AN ABSTRACT OF THE THESIS OF

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Adolescents are faced with many life changing decisions as they prepare for adulthood. The choice to engage in sexual activity is among the most difficult of these decisions. Risks, such as unplanned pregnancy, sexually transmitted infections (STIs), and other physical complications associated with early onset sexual activity are a harsh reality for many of the youth today (13). Adolescents should be informed of the consequences of sexual activity before deciding to engage in it.

Research has shown that adolescents may not be receiving an adequate sex education. Only 62% of sexually active females in the U.S. have reported receiving formal education about contraception before their first sexual encounter (9). The U.S. is the leader in teen pregnancy in the developed world and each year nearly 9 million STIs occur in adolescents in the U.S. (9). Adolescents in Mexico have exhibited similarities in their rates of STI transmission and teen pregnancy as the youth in the U.S. with high teen pregnancy and STI transmission rates (4). Studies conducted throughout the U.S. and Mexico have provided hope for an improved system of sex education. Investigators have found that a comprehensive sex education program that covers contraception, condoms, and HIV/AIDS/STIs, while stressing abstinence may delay the onset of sexual activity and increase condom use among sexually active teens. Effective programs should utilize different avenues to deliver content and should include a component for parent involvement. Successful programs should be introduced at the age of 12 and should continue throughout high school. The importance of teaching life skills such as refusal and negotiation techniques, and self-efficacy have been integral parts of effective sex education programs.

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Sex education
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Crossing Cultural Barriers: an analysis of sex education practices in the United States and Mexico

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I understand that my thesis will become part of the collection of Oregon State University. My signature below authorizes release of my thesis to any reader upon request. I also affirm that the work represented in this thesis is my own work.

_____
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Introduction:

Today, adolescents make up an estimated 20% of the global population (12). The world today poses a variety of challenges that may not have been present in the lives of the adolescents of yesterday. It is during this vulnerable time that young adults are forced to find their place in society, as well as endure social and physical changes.

In situations where young people may either choose or be forced to experiment with adult behaviors, they are also choosing or being forced into the risks of unprotected sex. Risks, such as unwanted or unplanned pregnancy, sexually transmitted infections (STIs), and other physical complications associated with early onset sexual activity are a harsh reality for many of the youth today (13). According to a study conducted by the Guttmacher Institute, the United States has one of the highest teen pregnancy rates in the developed world, almost double that of England, Wales, Canada, and eight times that of Japan and the Netherlands. Each year nearly 9 million sexually transmitted infections occur in teens in the United States and in 2002, only 62% of sexually experienced female teens had received formal instruction about contraception before their first sexual encounter (9). A report given by the Canadian Medical Association Journal, explains that babies born to teenagers compared with those born to older mothers are more likely to live in a less supportive environment, have poorer cognitive development, and if female, are at a higher risk of becoming a teen mother as well (11). Teen mothers compared with other teenagers are more likely to have fewer

educational and employment opportunities and characteristically come from an economically disadvantaged background (11). With the right combination of sex education, social skills, and family support, the youth of today can break the ongoing cycle of unplanned parenthood and disease transmission. These young people not only represent 20% of the global population, but are also a symbol of hope for a better global future.

According to the World Health Organization, an estimated 150,000 people aged 15-49 are currently living with HIV/AIDS in Mexico and an additional 2,400 children under the age of 15 are infected with HIV/AIDS (12). In 2005, the Center for Disease Control estimated approximately 900,000 adults and adolescents are living with HIV/AIDS in the United States. Of these infected individuals, 24-27% were unaware and/or undiagnosed of their illness (15). Each year, nearly 750,000 women ages 15-19 become pregnant in the United States (15). In Mexico, 1 in 6 babies are born to women under the age of 19 each year (4). As illustrated by these statistics, the need for an improved method of sexual education in both the United States and Mexico is imperative for the future of both countries' adolescent groups. However, the problem that arises when implementing a new sex education program is, how can we formulate a coherent policy given the very wide range of opinions on the subject? Do we need to increase comprehensive sex education which would cover condom and contraception use, or should we focus on abstinence-only education?

A recent poll conducted by NPR, Kaiser Family Foundation, and Harvard University found that 93% of Americans believe that sex education should be taught in schools (17). Although the majority of Americans have agreed that sex education should exist, there is some disagreement on what a sex education course should include (17). Approximately 15% of Americans support abstinence only education for middle and high school age students. These people typically believe that teaching adolescents about contraception and abortion encourages sexual promiscuity. Consequently, they oppose schools providing information about condoms or contraception to school children (6). 36% of Americans believe that sexual education should focus on teaching teens to make responsible decisions about sex, without stressing abstinence. Supporters of this type of sex education believe that providing education that covers contraception, abortion, and STI transmission does not influence adolescent behavior. These people are usually opposed to abstinence-only programs (6). Over half of Americans fall somewhere in between these two extremes (6), 46% of Americans believe in an "abstinence-plus" program that teaches sexual abstinence as the best option, but also provides information on condoms, HIV/AIDS/STIs, and contraception (4). The majority of Americans are in support of a combination of abstinence education, as well as contraception and reproductive educational programs. The majority of Mexican voters are in favor of a more conservative approach to sexual education covering only the basic reproductive aspects as well as abstinence.

This thesis is intended to examine the strengths and weaknesses of the various sexual education programs that are currently in use in both the United States and Mexico. Both countries share a number of similarities in their approaches to sex and health education for their youth. However, both countries also differ in their range of laws and restrictions that regulate the content and modes by which sexual education may be carried out. This thesis will investigate and analyze research that has been previously conducted on the various forms of sex education in the U.S. and Mexico. In the end, I will provide a list of guidelines that should be considered when designing a program for sex education that will cross cultural barriers in hopes of designing a better tomorrow.

Topics of research that will be evaluated include: the current strategy for sex education in the U.S., Mexico's current and future sexual education plans, an educational intervention program in Mexico, the examination of a variety of programs that incorporate life skills into sex education, a review of programs that have taught contraception and condom use, an examination of HIV/AIDS education programs, abstinence based program results, and a look into a peer-led sex education program.

Background Information:

Working definitions-

The term sex education may evoke a variety of sentiments for different people. However, regardless of the term's many connotations, it is meant to refer to programs and classes that are meant to inform and instruct adolescents on their changing bodies, feelings, and emotions as they enter into adulthood.

Although the term is quite broad, it is used to refer to education covering human sex anatomy, sexual intercourse, sexual reproduction, and other topics related to sex, such as pregnancy and sexually transmitted infections. The sexual reproduction portion usually follows the process from conception to birth. The sexual anatomy portion often times includes changes that occur during puberty, such as menstruation, vocal changes, and other secondary sexual characteristics.

In 1975, a group of World Health Organization (32) experts defined sexual health as, "the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love." Since the composition of this definition, the WHO has collaborated with the Technical Consultation on Sexual health in January of 2002, as well as with a number of other committees to further develop the definition of sexual health along with the definitions for sex, sexuality, and sexual rights.

In the year 1994, the International Conference on Population and Development met, discussed, and concluded that the definition for sexual health should include the teaching and definition of reproductive health. The purpose of

the inclusion of sexual health into reproductive health was to enhance life and personal relations, as well as counseling and care that relate to reproduction and sexually transmitted diseases. The definitions below represent a compilation of ideas from an international conference of experts convened by the WHO. They do not necessarily represent the exact thoughts and opinions of the WHO on these issues.

"Sex- Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females (32)."

"Sexuality- Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, and values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors (32)."

"Sexual Health- Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (32)."

"Sexual Rights- Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- Seek, receive and impart information related to sexuality;
- Sexuality education;
- Respect for bodily integrity;

- Choose their partner;
- Decide to be sexually active or not;
- Consensual sexual relations;
- Decide whether or not, and when, to have children; and
- Pursue a satisfying, safe and pleasurable sexual life (32)."

Approaches to sexual education-

There are two main approaches to sex education: abstinence-only until marriage curricula and comprehensive sex education programs, are both used in Mexico and the United States.

Abstinence-only programs emphasize abstinence as the only 100% effective way to prevent HIV, STIs, and unwanted pregnancy. The United States defines this type of sex education as: "having an exclusive purpose to teach the social, psychological, and health gains to be realized by abstaining from sexual activity. This approach to sex education teaches abstinence from sexual activity outside of marriage as the expected standard for all school-age children. It also teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems. It emphasized the belief that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity. It teaches that sexual activity outside the context of marriage may have harmful psychological and physical side effects. The program also teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society according to national statistics. Abstinence- only education also

teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances. Lastly, abstinence-only sex education teaches the importance of attaining self-sufficiency before engaging in sexual activity (510 soc act)." What abstinence education usually omits is information on many controversial topics, such as abortion, masturbation, and differing sexual orientations. Abstinence education also provides no information on forms of contraception other than the failure rates of condoms (1).

The comprehensive approach to sex education covers a broad set of topics including; human reproduction, transmission and prevention of sexually transmitted infections (STIs), abortion, abstinence, contraception instruction, homosexuality, and sexual intercourse education. Comprehensive sex education teaches that sexuality is a normal and healthy part of life. It teaches that abstinence from sexual intercourse is the most effective method of preventing unintended pregnancy and sexually transmitted diseases, including HIV. It also provides values-based education and offers students the opportunity to explore and define their individual values, as well as the values of their families and communities. It includes accurate, factual information on abortion, masturbation, and sexual orientation. This approach to sex education teaches that proper use of latex condoms, along with water-based lubricants, can greatly reduce, but not eliminate, the risk of unintended pregnancy and of infection with sexually transmitted diseases (STDs) including HIV. Comprehensive sex education teaches that consistent use of modern methods of contraception can greatly reduce a couple's

risk for unintended pregnancy. It also includes accurate medical information about STDs, including HIV and teaches that individuals can avoid STDs. It teaches that religious values can play an important role in an individual's decisions about sexual expression and offers students the opportunity to explore their own and their family's religious values. Lastly, it educates students on their options for unplanned pregnancy, such as adoption and abortion (1).

As shown by these two lengthy approaches to sex education, a great deal of thought and planning are needed when implementing a sex education program. Employing a new sex education program is not as simple as devising a program plan and then asking schools and communities to carry out the program. First, laws must be passed, allowing governmental funds to support the new curriculum. This involves convincing citizens to vote on such changes. So, how are voters swayed to support the most effective approach to sex education?

Influences on sex education-

There are many things that influence how a country or society will approach sex education. A major issue in the decision on how to educate a country's youth about sexuality is religion. This is because many religions provide followers with a set of guidelines to live by. For example, Christianity supplies the Ten Commandments in the Bible as a list of rules to govern the lives of believers. While Islam supplies rules for living in the holy book the Koran. The top five major world religions divided by population all have at least one belief in

common: premarital sex is not approved of (15). This may lead to the belief that abstinence-only education is the only acceptable means of educating our youth.

Other influences on sex education include ethnic and cultural beliefs. Many times a culture's moral code is concurrent with their religious beliefs. However, often times they do not exactly match up. It is important to look at cultural trends in addition to religion. Lastly, a program's political support will always play a large role in determining where to direct funding and, ultimately, which route educators will take when leading sex education classes.

Mexican Culture-

The Mexican people originated from predominantly indigenous groups of people coming from a variety of tribes across the land. These indigenous people included; Aztecs, Mayans, Incans, Purapechas, and many other smaller indigenous groups. During the Spanish colonization of Mexico in the 1500's, the Spaniards brought many slaves of African origin to Mexico. During the revolution, these predominantly African slaves fled to the coastal regions. Today, the majority of Mexicans can be referred to as *mestizos*, a term meaning of mixed origin. The integration of the indigenous people with the Spaniards, as well as the Africans, created a great diversity in the cultural patterns and belief systems that are observed today in Mexico (2).

Since the Spanish conquest, Mexicans have adopted the traditional religion of Spain. Today, approximately 87% of the population of Mexico is Christian,

with slightly over 80% practicing Catholicism. This makes Mexico the second largest predominantly Catholic country behind Brazil. However, with the conversion of such a large group of indigenous peoples to Christianity came a widespread example of religious syncretism. Religious *syncretism* is a term used to refer to the melding of traditions, practices and beliefs that are not normally shared by two different groups. Religious syncretism can be seen in the religious figure, the Virgin Guadalupe, who is said to be a representation of both the Virgin Mary in the Americas as well as the Indigenous goddess Tonantzin. The legend of the Virgin Guadalupe tells of a figure of the virgin who appeared one night to a young indigenous girl. The account serves as the glue to help paste the two cultures together. Another example of religious syncretism is seen with the prevalence of *curanderos*, or healers in the rural Mexican society. These healers use indigenous remedies along with Christian faith healing to attempt to cure the sick of their ailments (2). All of these elements combined have created the conservative and formal religion of Mexico.

Another important feature of Mexican society is their centralized view of the family. The majority of Mexicans take pride in their communities, as well as their families. They spend a great deal of time interacting with each member of the family and are close with their families (2).

The business day in Mexico is set up such that businesses open at seven in the morning, then there is a two hour break in the middle of the day referred to as a siesta. During the siesta, most families gather at home to take part in a midday

meal full of talking, laughing, and general congregation of the family and neighbors. Following the midday meal, some people will return to work for two more hours. However, many businesses are closed following the midday siesta (2).

Although the family is seen as the center of life in Mexico, the society still operates in a fairly formal environment which is not conducive to talks covering sexuality. In Mexico, a more conservative and formal view of sexual education has taken charge, originating from the traditional values instilled in the people by the Christian religion. With the teen pregnancy rates increasing and HIV transmission at an all time high, it may be time for Mexico to reexamine their sexual education programs in search of a possible solution for their youth.

United States Culture-

The United States has traditionally been called a *melting pot*, referring to the mixing and blending of many different cultures into the one culture that is seen as "American." However, recently the term *salad bowl* has come into use in place of the *melting pot*, in order to demonstrate the importance of cultural diversity as opposed to one specific culture.

During the colonization of the United States, a large population of people immigrated to the United States from countries in Western Europe, such as Germany, Ireland, Poland, and Italy. Due to the largely European influence, approximately 75% of U.S. citizens are of Caucasian origin (2) and 76% of Americans identify themselves at Christians (1). Approximately 1% of Americans

identify themselves as Muslim and an additional 14% declare they are agnostic or atheist (1). The second largest ethnic group in the U.S. is that of Hispanic or Latino origin at 14%. The third largest group of U.S. citizens is of African origin at 12%, who customarily follow the Christian faith. Lastly, U.S. 4.5% of American citizens are of Asian decent (2).

Although the U.S. is represented by a variety of different cultures, beliefs, and ethnicities, the country does hold a few norms that span cultural barriers. One cultural norm is the belief in the virtue of honesty, as well as personal independence. Family is also a strong component in many of the households in the United States. However, Americans are viewed from an outsider's perspective as operating in a relatively independent fashion, apart from their family life.

Each of the ethnic and cultural groups that make up the U.S. has contributed their own unique beliefs to the country, as well as the culture of the United States. With the differing ethnic backgrounds, one might assume that sex education is a very controversial matter in the United States. As a rule set by the United States constitution, church and state are deemed to be separate entities, operating entirely on their own. As a result, the decision to provide sex education is not the controversial matter, it is the material contained in the sex education program that is of concern for most Americans.

Popular culture in the United States, such as music, fashion, and television programs, has contributed a great deal to the way that teens perceive sexuality. Today's teens are in frequent view of sexual innuendos. From music videos,

commercials, reality shows, video games, billboards, and even songs, sex is an integral part of the young person's life today. But if teens are not educated on safe sex, how can they cope with the sexual references that they see on a daily basis? This thesis will examine the current modes of sex education and propose guidelines for a program which will not only educate adolescents on safe sex, but will provide these young people with the skills to carry out their new found knowledge.

Methods:

Information for this thesis was gathered by conducting a literature review. Primary data collection was not involved in the production of this thesis. However, the idea for the thesis came about while attending a pre-medical internship in Morelia, Michoacán, Mexico. There I had the opportunity to interact with many different people from varying social classes, with many different levels of education, as well as financial status, and sexual orientations. I was able to get a rough idea of the depth of their individual knowledge of sexual health. From there I began my secondary research.

I launched my research at the Valley Library at Oregon State University. Leading the research was a simple keyword search through the database *Academic Search Premier* using the phrases; "sex education," "condom use," "sexual education + Mexico," "sex instruction + United State," "sex instruction + Mexico," "teenagers + sexual behavior," and "sexual abstinence." With each search I scanned through pages of results choosing to look at journal articles that contained results of specific studies pertained to the differing approaches to sex education.

Next, I moved to the database *Medline (PubMed)* where I began a keyword search using the terms; "sex education + Mexico," and "sex education + United States." Through the Medline search I found a number of journals that contained a wide selection of research articles pertaining to my thesis subject. Continuing my journal article search, I traveled back to the Valley Library's Catalog *Oasis*, where

I searched for journals such as, the *Journal of Transcultural Nursing* and the *Journal of the Association of Nurses in AIDS care*.

Using the database *ERIC (Education Resources Information Center)* which can be reached through a simple Google keyword search or by using the website, http://www.eric.ed.gov, I carried out another keyword search starting with the phrase, "sex education + Mexico." This search did not return any applicable journal articles. Next, I used the keyword "Sex education + United states," which also did not produce any relevant journal articles. Finally, I searched the keyword phrase, "sex education," which finally produced a number of pertinent journal articles.

The articles found through the keyword searched of the databases, *Academic Search Premier, Medline (PubMed), and ERIC* were all separated according to subject and method of sexual health education transmission. Articles were also sorted by country. Approximately half of the articles pertained to the United States while the other half of the articles covered sexual health education in Mexico.

Next, I went to the World Health Organization's website where I clicked on *Health Topics*, and then I went to the sexual health site. There I found three publications that I was able to extract information from pertaining to my thesis topic. The publications were as follows; "Defining Sexual Health: report of a technical consultation on sexual health 28-31 January 2002, Geneva," "Growing in Confidence: programming for adolescent health and development, lessons from

eight countries," and "Progress in Reproductive Health: sexual health- a new focus for WHO." The WHO website also offered many other journal articles pertaining to my thesis subject. The relevant articles were sorted by country and subject and added to my journal article collection.

I went to the CDC (Center for Disease Control) website where I searched for HIV/AIDS global statistics, as well as pregnancy statistics for the United States and Mexico. This keyword search led me to the Guttmacher Institute of New York. The Guttmacher Institute website includes a number of recent statistical collections. Among their extensive set of reports was one on the national teen pregnancy rates in the United States. This report along with the information from the CDC provided sufficient statistics to form my introduction and background information sections.

In order to collect accurate data about the United States sex education laws, I started with a simple Google keyword search using the phrase, "state sex education laws." This search produced thousands of results, many of which were not necessarily accurate. I chose to use data from the *Georgetown Journal of Gender and Law*[1], The U.S department of Health and Human Services, The U.S. department of Education, and Teen-Aid.[2]

[1] Used as a base reference for the primary state laws on sex education.
[2] Used only for the purpose of cross-checking the accuracy of other documented sources on State sex education laws.

To gather accurate information on the current state and federal laws on sex education in Mexico, I went to the federal website, Plan Nacional de Desarollo[3]. This website is maintained by the current Mexican President, Felipe Calderon's committee.

Finally, to put together an accurate depiction of the Mexican culture and the American culture, I performed a book search on the catalog *Oasis* at the Valley Library. This search supplied a number of books committed to the Mexican and Americans cultures.

[3] English translation: plan for national development

Results-Literature Review

The United States Current Sex Education Program-

Sex education in the United States is based on the idea that individual states should govern their own educational standards (27). However, states still rely on federal funding in order to support a number of their education programs. In the past, many states and individual communities have depended on annually allocated funds provided by the federal government. Today states rely on governmental grants for the funding of their various sexual education programs. As a result, the majority of the sexual instruction that the American youth receive today is a product of the governmental grant guidelines, some of which are set forth by the Social Security Act.

The Social Security Act was approved on August 14, 1935. Since its composition, the act has been amended many times. However, the main purpose of the act remains intact. The Social Security Act was designed to provide support to the elderly, dependent and crippled children, women who are with child, the unemployed, public health, and also to endow the individual states with more power to make and enforce their own laws regarding these subjects (8).

Title V, section 510 of the Social Security Act is an amendment that allows separate funds to be allocated to abstinence sex education programs in the United States (8). The term "abstinence-only education" is defined according to title V section 510 of the Social Security Act in the background section, *approaches to sex education* in this thesis.

Funding for section 510 was made available for disbursement in 1998 and was meant to continue through the year 2006. However, an extension through the December 31, 2007 has recently been approved by Congress (8). As a result, 50 million dollars is awarded annually to state and health departments for abstinence-only education in public schools. The program requires the individual state to match 75% of the funds allotted by the grant. In other words, if the grant awards $4, the state must fund an additional $3 for the same program (8). Several states have rejected these funds opting to fund their own sexual education program designs (9). See Table 1 for a detailed account of federal funding for abstinence education.

In addition to the provisions given in title V section 510, title XI section 1110 describes a second route for abstinence education. This amendment to the Social Security Act authorizes the allocation of funds to states for the specific purpose of community-based abstinence education (7). The purpose of CBAE is to provide funding to public and private institutions in order to educate adolescents ages 12-18 on their sexual health in order to prevent out-of-wedlock childbearing as well as the transmission of HIV and other sexually transmitted infections. The CBAE hopes to create environments within communities that encourage the postponement of sexual activity until marriage. Funding through CBAE is provided in project grants ranging from $250,000 to $600,000. In 2006, 152 grants were awarded across the nation and it is estimated that 202 grants will be awarded in the year 2007 (7).

Related to CBAE is the Adolescent family life research grant program (AFL). This governmental grant program is operated by the office of adolescent pregnancy program (7). The AFL is intended to design, implement, and assess abstinence-only education and intervention programs for adolescents in the United States. In 2006, the program awarded over 30 million dollars in the support of two basic programs across the country. The first program is aimed at the design and implementation of education and activities in the classroom to encourage adolescents to delay sex until marriage. The second program is meant to provide health care, education, and social services to pregnant and parenting adolescents (7). In the fiscal year 2007, AFL is supporting 36 abstinence education programs and 31 adolescent care programs (7).

Aside from the abstinence education programs funded by the federal government, states are still allowed to decide what type of sex education they will provide for their youth. The U.S. government does not allocate any funds for the specific purpose of comprehensive sex education (9). It does provide funding for general education. States are permitted to disperse these funds how they see fit, including the dispersal of funds for comprehensive sex education programs. Many states have opted to provide education covering abstinence, contraception, and STI/HIV prevention, while others have decided to let each individual school districts decide what type of education its students receive. Table 2 shows a list of the requirements for sex education by state. If a state does not require sex education, but a school district decides to provide it anyway, the state will regulate

what type of information is given. For example, in Oregon, schools are not required by law to provide sex education. However, if they choose to do so, they must cover abstinence, as well as contraception.

On March 22, 2007, Senator Frank Lautenberg (NJ) and state representatives Barbara Lee (CA), and Christopher Shays (CT) introduced the Responsible Education About Life Act (18). If passed, the act would create federal funding, administered by the U.S. Department of Health and Human Services, for comprehensive sex education. The act would include sexuality education that is age appropriate, is medically accurate, and stresses abstinence, but also covers contraception, as well as other controversial issues, such as abortion and information on sexual orientation. The REAL Act also aims to develop strong parent-child communication skills in hopes of producing strong decision-making skills in adolescents (18).

The United States has expanded its stance on sexual education to 12 African countries, Vietnam, Haiti, and Guyana through PEPFAR (president's emergency plan for AIDS relief). The plan, approved in 2003, was originally set to commit $15 million dollars over five years to the treatment, prevention, and care of individuals threatened and infected with HIV/AIDS. On May 30, 2007, President Bush announced his plan to increase the budget to $30 million over an additional five years. This would make the grand total of the plan's budget over $48 million. Although the plan includes a number of programs designed to reach millions of people infected with the virus, skeptics are concerned with the cultural

implications that the plan might include. In PEPFAR's prevention portion, the plan requires countries receiving funds to promote abstinence-only education. Countries unwilling to stress abstinence in their sex education programs will not receive funds. However, a new measure if approved by Congress and signed by the President would allow countries to opt out of the abstinence only portion of the emergency relief plan (21).

The United States' laws governing sex education encompass a broad spectrum. Some require contraception and STI/HIV instruction, others only require abstinence promotion. However, one point is clear; the majority of federal funding is used to promote abstinence education in the United States and in other U.S. funded projects on a global perspective.

Mexico's current and Future in Sexual Health Education Plan-

The general law on health in Mexico was passed and added to the constitution of the United States of Mexico on December 26, 1984 (24). The law on health governs many different issues, such as health education, basic health services, family planning[4], disease prevention and control, and much more (24). Set forth in its newest amendment on April 29, 2003 is the right to "receive comprehensive health services." This amendment implies that every Mexican citizen has equal access to healthcare (31), however, in reality this is not the case. Many rural and poor residents do not have access to any healthcare, and it was

[4] Family planning services are to include sex education.

estimated that in the year 2000, over 66,000 people died of preventable illnesses in Mexico (2). Furthermore, Mexico is currently the leader in HIV/AIDS infections in Latin America (2).

The Mexican constitution guarantees all adolescents ages 6-14 have the right to a free and well-developed secular education. However, this law is virtually never enforced. Many rural and poor Mexican citizens remove their children from school for economic reasons. If schools are required to provide sex education as a part of the general law on health, but not all children are attending school, then when and where are they receiving sex education?

One problem with the system is in the target age group for sex education in Mexico. By law, primary school students ages 6-10 are required to receive a formal sex education. However, oftentimes sex education is postponed until secondary school ages 13-15. This causes a problem because only 87% of students in Mexico attend secondary school (19). Recently, a law was proposed to Congress that would allow schools to begin teaching sex education as young as four years old. However, that law was opposed by the Catholic Church and remains stalled in Congress (19).

The material that is taught as a part of sex education programs in Mexico varies in each state and district. The majority of public schools cover the basic reproductive anatomy, with an additional portion on contraception and STI/HIV prevention. However, private schools have very few laws regulating what sort of

material is acceptable in their programs. As a result, students in private schools may receive an inaccurate or incomplete sex education (2).

Since President Calderon's election in 2006, he has proposed a plan for national development. Included in this plan is human sustainable development, state rights and security, economic competition for employees, equal opportunities for, healthcare, the poor, indigenous towns, gender equality, vulnerable groups, and an educational transformation plan. The president's plan to improve general health in Mexico covers a number of significant public health problems, such as deaths associated with poverty, like malnutrition, and infections, obesity, and even the dangers of unprotected sex (16). Although the plan recognizes the dangers of unprotected sex, such as human papilloma virus, HIV, and other STIs, it does not include a plan to improve or change sexual education for Mexican youth.

Furthermore, the president's plan to transform education includes providing quality education to rural and indigenous families in Mexico. It also plans to encourage more students to continue their education past the required secondary school. However, the educational transformation does not include a plan to change or improve sex education either (16).

According to the World Health Organization, a program referred to as CARA (rural health programs for adolescents) was introduced 1997 to Mexico. The program was designed to provide primary health care services, as well as counseling, health education, and self care for adolescents living in rural communities in Mexico. Since the initiation of the program, there have been no

studies to indicate its effectiveness. The program did not state a clear intent to focus on sex education for adolescents, however, there may have been an increase in sexual health knowledge as a result of this program (13).

HIV/AIDS prevention Strategies:

HIV prevention in Mexican Schools-

A study conducted in 40 public high schools in Morelos, Mexico, was intended to assess the effects of condom use and other sexual behavior in an HIV prevention program that promotes condom use with and without emergency contraception. 10, 954 first year high school students were randomized into one of three groups, an HIV prevention course that promoted condom use, the same HIV prevention course with emergency contraception education, and the existing biology based sex education course administered by the Ministry of Health in Mexico. Students at intervention schools received a 30 hour course over 15 weeks on HIV prevention. The condom promotion with emergency contraception group received an additional 2 hours on emergency contraception information. Self-administered, anonymous surveys were given at baseline, 4 months, and 16 months. Participating schools chose 106 teachers to take part in a 40 hour, week long training program. Teachers randomized to teach emergency contraception had an additional 2 hours of training covering emergency contraception.

The results showed that the intervention did not have an effect on reported condom use. Reported sexual behavior was similar in all three randomized groups.

Both intervention groups had a significant impact on HIV knowledge, but not on sexual behavior. The emergency intervention group reported an increased knowledge and use of emergency contraception. Both intervention groups reported breaking and mal-fitting of condoms. The results of this study indicate that the intervention program was successful in educating adolescents effectively, but not on having a significant impact on sexual behavior. The combination of condom and emergency contraception education did not increase sexual activity in the students. Sexual behavior increased at the same rate with age across all three randomized groups. This suggests that providing information about condoms and contraception will not increase sexual activity in adolescents (6).

La Uniendo de las Fronteras: HIV prevention for Mexican youth-

The goal of this study was to develop and test a culturally based effective behavioral intervention designed to reduce HIV risk behavior in Latino adolescents. This study performed two clinical trials, one in Monterrey, Mexico and one with the Latino adolescent population in Philadelphia, Pennsylvania. Each trial randomized nearly 700 students ages 12-17. Adolescents were both in and out of school and were either English speaking or Spanish speaking. Participants were separated according to age, gender and first language and then were randomly assigned to an HIV prevention program or a general health promotion program. Adults were recruited from the community and were randomly assigned and trained to facilitate one of the two groups. All facilitators were bilingual and

received 2.5 days of training. The program took place over 2 day, with follow-ups scheduled at 3, 6, and 12 months. The retention rates of the follow up sessions were, 93%, 87%, and 81%, respectively (29).

The intervention program was designed to consider cultural values, gender roles, family, and religion. The study is currently still in progress. However, researchers have reported that Mexican adolescent males are likely to feel that condoms decrease sexual pleasure and a less likely to use them, while female Mexican adolescents hold higher levels of self-efficacy in avoiding sexual risk behaviors. They have also reported that, "culturally prescribed gender roles play a major part in determining contraception and condom use (29)." Through the use of a survey, researcher found that 86% of the adolescents involved in the study were sexually active without using condoms. 61% indicated that they did not know how to properly use a condom. 78% of participants indicated that they wanted advice and skills to help them avoid HIV and other STIs (29).

These results illustrate the fact that adolescents in Mexico and the U.S. are aware of their lack of sexual health knowledge, but are willing to make a change towards improving their knowledge.

REAL Men: HIV prevention for adolescent boys and their fathers-

REAL men (responsible, empowered, aware, living) was designed to test the efficacy of an intervention program to delay the onset of sexual intercourse, to encourage condom use among those who were already sexually active, and to

improve communication about sexuality between fathers and sons. 277 adolescent boys ages 11-14 were randomized into the study along with their fathers. Seven sites were selected, 4 sites dedicated to the intervention program and 3 to the control group. Fathers attended 7 two hour sessions, once a week. The sons attended the last session with their fathers. Due to strained contact between some of the participants and their fathers, some boys were allowed to bring a non-biological father figure, given that he was at least 18 years of age and was identified by the mother as a strong role model in the boy's life (5).

Sessions contained information on communication, parenting, peer relationships, sexual topics, and HIV transmission and prevention. The information in each session was conveyed through a combination of lectures, discussions, role plays, games, and videotapes. Fathers were also given homework to complete with their sons (5). The control group participated in 7 exercise and nutrition sessions, once a week for 7 weeks.

Adolescent participants were given a survey during the last session. The survey asked questions regarding abstinence, such as, "Have you ever had sexual intercourse?" Follow-up questionnaires were given at 3 months, 6 months, and 12 months. At the each follow-up a significantly higher portion of adolescents reported delaying sexual intercourse in the HIV group than in the control group. Fathers in the HIV group also reported more communication with their sons than the fathers in the control group. A larger percentage of the sexually active

participants in the HIV group reported the use of condoms than in the control group (5).

These results suggest that involving fathers in their child's sex education could be an effective way of preventing HIV transmission among adolescents and also in delaying the onset of sexual intercourse (5). It also shows that condom use can be increased among sexually active adolescents when they are presented with an intensive and lengthy intervention program.

Condom use and Gender roles:

Gender differences in Condom use-

This study took place in Tijuana, Mexico. The purpose of the study was to examine gender-related differences in condom use and related attitudes and perceptions among adolescents in Tijuana. 370 10^{th} and 11^{th} grade students from 4 high schools participated in the study. During the study, participants took part in a one-on-one interview followed by an anonymous survey. Variables that were analyzed included: sexual behaviors lifetime and during the past 3 months, unprotected sexual practices during the past 3 months, likelihood of unprotected sex in the future, condom use self-efficacy, attitudes towards condoms, and stereotypes about condom use (12).

Results of this study showed that 32% of the students reported ever having sexual intercourse and 20% of students having engaged in sexual intercourse in the last 3 months. Males were more likely to have ever had sexual intercourse than

females (46% vs. 22%). Approximately 55% of students who reported sexual intercourse in the last 3 months also reported inconsistent or no condom use (12).

The study also showed that most students (66%) thought the man or the more sexually experienced partner should purchase and suggest the use of condoms. Approximately 79% of the students did not believe that the female should bring up condom use. This suggests that males prefer to have more responsibility on the use of condoms and females prefer to give the responsibility to the male (12).

One last point made by the study was that females tend to have older sexual partners. Therefore, the data provided by the study may not be representative of sexual partners in reality. The age difference suggests a power imbalance in the relationships of female adolescents and their older partners. This power imbalance may play a role in the inability for Latina women to avoid having unprotected sex. The majority of females reported a need for skills on how to obtain and use condoms correctly without, "ruining the mood." However, most males said they would not risk losing the opportunity to have sex by refusing to use a condom (12).

Researchers in this study suggest that an HIV prevention program that stressed communication between the male and female sexual partners may increase condom use (12).

Masculinity and Condom use among Mexican Teenagers-

A study conducted in Xochimilco, Mexico used small group discussions of adolescents age 15-16 to gather information on condom use, and general ideas and feelings about contraception use between males and females (28).

The study found that most males see sexual activity as a token of masculinity. Whereas females are perceived as more feminine and modest if they do not discuss sex. During the study, researchers found male assertiveness to be consistent with masculinity. Female assertiveness was usually followed by a promiscuous sexual reputation. The fear of HIV and unwanted pregnancy was present but was not strong enough to increase the use of condoms (28).

Condom use in the U.S.-

A study conducted in the United States examined the relationship between gender, and differences between sexually experienced and inexperienced youth, and their intentions for future sexual contact. The study included 1,173 boys and girls grades 3-6. The boys and girls were surveyed annually for 7 consecutive years, with the final year conducted when the youth were in the 9^{th}-12^{th} grades. The participants were given questionnaires that addressed their knowledge and attitudes about HIV/AIDS as related to sexual activity (10).

Results showed that the percentage of students ever engaging in sexual intercourse increased with age, and boys were more likely to have sexual intercourse than girls. In 8^{th} grade 18%, 9^{th} grade 30%, and 10^{th} grade 43%, of

students had engaged in sexual intercourse. Those students who had already engaged in sexual intercourse were more likely to intend to do so again. In the 9th and 10th grades, students who had already engaged in sexual intercourse were less likely to intend to use condoms during their next sexual encounter compared to those students who had not had sexual intercourse. Girls in the 9th grade were much more likely to intend to use condoms in the next year than boys of the same age. Lastly, girls reported feeling a significant amount of pressure to engage in sexual intercourse than boys did (10).

These results suggest that boys and girls are engaging in sexual activity at young ages. Researchers in this study suggest sex education programs should focus on emphasizing condom use over time, especially for girls. They believe that this may increase condom use by adolescents in high school. It also shows that sexual experience increases with age in adolescents. Although, boys are more likely to engage in sexual intercourse than girls, females reported feeling greater peer pressure to engage in sexual intercourse than boys did.

National Survey of Adolescents and Young Adults: sexual health knowledge-

A survey conducted by the Kaiser Family Foundation looked at a sample of 1800 adolescents ages 13-14, 15-17, and 18-24. The survey found that 70% of 15-17 year olds reported using birth control or no protection all of the time during sexual intercourse. Additionally, 42% reported using the "pull out" or withdrawal method as their primary form of birth control. When asked about gender roles

relating to condom use, 40% of female participants and 41% of male participants said it is usually the girl, "who brings up using condoms." Although 63% of male and female participants agree it is usually the boy, "who provides the condom."

The survey also asked participants about their feelings regarding abstinence. Of the participants ages 15-17, 60% of females and 66% of males, "strongly agree" or "somewhat agree" that waiting to have sex is a nice idea but nobody really does it. The majority (72%) of females and (69%) males said they are "very" or "somewhat" concerned about HIV/AIDS and unintended pregnancy (10).

These results show that the gender-related roles regarding condom use are prevalent in the United States as well as in Mexico. These results are also concurrent with the idea that adolescents want comprehensive sex education in their schools (10).

Abstinence-only program efficacy-

A 10-year study ordered by the federal government to examine the efficacy of abstinence-only sex education programs in the U.S. has recently come to a close. The study examined two rural and two urban communities of approximately 2000 students. All students received family life services available in their community, and half of the students received abstinence-only education during elementary and middle school. At the close of the study approximately 50% of the students had remained abstinent. Among the students who had engaged in sexual intercourse, the median age of first intercourse was 14 years 9 months. This age

was the same for both groups, regardless of whether or not they had received abstinence education. Of the sexually active teens, approximately 50% reported using a condom "sometimes" or "never." Less than 25% of the sexually active teens reported using a condom every time they had sex. The two groups also tended to share the same number of sexual partners and used contraception at about the same rate (23).

Researchers indicated that students who had strong peer and family support tended to remain abstinent. They also noted that problems with the study lie in the fact that the study only looked at existing abstinence-only programs and did not cover new abstinence-only programs. These results have shown that students who received abstinence-only education decided to engage in sex at the same age and rate as the students in the community family life program. These results have clearly undercut the effectiveness of abstinence-only sex education programs (23).

Teaching Sexuality and Life Skills-

Researchers for this study hoped to develop an intervention program that would take into account economic factors, varying education levels, sociocultural factors, communication issues, religion, and living conditions. Investigators traveled across Latin America in order to analyze the existing sexual education programs. It was found that most sex education programs were very formal, and did not allow for student participation. They also focused on the physical and anatomical aspects of sexuality such as menstruation, pregnancy, and the sex

organs. What emerged from their research was a need for solid information relating to contraception, HIV/AIDS, as well as education on the skills needed to make safe decisions such as condom use. In addition, researchers found that girls needed to be presented with options other than childbearing for their lives (22).

Based on these observations, researchers developed the life skills education program, Planeando tu Vida (planning your life). The program addresses issues such as HIV/AIDS, pregnancy, contraception, and condom use. However, the program goes beyond that to improve life skill such as communication, self-assertion, self-efficacy, self-esteem, and decision making. The program includes role playing, letter writing, debates, practices such as going to the pharmacy to buy condoms, and lectures (22).

Results of this program have shown a significant increase in the knowledge of participants regarding pregnancy and HIV/AIDS. Another finding was the likelihood of adolescents' using protection greatly increased after having participated in the program. Positive effects were also found in decision making and self-esteem of participants of the program (22).

Peer-led Sex Education-

A research study conducted in England examined the effectiveness of peer-led sex education. During this study, 16-17 year old students underwent an intensive training program in order to deliver sex education to 13-14 year old students. 18 focus group discussions and numerous questionnaires were conducted

following the sex education program. The sex education program covered HIV/AIDS education, STD information, contraception, and condom use. Information was conveyed through role playing, small group discussion, lessons, and brainstorming. Opportunities to practice putting condoms on a mannequin were also given. The study found that peer leaders have an advantage over teachers because they are usually regarded as being more credible sources of sexual information by middle school age students (25).

The majority of the peer educators had positive views about school-based peer-led sex education. Leaders noted a relationship between the effectiveness of the program with how "outgoing" and "connected" each peer leader was with their students. Results of this study show that peer-led sex education may be effective as a component to a comprehensive sex education plan (25).

Discussion- Guidelines for a cross-cultural comprehensive sex education program

The results of the sex education program research projects analyzed above have given a clear representation of the content needed to create an effective adolescent sex education program. As displayed by the results from the *condom use and gender roles section*, adolescents in Mexico and the United States share similar attitudes towards condom use. Both groups agree that it is generally the female's job to bring up condom use in the relationship, however, it is the male that should provide the condom (12). It is also common between the two groups to avoid condom use in order to prevent "ruining the moment." Studies have also shown that increasing communication between intimate partners may have a positive effect on condom use (14). The female's role in determining whether protection should be used during sexual intercourse is closely related to the power in gender roles in the relationship (28). Research has shown that providing female adolescents with skills such as, decision making, communication, and self-esteem can greatly increase her chances of abstaining or having protected sex (14).

The results have also shown that parents can play an integral role in the sexual education of their children. Creating programs that involve parents in the education process may prove to increase communication about sex between parents and children and ultimately, may result in fewer risk behaviors (5).

HIV/AIDS programs in the U.S. and Mexico have proven to be effective in increasing knowledge on HIV/AIDS and sometimes may even decrease risky behaviors such as unprotected sex.

Peer-led sex education has become a great avenue for grasping and holding the interest of middle school age students in both countries as well (25). According to these results, a cross-cultural comprehensive sex education program should include:

- Information on contraception, including where and how to obtain it, as well as how to properly use it.
- Condom use, including where to purchase them and a demonstration on how to properly use one.
- Emphasis on abstinence or delaying sexual activity until mentally, emotionally and physically ready.
- Focus on reducing sexually risky behaviors such as unprotected sexual intercourse.
- Provide medically accurate information regarding the risks of unprotected sexual activity.
- Cover abortion, masturbation, and sexual orientation.
- Provide education and practice for skills such as communication, decision making, refusal skills, and negotiation techniques.
- Include a component led by a peer group.

- Include an avenue for parent involvement.
- Utilize curricula that encourage student involvement such as, role playing, brainstorming, letter writing, etc.
- Provide adequate training for teachers and/or community leaders.
- Teach content that is age appropriate.
- Include content that considers cultural aspects, religion, and gender roles.
- Duration of the program should extend past one week. The majority of effective programs in this study have last over 3 weeks.
- Specifically related to Mexico, the program must include a plan to reach adolescents in rural communities, as well as children who are no longer attending school.

Conclusion-

The content of sex education in schools has long been a debate in the United States and Mexico (15). One element has finally been agreed upon, sex education should be an essential component in the curricula for all adolescents beginning in middle school in both the U.S. and Mexico.

Although, many Americans and Mexicans believe in teaching youth about abstinence, surveys have shown that (46%) of Americans believe in teaching as contraception and HIV/AIDS in addition to education (15).

Barriers to providing an effective comprehensive sex education program in both the United States and Mexico have been associated with culturally related obstacles, such as gender roles, and attitudes regarding contraception. Other complications with developing successful sex education programs have dealt with reaching all adolescents. For example, the section on *Mexico's current and future sexual health education plan,* explains that 13% of adolescents drop out of secondary school in Mexico (2). Therefore, they are not able to receive a formal sex education. Additionally, a large number of adolescents live in rural communities where formal education is not an option for many youth who must work to help provide for their families (13).

Both the U.S. and Mexico allow individual states to govern their sex education laws, however, as noted above, sex education is federally funded. The hindrances to offering youth a comprehensive sex education are related to culture,

federal law, and public opinion, however, as clearly stated by the statistics, there is a great need for a solution to these obstacles in sex education.

Research has shown that effective sex education programs usually provide information regarding pregnancy, contraception, condoms, and HIV/AIDS/STIs (6). Successful programs typically utilize many avenues to convey their message such as, games, role plays, letter writing, and brainstorming (22). Introducing sex education to adolescents around the age of 12, and continuing through high school has also been linked with the delayed onset of sexual activity and increased condom use (5).

With the right combination of these elements taken from successful intervention programs, the U.S. and Mexico should be able to create an effective sex education program that reaches all youth. A positive intervention program that considers culturally-prescribed elements, religion, and gender, in order to break the cycle of unplanned pregnancy and sexually transmitted disease for the youth in Mexico and the U.S is a goal for both countries with an finish already in view.

Suggestions for Further Research-

Through this thesis, a number of similarities between the American and Mexican cultures in terms of sex education were brought into view. Continuing research may further develop these similarities and even examine the relationship between the cultures in Central and South America. A cross-cultural sex education intervention program that could be implemented in the United State, Mexico, and other Latino countries should be examined.

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Tables 1- Please note this table was created by SEICUS it is not an original work (18).

Federal Abstinence-Only-Until-Marriage Funding by State

STATE	Title V	CBAE	AFLA	Other Federal Funding	TOTAL
Alabama	$955,157	$3,087,856	$225,000		$4,268,013
Alaska	$88,501	$663,845	$0		$752,346
Arizona	$1,034,776	$2,687,410	$198,380		$3,920,566
Arkansas	$587,519	$1,523,263	$0		$2,110,782
California	$0	$5,194,486	$1,298,214		$6,492,700
Colorado	$488,314	$2,813,206	$225,000		$3,526,520
Connecticut	$0	$1,251,800	$0		$1,251,800
Delaware	$93,978	$617,516	$0		$711,494
Florida	$2,521,581	$7,104,339	$1,074,227		$10,700,147
Georgia	$1,467,206*	$6,438,469	$1,274,520		$7,712,989
Hawaii	$162,787	$1,585,038	$0		$1,747,825
Idaho	$208,264	$0	$0		$208,264
Illinois	$1,834,583*	$5,570,553	$225,000		$5,795,553
Indiana	$754,073	$1,860,866	$0		$2,614,939
Iowa	$318,198	$0	$0		$318,198
Kansas	$337,110	$1,423,268	$0		$1,760,378
Kentucky	$817,297	$1,916,502	$0	$336,516	$3,070,315
Louisiana	$1,283,563*	$1,462,062	$0		$1,462,062
Maine	$0	$499,000	$165,000		$664,000
Maryland	$569,675	$0	$400,978		$970,653
Massachusetts	$712,241	$1,088,434	$209,826		$2,010,501
Michigan	$1,417,131	$2,636,327	$404,052		$4,457,510
Minnesota	$488,623	$0	$0		$488,623
Mississippi	$828,953	$4,881,561	$260,633		$5,971,147
Missouri	$1,417,131	$4,032,858	$0		$5,449,989
Montana	$172,303	$0	$0		$172,303
Nebraska	$218,740	$1,037,941	$0		$1,256,681
Nevada	$280,174	$371,358	$200,000		$851,532
New Hampshire	$94,901	$0	$0		$94,901
New Jersey	$914,495	$2,408,758	$293,156		$3,616,409
New Mexico	$502,785	$1,336,466	$0		$1,839,251
New York	$3,676,827	$5,562,785	$1,425,000		$10,664,612
North Carolina	$1,248,963	$46,250	$375,000		$1,670,213
North Dakota	$88,991	$0	$0		$88,991
Ohio	$1,640,982	$5,491,634	$750,000		$7,882,616
Oklahoma	$690,342	$0	$0		$690,342
Oregon	$487,695	$1,758,399	$225,000		$2,471,094
Pennsylvania	$1,693,422	$1,052,662	$838,531		$3,584,615
Rhode Island	$165,277	$400,260	$0		$565,537
South Carolina	$751,961	$2,155,203	$433,937		$3,341,101
South Dakota	$136,379	$612,193	$225,000		$973,572
Tennessee	$993,367	$5,445,322	$175,000		$6,613,689
Texas	$4,777,915	$11,411,193	$1,153,656		$17,342,764
Utah	$288,156	$600,000	$0		$888,156
Vermont	$66,633	$0	$0		$66,633
Virginia	$841,329	$1,344,482	$369,031		$2,554,842
Washington	$814,663	$884,539	$0		$1,699,202
Washington, DC	$142,008	$754,785	$0		$896,793
West Virginia	$385,852	$0	$0		$385,852
Wisconsin	$602,958	$3,100,441	$377,000		$4,080,399
Wyoming	$73,138	$0	$0		$73,138
TOTAL	$35,551,565	$104,113,330	$12,801,141	$336,516	$152,802,552

**SIECUS was unable to obtain the exact amount the state received. The amount shown reflects how much the state was eligible for according to the Fiscal Year 2006 Title V Program Announcement.*

Table 2- Please note this table was created by SEICUS and is not an original work (18).

SEXUALITY EDUCATION POLICIES – SELECT TOPICS					
STATE	ABSTINENCE[1]	CONTRACEPTION[1]	ABORTION[1]	MARRIAGE[1, 2]	LGBTQ[1]
Alabama	Stress	Cover			Negative[3,4,5]
Alaska					
Arizona	Stress				Negative[4,6]
Arkansas	Stress		Banned[7]		
California	Cover	Cover			Positive[8]
Colorado	Stress[9]				
Connecticut	Cover		Mentions[10]		
Delaware	Stress	Cover			
Florida	Stress				
Georgia	Cover				
Hawaii	Stress	Cover			
Idaho					
Illinois	Stress	Cover[12]			
Indiana	Stress				
Iowa					
Kansas		Cover			
Kentucky	Cover				
Louisiana	Stress				Banned
Maine	Stress	Cover			
Maryland	Cover	Cover			
Massachusetts	Cover				
Michigan	Stress		Banned [10,11]		
Minnesota	Cover[12]				
Mississippi	Stress				Negative[3]
Missouri	Stress	Cover[12]			Negative
Montana	Cover				
Nebraska	Stress				
Nevada					
New Hampshire	Cover	Cover			
New Jersey	Cover	Cover	Mentions	Mentions	Mandated
New Mexico	Stress[9]	Cover[9]			
New York	Stress[9]	Cover[9]			
North Carolina	Stress		Mentions[13]	Mentions	Negative[3]
North Dakota					
Ohio	Stress[9]				
Oklahoma	Stress[14]/Cover[12]	Cover[9]			Negative[15]
Oregon	Stress	Cover			
Pennsylvania	Stress[9]				
Rhode Island	Stress	Cover[12]			
South Carolina	Stress	Cover[16]	Banned[5]		Negative[4]
South Dakota	Cover				
Tennessee	Stress				
Texas	Stress	Cover			
Utah	Stress	Mentions			Negative[4]
Vermont	Cover	Cover	Cover		
Virginia	Cover	Cover			
Washington	Stress	Cover			
Washington DC		Mandated	Mandated		Mandated
West Virginia	Stress	Cover			
Wisconsin	Stress			Mandated	
Wyoming	Stress				

1Unless otherwise specified, the same is required of both sexuality education and STD/HIV/AIDS education.
2 Specifically refers to states that say marriage must be promoted. Does not include states that have an abstinence-only-until-marriage approach.
3 Must reference state laws that outlaw sodomy.
4 Must refer to homosexuality and/or same-sex sexual activity as a public health risk.
5 Must state that homosexuality is not acceptable to the general public
6 Cannot promote homosexuality as a positive lifestyle.
7 Cannot give students information about abortion or refer them to abortion services.
8 Must respect all relationships.
9 If school receives state funds for sexuality education.
10 Cannot portray abortion as an alternative to family planning.
11 Cannot refer student to abortion services
12 Applies only to HIV/AIDS education
13 "Students may receive information about where to obtain contraceptives and abortion referral services only in accordance with a local board's policy regarding parental consent."
14 Applies only to sexuality education
15 Must instruct students that "engaging in homosexual activity or promiscuous sexual activity is now known to be primarily responsible for contact with the AIDS virus."
16 "Contraceptive information must be given in the context of future family planning."