremely influential in decreasing the prevalence of STDs among African American adolescents. Four out of five African Americans belong to a faith tradition, according to the CDC in their November 1999 satellite broadcast, "HIV Prevention Within Faith Communities and Communities of Color" (Menter, 2000). The church has been identified as the "most independent and self-sufficient institution in the African American community (Hill, 2001)." The black church currently provides a wide range of social services that are aimed at strengthening families and enhancing the lives of children and youth in the community.

In a study known as the Black Church Family Project, six hundred and thirty-five northern black churches were surveyed regarding youth programs offered at their church. Of these, 176 reported that they have at least one program that targets adolescents in the community, primarily from low-income families. Thirty-nine percent of the churches reported having teen support programs which consisted of Christian fellowship, ministry, counseling, group discussion, seminars, and workshops. Thirty-one percent offered sports activities, fifteen percent substance abuse programs, and fifteen percent fell into the categories of parenting and sexuality education through counseling, classes, and seminars (Rubin, Billingsley, 1994).

Black churches can adequately address some of the most prominent issues facing black adolescents. The Louisiana Office of Public Health has a goal to form a coalition with African American churches to provide HIV prevention education through ministers and in faith-based workshops. In a study of church leaders they found that there was a large interest in providing collaborative HIV prevention education programs. Three strategies were identified for administering a faith-based HIV prevention program. Fifty percent of church leaders
recommended that HIV prevention information be given to the leaders of the church so that they can disseminate the information to the ministers under their leadership and their congregation. Forty percent recommended an expert provide HIV prevention education workshops and seminars to their parishioners and ten percent thought that an HIV positive person should publicly speak to the congregation (Menter, 2000).

Although there is intense controversy over sex education classes, no one program has been proven to be 100% effective in prevention and education. Public Health initiatives would benefit from an integration of all program types. The author completed a field experience with The Black Child Development Institute of Greensboro, Inc. (BCDI-G) from August 2002 through February 2003. An STD/HIV curriculum was developed and incorporated into existing programs within BCDI-G. BCDI is a community based, non-profit organization whose mission is to improve and protect the quality of life of children, youth and families in the greater Greensboro community.

The goal of this field experience was to incorporate health promotion and prevention into already existing programs. The agency has implemented various programs that focus on youth development and violence prevention. The STD/HIV curriculum was designed to give instruction on how to deliver information about STDs and HIV. The target population was adolescents aged 13-19 and parents and guardians of adolescents. The curriculum covered the transmission, signs and symptoms, and consequences of sexually transmitted infections and HIV. It also covered information on effective parent-child communication, relationship dynamics, and abstinence.

During the field experience two workshops were held for parents and guardians of adolescents. The first workshop had only seven participants. The second workshop had twenty-
two parents and guardians in attendance. Information was shared and discussed about the importance of communicating with teens about sexual activity and the incidence of sexual transmitted infections in Guilford County, the state, and the nation. Representatives were also present from Project Star—a program sponsored by Guilford County Department of Public Health and Triad Health Projects.

Each participant was given a program evaluation to complete at the end of the workshop. Participants were asked to rate the overall program and knowledge of the presenters. They were also asked if there was information covered in the curriculum that should not be discussed with adolescents age 13-19. And finally participants were asked what they learned from the workshop and if they think that it is important for adolescents to receive this type of education.

The results from the evaluation show that parents agree that they need more education and guidance about communicating with their teens. They say that such programs and workshops enable them to obtain this much-needed information. They also agree that adolescents need to be aware of the affects of unprotected sex and the reality of the risk of sexually transmitted infections in their age group. All information covered in the curriculum was said to be appropriate for the age group and population. Parents and guardians that attended were all amazed of the incidence and prevalence rates of sexually transmitted diseases and HIV among adolescents. Most were unaware of the seriousness of immature, sexual behaviors of this population, especially in Guilford County.

Conclusion

Providing a combination of education tools and programs ensures that children and youth obtain the knowledge necessary to become well-rounded, healthy individuals. STD/HIV curriculums could be developed for use by churches as well. This would give church leaders and
youth directors a guide to STD/HIV education. Leaders and youth directors could receive training on how to deliver sexual health education in a faith-based setting. It is highly important for public health practitioners to work with community organizations, including churches, to implement effective interventions.

Surgeon General, David Satcher (2001) summarizes the hidden epidemic of sexually transmitted diseases and HIV very well. He stated:

“Society’s reluctance to openly confront issues regarding sexuality results in a number of untoward effects. This social inhibition impedes the development and implementation of effective sexual health and HIV/STD education programs, and it stands in the way of communication between parents and children and between sex partners. It perpetuates misperceptions about individual risk and ignorance about the consequences of sexual activities and may encourage high-risk sexual practices. It also impacts the level of counseling and training given to health care providers to assess sexual histories, as well as providers’ comfort levels in conducting risk-behavior discussions with clients. In addition, the “code of silence” has resulted in missed opportunities to use the mass media (e.g., television, radio, printed media, and the internet) to encourage healthy sexual behaviors.”

Private and Public health care providers, public health leaders, community-based organizations, faith-based organizations, and parents must work in a collaborative effort to ensure that children and youth obtain the necessary information to become healthy adults. Morals, values, beliefs, and culture norms must be a part of this education. The topic is sensitive for society to discuss openly. However, adequate education can help to overcome communication barriers. Public Health initiatives need to step outside of the box of traditional methods of delivery and reach populations in a setting that is most familiar to them.
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