

Black Girls
and Sexuality
Education:

Access. Equity. Justice.

Commissioned through the
Gwendolyn J. Elliott Institute
at Gwen's Girls

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The Black Girls Equity Alliance (BGEA) is comprised of individuals, community-based organizations, universities, and government entities that work with Black girls and acknowledge that their lives and experiences are unique within existing societal constructs.

Our mission is to eradicate inequities affecting Black Girls in Allegheny County.

Many thanks to all the members of the Black Girls Equity Alliance Health and Wellness Working Group.

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Reproductive Justice

as a Framework for Understanding Black Girls’ Sexual and Reproductive Health

This report is the result of a community-based needs assessment of sexuality education in Allegheny County, Pennsylvania conducted by the Health and Wellness working group of the Black Girls Equity Alliance (BGEA). The purpose of the Health and Wellness group is to support Black girls in obtaining accurate health information and services and to support the overall health and well-being of Black girls in the region.

Throughout this report, our use of the term “Black girls” is used to reflect an intersectionality framework, one that includes girls and femmes and recognizes gender as a social construct. We also recognize that the term “Black” is situated in a specific geopolitical framework and includes a range of individuals who self-identify as Black as well as those who experience discrimination as a result of others’ perceptions of them as Black girls.

Black girls and femmes have uniquely faced a history of violence and injustice regarding their reproductive rights in the United States. This report is rooted in a theoretical model of reproductive justice, which extends mainstream reproductive rights arguments to examine the sociocultural contexts in which women engage in reproductive decision-making.² Access to comprehensive, culturally relevant, high-quality sexuality education is an important element in fostering the agency of Black girls and femmes to make decisions about their sexuality.



Reproductive justice is defined by SisterSong as the “human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”¹

¹ <https://www.sistersong.net/reproductive-justice/>

² Ross, L., Gutierrez, E., Gerber, M., & Silliman, J. (2016). *Undivided rights: Women of color organizing for reproductive justice*. Haymarket Books.

Within the United States, movements related to reproductive rights, historically and contemporaneously, have focused on the needs of White women and have emphasized access to contraception and abortion. These narratives have often neglected the needs and experiences of Black girls and women, often ignoring the essential intersections of race and gender.

Although an extensive review of the systematic abuse of Black girls and women tied to reproduction and sexuality is outside the scope of this report (see Roberts³ for a detailed account), we believe that we cannot fully understand the landscape currently influencing Black girls' reproductive health without accounting for the history of this oppression.



The United States has one of the highest maternal mortality rates in the developed world, and Black women are

4x

more likely to die from childbirth or complications than White women.⁴

The United States was built on the exploitation of Indigenous people and Black people. Reproductive oppression has expanded from outright control of Black people and their bodies to a more insidious approach that undergirds policy and legislation and is tied to racist beliefs and practices.

Black women and girls in the United States have been and continue to be denied reproductive autonomy through current efforts and legislation to further restrict access to comprehensive sexual and reproductive healthcare and information. Black women and girls are dying because of these racist systems and policies. The United States has one of the highest maternal mortality rates in the developed world, and Black women are four times more likely to die from childbirth or complications than White women.⁴ A majority of medical students believe that Black patients have a higher tolerance for pain.⁵ As a result, physicians often minimize Black women's pain, leading to a higher rate of undiagnosed uterine



A majority of medical students believe that Black patients have a higher tolerance for pain,⁵ which leads to a higher rate of undiagnosed uterine cancers.⁶

cancers.⁶ Black women who did not complete high school have a 25% higher chance of a pre-term birth.⁷ These disparities permeate every level of healthcare, education, and policy with Black women consistently being left out of decision-making processes that will affect their health and the health of their communities.

These disparities for Black women and girls are perpetuated by major gaps in access to comprehensive sexuality education (CSE) across the U.S. Although CSE is not a panacea, it represents an incredibly important component of mitigating and ultimately eradicating reproductive health disparity, helping students build autonomy and agency, and giving them the information to advocate for themselves in their sexual lives and when they access reproductive health services. The history of CSE is rooted in many of the same problems of racial bias that have plagued healthcare and healthcare research and as such, the way forward for sex education is through a reproductive justice framework that accounts for this history and is intentionally congruent with Black girls' intersecting identities and cultural context.

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25%

higher chance of a pre-term birth⁷

³ Roberts, D. (2017). *Killing the Black Body: Race, Reproduction and the Meaning of Liberty* (2nd ed.). New York, New York: Vintage Books.

⁴ Flanders-Stepans, M. B. (2000). Alarming Racial Differences in Maternal Mortality. *The Journal of Perinatal Education*, 9(2), 50-51.

⁵ Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2015). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci U S A*, 113(16), 4296-4301.

⁶ Baskovic, M., Lichtensztajn, D. Y., Nguyen, T., Karam, A., & English, D. P. (2018). Racial disparities in outcomes for high-grade uterine cancer: A California cancer registry study. *Cancer Medicine*, 7(9), 4485-4495

⁷ Sealy-Jefferson, S., & Misra, D. P. (2019). Neighborhood Tax Foreclosures, Educational Attainment, and Preterm Birth among Urban African American Women. *Int. J. Environmental. Res. Public Health*, 16(904).

What Is Comprehensive Sexuality Education?

Sexuality education is a wide-ranging term that encompasses many things. At its most basic, sex education covers the social, emotional, and physical aspects of human sexuality. The goal of high-quality sex education should also be to foster agency in students and to help give them the tools they need to make decisions that support their health and happiness.

Comprehensive sexuality education (CSE) is the approach that is recommended by leading public health organizations and represents a minimum standard for what should be provided in school settings. CSE moves beyond stigma and fear tactics and teaches that sexuality is natural, normal, and healthy. CSE provides positive messages about sexuality and sexual expression, including the benefits of abstinence, but also educates on risk prevention strategies such as birth control and condoms. By contrast, abstinence-only education advocates for complete abstinence from sex outside of marriage. CSE helps students to explore their personal values as well as those of their family and community to decide what is right for their lives. High-quality CSE helps young people to fully realize their bodily autonomy and the responsibility that comes with it.

Decades of research have demonstrated that CSE is the most effective way of helping students to reduce the risk of unintended pregnancy and STIs, among other incredibly important but often less well-studied impacts.⁸

It is also important to note that although CSE is certainly more



effective in general, CSE programs, including those established as evidence-based, use curricula designed within a system set up by and for White students' needs and concerns, and as such, are not tailored to Black girls and femmes. Historically, as in so many fields, researchers, doctors, and educators in the field of sex education are predominantly White, and a deficit in diverse leadership has persisted. As such, many of the topics and approaches used in existing CSE curricula have been arrived at through a predominantly White lens.

Furthermore, since research is lacking around culturally congruent sex ed for Black girls, polarizing statistics about teen birth and STIs have unfortunately had an outsized influence on how educators approach Black students in the classroom, directing educators' focus overly towards preventing these outcomes, rather than building on students' strengths and addressing other crucial topics such as healthy relationships, positive self-image, and self-advocacy. Taken all together, Black girls are left facing a far less than ideal experience of sex ed in the United States. When we see that their only choices are either CSE developed through a White lens, abstinence-only education, or no sex ed at all — it becomes clear that we are failing Black girls when it comes to providing them with the high-

quality sex education they need and deserve.

HISTORY OF SEX EDUCATION

The history of sex education has been rife with stigma, shame, and misinformation. The introduction of sex education in schools in the early 1900s was quickly met with opposition from religious leaders based on protecting students' morality and purity. In the beginning, sex ed focused on the prevention of sexually transmitted infections (STIs) and curtailing masturbation and premarital sexual expression as part of the social hygiene movement. Social hygienists emphasized sexual continence and strict self-discipline as a solution to societal ills, tracing prostitution, drug use and illegitimacy to rapid urbanization. In 1975, the World Health Organization proposed a new definition of sexual health that challenged the more stigmatized idea that was put forth by social hygienists, as "...a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counseling and care related to procreation or sexually transmitted diseases."⁹ As a major tool for the promotion of sexual health, ideally, this definition would have influenced sex education policy writ large, but unfortunately, to this day, many educational institutions have failed to adopt this more positive approach, and continue to use fear tactics and morality to encourage abstinence from sexual activity above all else.

The sole focus on STI and pregnancy prevention, as well as the proliferation of abstinence-only education, has left many current students of sex ed facing much of the same shame and stigma that was present throughout the 20th century. While government funding during the first two decades of the 21st century was directed towards pregnancy prevention programming including comprehensive sex education (CSE)

⁸ Hall, K. S., McDermott Sales, J., Komro, K. A., & Santelli, J. (2016). The State of Sex Education in the United States. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, 58(6), 595–597. doi:10.1016/j.jadohealth.2016.03.032

⁹ WHO, 1975

programs, sex ed offered outside of these programs is still sporadic, with approaches differing by state, district, school, and even individual educator.

CONTINUED OPPRESSION IN SEX ED LANDSCAPE FOR TODAY'S BLACK GIRLS

As described above, the history of sexual health research and theory is rooted in practices that have oppressed, subjugated, and denied rights to Black people in general and girls and women in particular. In the present, Black girls are still woefully underrepresented in health research, which has a toxic trickle-down effect on sex education since medical professionals base their recommendations for sex ed on the greater canon of health research.

Throughout history, Black girls and women have also been subject to several harmful tropes, stereotypes, and biases around sexuality and reproductive health, which educators must be informed about and curricula must be informed by. These include, but are not limited to:

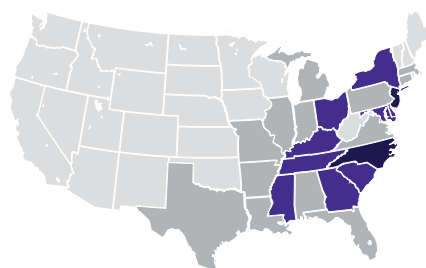
- **the adultification of Black girls**,¹⁰ a bias that Black girls are more knowledgeable about sex than White girls of the same age, which can lead to sex ed that is not age-appropriate;
- **exoticization**, where Black girls are fetishized and objectified as “exotic” by toxic masculine White culture; and,
- **the concept of Black girls being “at-risk,”** the use of “problem-language” to frame Black girls as in need of saving,¹¹ rather than as young people with myriad strengths who need accurate information to help them navigate their lives.

These oppressive frameworks have a major impact on Black girls, but other historical and current forms of racism

and discrimination also come to bear on Black girls’ many intersecting identities. All of these forms of racism and discrimination have ripples in the sex education classroom just as they do in girls’ lives. Topics like power, autonomy, control, relationship, and love of self and others are tied up in historical oppressions as well as in the conversations that are crucial to high-quality sex education.

SEX EDUCATION TODAY

When we focus in on Black girls’ experience of sex education today, what we find is deeply lacking at best. Of the 25 U.S. states with the highest populations of Black residents, only 11 mandate sex education and of those, only 3 require that the information presented is medically accurate.¹² Furthermore, these mandates do not necessarily require CSE and state policies can act as barriers to comprehensive sex education. Mississippi, for example, the state with the largest percentage of Black residents (37.3%), mandates sex education but requires that districts receive special permission from the state to include fundamental topics like contraception and STIs.



Of the 25 U.S. states with the highest populations of Black residents, only 11 mandate sex education and of those, only 3 require that the information presented is medically accurate¹²

Although updated research is needed, the Guttmacher Institute has described that overall, Black youth, low-income youth, and youth from single-parent households were less likely to receive formal sex education.¹³ Furthermore, black youth are more likely to receive abstinence-only education, which is ineffective and stigmatizing.¹⁴ As a result, in the United States, we leave Black youth with fewer resources to support their reproductive health even as they suffer disproportionately from STIs, unintended pregnancy, and sexual assault. These racial disparities in sexual and reproductive health are directly linked to lack of access to comprehensive and culturally appropriate sex education.

Despite the consensus among public health leaders that CSE should be standardized in schools, abstinence-only education persists, with federal funds and public policy running in opposition to science as Black girls bear the burden. Nationally, there is a movement towards addressing the specific needs and concerns of Black girls through sex education, under the leadership of such organizations as the Women of Color Sexual Health Network (WOCSHN), and the Association of Black Sexologists and Clinicians (ABSC). Recently, Planned Parenthood Federation of America (PPFA) took an important step in bringing on its new Director of Education, Dr. Sara Flowers, a WOCSHN member whose work has focused on the importance of representation and intersectionality in sex education.

In Western Pennsylvania, the Black Girls Equity Alliance is working to address the needs of Black girls. Below, we detail the findings of a local needs assessment designed to examine Black girls’ access to comprehensive sex education in the region.

¹⁰ <https://www.law.georgetown.edu/poverty-inequality-center/wp-content/uploads/sites/14/2017/08/girlhood-interrupted.pdf>

¹¹ <https://siecus.org/sex-ed-is-a-vehicle-for-racial-justice/>

¹² Guttmacher Institute. (2019). State Laws and Policies: Sex and HIV Education. Retrieved from Guttmacher Institute: https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education?gclid=Cj0KCOjw753rBRCVARIsANe3o44kxv_07i_hheK8zU8S8QRMKzBiGO_qn1cEowpc0kT340Q4GzNJuoJMaAgGuEALw_wcB

¹³ Guttmacher Institute. (2006). One in Three Teens Get No Formal Education About Birth Control. Retrieved from Guttmacher Institute: <https://www.guttmacher.org/news-release/2006/one-three-teens-get-no-formal-education-about-birth-control>

¹⁴ Kuehnel, S. S. (2008). Abstinence-only education fails African American youth. Wash. UL Rev., 86, 1241.

Access to Comprehensive Sex Education In Allegheny County: Our Findings

This community-based research project examined Black girls' reproductive health outcomes and access to comprehensive sex education in Western Pennsylvania. We combined quantitative surveys of internal and external providers of sex education, public health data, and

focus groups with youth to examine Black girls' experiences of sex education.¹⁵

All surveys were completed anonymously. The respondents to our study reported on sex education being offered at 61 schools.

We believe it is essential to include the perspectives of the youth who are impacted by the reproductive health landscape in the county, so we also offer quotes from adolescent Black girls who participated in a focus group about their experiences of sex education.

Reproductive Health Data for Black Girls in Allegheny County

Teen birth and STI rates are major sexual health outcomes with potential lifelong impacts. These data are reported by health departments and are the broadest data available to illustrate disparities for Black girls. However, when we limit discussions about sex education's impact to only these outcomes, we paint an incomplete picture and face limitations.

One such limitation is that standard teen birth rates report on an age range of 15-19, which is broad. Pregnancy decisions and birth are quite different at 15 than at 19.

Another is that by reporting high rates of teen birth and STIs for Black girls as a group, we risk being misinterpreted as stating that Black girls are at fault for these outcomes. Over time, teen parents, and in particular Black teen parents, have been publicly and privately shamed and stigmatized. Funding has been directed largely at pregnancy prevention, while teens with children receive little support. Many researchers frame teen pregnancy

and birth as a dire public health problem.^{16,17} On the contrary, we believe that the structural factors in Black girls' lives that fail to provide them with the information, services, and self-efficacy they need to prevent these outcomes — when preventing them is their goal — are to blame. These include systemic racism, lack of access to healthcare, low income, and educational inequity, among others. The failure is ours as a society, not that of Black girls.

Finally, a focus on these data neglects outcomes like healthy relationships, the absence of violence, girls' feelings of agency, and positive constructions of sexuality, to name a few, which are also extremely important, but infrequently reported on. As a community, we need to understand more about what is important to Black girls themselves: how they define sexual and reproductive health and what supports *they* vocalize that they believe they need to achieve it.

Because of this and the other limitations above, we present



Black females in the 15-24-year age group are disproportionately affected, representing 19% of... cases in 2017 but only 1% of the total population in Allegheny County¹⁸

the following data as a concrete, but complicated and incomplete indication that major disparities around reproductive health exist for Black girls in our region.

In Allegheny County, it is clear that Black girls experience particular disparity around rates of STIs. Regarding one of the most common STIs — chlamydia — the Allegheny County Health Department reported that "Black females in the 15-24-year age group are disproportionately affected, representing 19% of...cases in 2017 but only 1% of the total population in Allegheny County."¹⁸ In looking at the connections between poverty and STI rates in

¹⁵ For more info about the methodology used to generate the report, contact Dr. Britney Brinkman at bbrinkman@pointpark.edu. Procedures were reviewed by the IRB at Point Park University.

¹⁶ Black, A. Y., Fleming, N. A., & Rome, E. S. (2012). Pregnancy in adolescents. *Adolescent medicine: State of the art reviews*, 23(1), 123-38.

¹⁷ Fraser, A. M., Brockert, J. E., & Ward, R. H. (1995). Association of young maternal age with adverse reproductive outcomes. *New England journal of medicine*, 332(17), 1113-1118.

¹⁸ https://www.alleghenycounty.us/uploadedFiles/Allegheny_Home/Health_Department/Health_Services/STD_and_HIV-AIDS_Clinic/2017-STD-Report-Feb-11-2019.pdf

Teen birth rates overall by race for Allegheny County

4.2 vs. **32.7**

white teens,
births per 1000

black teens,
births per 1000

Black communities, our analysis found that of the 39 zip codes comprising the city of Pittsburgh, six zip codes (15208, 15210, 15204, 15206, 15212, and 15221) ranked in the highest ten for all three in percentage of their population living below 150% of poverty, percentage of Black residents, and rates of chlamydia among teens 15-19. Teens in four of the five City of Pittsburgh zip codes with the highest percentage of Black residents were faced with higher rates of chlamydia infection than the national average of 2,072.4 per 100,000 population, with teens in 15233 facing rates over 4.5 times the national average (9722.22 per 100,000).

Additionally, of the 79 City of Pittsburgh neighborhood designations used in our data, 17 had a majority Black population. Of these, 13 neighborhoods had average teen birth rates from 2013-2017 above the 2017 county average of 10.2 births per 1000 for girls aged 15-19. The remaining four neighborhoods had insufficient data on which to report, but all had incidence of teen birth in the 5-year period. Most of the rates in the thirteen neighborhoods were between five and ten times the county average. In looking at birth rates overall by race for Allegheny County, disparity is also quite evident, as the White teen birth rate remains below average at 4.2 births per 1000 and the Black teen birth rate is far above average at 32.7 births per 1000. Ten majority Black neighborhoods (East Hills, the Upper Hill, Larimer, Bedford Dwellings, Fineview, Manchester,

Northview Heights, Perry South, Homewood North, and Garfield) have teen birth rates higher even than the overall Black teen birth rate and of these, six are among the ten neighborhoods with the highest rates of poverty, clearly demonstrating the relationship between poverty and the outcome of teen birth.¹⁹ Even with the understanding that teen birth is extremely complex socially and in terms of health, disparities such as these point to major gaps in access to reproductive health services and sex education.

PROVIDERS OF SEX EDUCATION

To learn about sex education in Allegheny County, we surveyed internal and external providers. *Internal providers* included 33 providers from Pittsburgh Public Schools who indicated they would be offering sex education at their school. Internal providers are school staff — often health and physical education teachers, but also science teachers, social workers, and even school nurses. In most cases, sex education responsibilities are assigned — not chosen — regardless of a staff member's comfort level with sexuality topics, prior training, or knowledge base. In the best-case scenario, staff receive professional development, curricula, and ongoing support over time; thus they develop the skill set required for this sensitive material. Because of their potential for long-term, close relationships with students, a well-trained internal provider can serve as an incredible resource, linking the student body to healthcare services and providing ongoing support for students'

questions. Unfortunately, the best-case scenario is not the norm and teachers often report feeling unprepared and uncomfortable.

External providers included responses from over 20 organizations who offer sexuality education. External providers are employed by community-based organizations and regional health departments and travel among multiple school sites. The number of sessions and content they deliver varies depending on the wants, needs, and restrictions of each school. Some external providers are specialized in sexuality topics, while others provide instruction on a range of health education topics. Because sex education is a primary job responsibility, these providers have often specifically chosen to teach sex education as a profession. However, it is also often the case that their brief time with students limits deeper relationship-building.

Little research has compared school sex education as provided by internal versus external providers. Neither is objectively preferable and provision of sex education by either group has benefits and limitations that are important to consider at as we work towards standardizing high-quality sex education across our schools.

To protect the anonymity of the internal and external providers of sex education, we are not reporting the specific schools where our respondents are offering sex education.

The data we gathered from internal and external providers indicated they were offering sex education in a range of cities, borough and townships, including:

- Braddock Hills
- McKees Rocks
- Pittsburgh
- McKeesport
- Turtle Creek
- Duquesne
- Munhall
- Homestead
- East Carnegie
- Pitcairn

¹⁹ This data is provided by the Allegheny County Health Department, Bureau of Assessment, Statistics, and Epidemiology through a cooperative agreement with the Pennsylvania Department of Health which requires the following

disclaimer: "These data were supplied by the Division of Health Informatics, Pennsylvania Department of Health. The Pennsylvania Department of Health specifically disclaims responsibility for any analyses, interpretations or conclusions."



Who Receives Sex Education?

Internal providers gave a range of students served annually in a given school from 15 students to 400 students. External providers reported that the percentage of students in a given school who received sex education from their group **ranged from less than 10% to 75-100%.** *It is unclear how many students within any given school are receiving sex education.*

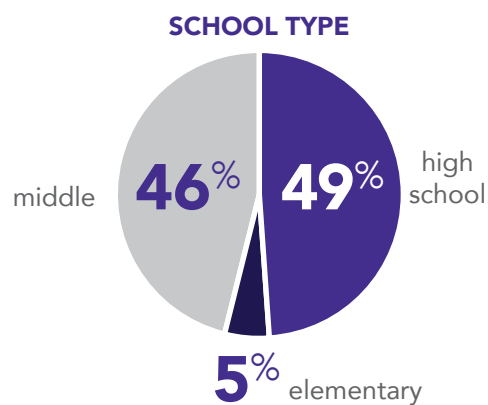
Of the respondents to our surveys, only 5% were offering sex education in elementary schools; most were working in middle and high schools. Girls in our focus group discussed the need for sex education earlier.

"I feel like sex ed should start in like 4th or 5th grade also because that's a time when a lot of girls do get their periods and so that is kind of a part of learning about you know sex and all that."

- focus group participant

In their surveys, external providers indicated that they had previously provided sex ed at just over half of all sites reported on (n=19; 56%), and that 85% (n=29) of all sites would receive sex ed again in the future.

Focus group members were asked whether they had sex ed in school. Their responses reflected gaps in coverage of sex education.



"It only occurred in my 9th-grade year."

"The first part was sexual health and we didn't finish the whole book."

"...sex education isn't talked about at all...it's not something that's discussed."

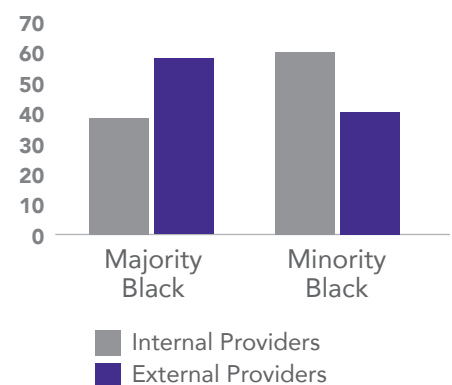
"It's touched on a little bit in health class but health class is only one semester."

"Only 1 section of 8th grade that had it [sex education]."

SEGREGATED SCHOOLS

We examined the racial demographics reported by each school to be able to understand the experiences of Black students in Allegheny county. The percentages of the student body that the school reported being Black or African American varied broadly, from 12% to 98%.

Percentage of schools served



Note: We defined schools as being majority Black students if their reported student body was 50% or higher Black/African American.

Curriculum

Best practices in sex education recommend that providers use structured curricula that are based on existing evidence about what works, while being adaptive to the particular needs of the student body. Although use of a structured curriculum does not guarantee effective sex education, failure to use one could indicate a site or provider's lack of resources, standards, training, or all of these.

Some internal providers in our study noted that their biggest challenge in offering sex education in their school is not having access to updated curriculum:

"I need updated material since it is continuously changing and new data and statistics are being developed."

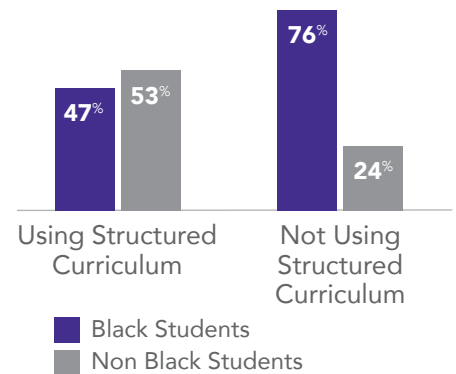
Internal providers at schools with a predominantly Black student body were less likely to use a structured curriculum. External providers did not vary in their use of curriculum based on the racial demographics of the school.

We asked internal and external providers to indicate which topics they covered in their curriculum. Some topics (including dating, STIs and HIV) were covered at approximately the same frequency by internal and external providers, while body image and families were much more likely to be covered by internal providers, and consent, communication, and masturbation were much more likely to be covered by external providers.

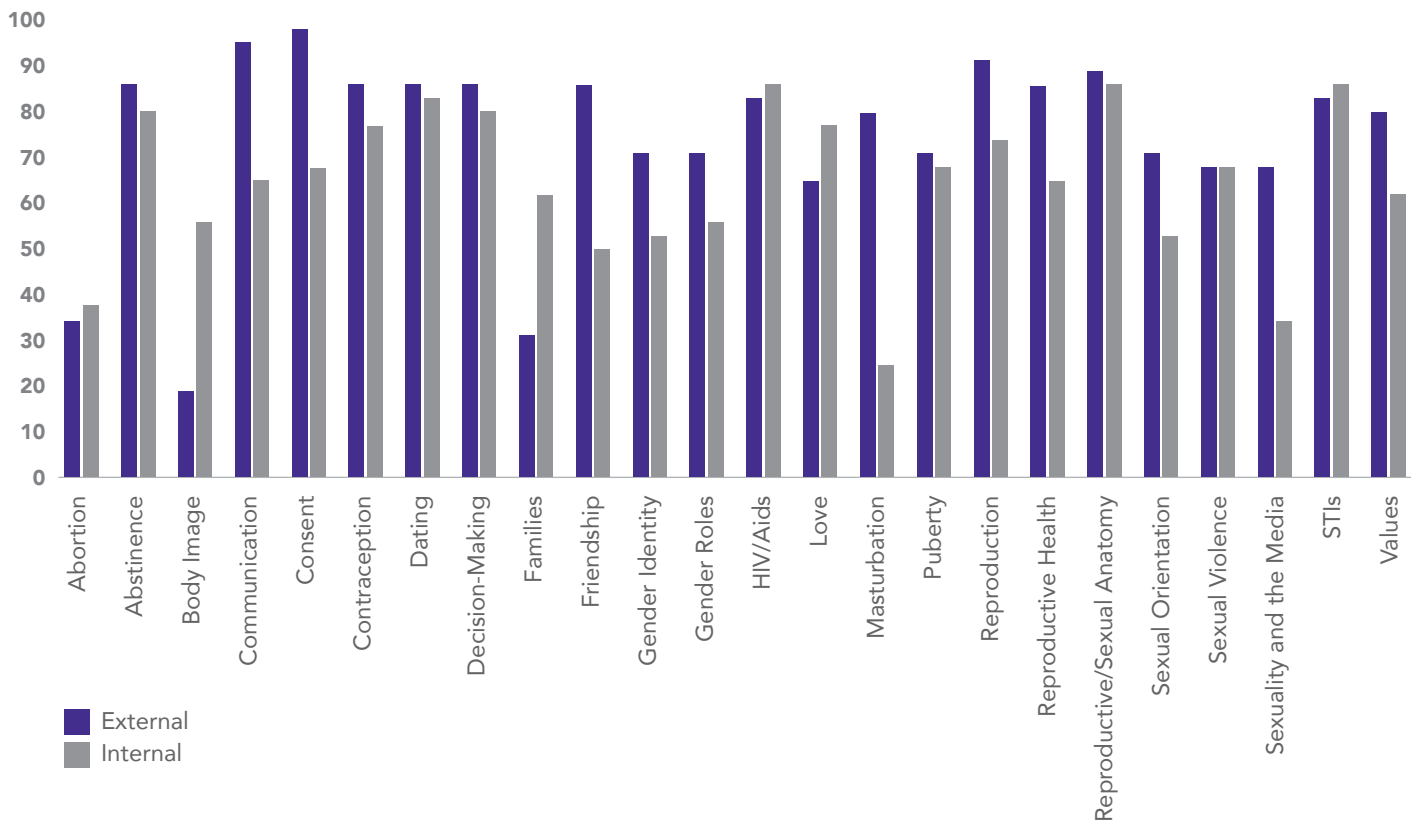
Percentage of Providers Using Structured Curricula



Average Racial Demographics of Schools with Internal Providers



Percentage of Providers Covering Topic



Abstinence

Students and providers commented on the fact that some topics are covered more often than others. It is important to note not only whether a topic is covered but how it is presented in context with other information. The majority of both internal providers (79%) and external providers (85%) reported that they cover abstinence in their curriculum.

While we agree that abstinence should be covered as part of CSE, focusing solely on abstinence may lead to neglecting conversations about the emotional/psychological aspects of sex and sexual pleasure.

"If you do have sex ed the class is mostly about prevention and how to wait till you are older and all that but if you do [have sex] they don't teach you how to mentally prepare for it or like things like that they should go into depth for people who have already done it to feel good."

- focus group participant

"They talk about like how you should not do it [have sex] and I feel like there are appropriate times for it but they shouldn't try to instill in kids' minds like you have to be this age or this mature in order to... They should be there to help them if they do decide to make the decision instead of trying to put in their mind that it's such a bad thing to do it at young ages."

- focus group participant

Sexual Orientation, Gender Identity and Expression (SOGIE)

Sexual orientation and gender identity/expression were topics noted as receiving less coverage by internal providers. Many of the teachers reported that they want to cover these topics, but need more information and training on how to do so. The barriers described around SOGIE topics are not unique to our region, with studies finding that both abstinence-only and evidence-based comprehensive sexuality education curricula often center cisgender, heterosexual identities and bodies to the exclusion of LGBTQIA+ students.²⁰

52% of internal providers include discussions of gender identity or sexual orientation in sex education, compared to 70% of external providers.

"I'm a part of the LGBTQ community and they don't talk about it at all. They talk about the male the female but they don't talk about transgender... I feel like that's basically frowned upon."

- focus group participant

CONDOMS

Although most providers indicated that they cover contraception in their curriculum, many of the external providers indicated that one of their biggest barriers or challenges to providing sex education in schools is the limitation placed on condom demonstrations and passing out condoms to students. This is problematic because evidence-based comprehensive sex education should include hands-on skill building around proper condom use.²¹

85% of external providers and 79% of internal providers include contraception as a topic in their curriculum.

Research has shown

- Confidence around condom use increases and anxiety decreases when youth are given the opportunity to handle condoms in educational environments²²
- STI risk decreased for those who engaged in hands-on school-based condom education²³
- Condom failures are related to not having received education on proper condom use.²⁴

When asked whether students would benefit from condom demonstrations, one focus group member responded:

"I feel like a lot of people learn from hearing and seeing you know stuff like that or doing it themselves so I feel like if they incorporate that into sexual education I feel like that might help. That's how they teach you with reading writing math and things like that so why not sex education?"

- focus group participant

Further, even if students are provided with the educational opportunity to learn the skills, access to condoms is essential. While this is certainly not the only form of contraception that Black girls should have access to, condoms play an important role in preventing both pregnancy and STIs.

²⁰ <https://siecus.org/resources/a-call-to-action-lgbtq-youth-need-inclusive-sex-education/>

²¹ Schantz, K. (2016). The case for condom education. ACT for Youth.

²² Williams, R. L., & Fortenberry, J. D. (2011). Update on adolescent condom use. *Current Opinion in Obstetrics and Gynecology*, 23(5), 350-354.

²³ Dodge, B., Reece, M., & Herbenick, D. (2009). School-based condom education and its relations with diagnoses of and testing for sexually transmitted infections among men in the United States. *American Journal of Public Health*, 99, 2180-2182.

²⁴ Graham, C. A., Crosby, R. A., Sanders, S. A., & Yarber, W. L. (2005). Assessment of condom use in men and women. *Annual Review of Sex Research*, 16, 20-52

Key Findings

1 Our findings indicate that **access to comprehensive sex education in Allegheny County is inconsistent and non-systematic**. The dissatisfaction voiced among youth in the focus groups is not surprising if sex education at their school mirrors that described in providers' responses, together illustrating that sex education in Allegheny county is not in keeping with best practices in many of our schools.

2 **Sex education in Allegheny County is offered by both internal providers** (school teachers and staff members) **and external providers** (community-health organizations and health departments). Some schools have both internal and external providers.

3 **The type of sex education offered varied based on the ethnic make-up of the schools**. Internal providers at schools with higher percentages of African American students were less likely to utilize a structured curriculum. When schools either do not have access to or are not required to use a curriculum, health teachers facing competing demands are tasked with preparing lessons regardless of their background in these best practices. In the worst cases, this can lead to sexuality education instruction that is not grounded in theory; that uses ineffective, even fear-based approaches; and that fails students in terms of delivering the targeted information and skills practice that they need.

4 **Internal and external providers indicated experiencing various barriers and challenges to offering comprehensive sex education in schools**. The types of barriers differed between the external and internal providers. External providers listed barriers including not being allowed to do condom demonstrations in the school, time constraints, and getting parental permission to "opt-in" to participation, which created barriers for some students to participate. Internal providers indicated they experience challenges related to dynamics in discussions of sex and sexuality, needing updated curriculum, challenges related to the maturity level of students, and needing more information regarding integrating sexual orientation and/or gender identity discussions into sex education.

Recommendations

To arrive at high quality sex education that is delivered to students across the U.S., we need:

- **Sex education mandates** that include all states and require minimum standards of medical accuracy and inclusion, leading to consistency across schools and districts in the sex education that is provided;
- **An overall cultural shift** towards a more open and tolerant view of sexuality;
- **Educators** who have the comfort, skills, and knowledge to deliver the material in a manner that is age- and stage-appropriate; and,
- **Support for families** around approaching conversations about sexuality as an ongoing process and not a single conversation.

Furthermore, it is incumbent upon those who provide sex education for Black girls and other students, to combat, dismantle, and speak to tropes, stereotypes, historic injustices, and disparities, since the repression that they cause in Black girls' lives can and does have powerful and harmful effects on Black girls' sexual health overall.

Mariotta Gary-Smith and Nakisha Floyd, two prominent Black sex educators, outlined important approaches to advancing racial justice in sex ed classrooms in a recent interview with the Sexuality Information and Education Council of the US (SIECUS), including keeping "...the impacts of racism — both past and present — at the forefront of our programming" and seeking not to target Black youth with a "monolithic lens," instead "meeting the needs of youth as they show up in our classrooms." They also emphasized the importance of understanding that it is people of color who have traditionally been doing the groundwork in communities and that "their wisdom and resiliency and strength are necessary to turn the tide."

Crucially, doing the work of advancing racial justice is work that White people in the field of sex education must be most responsible for, since they have historically been granted the most power, access, and privilege in this field, as in so many spheres.²⁵

Therefore, to arrive at a place where high quality sex education actually addresses the needs of Black girls, we need:

- **A positive, holistic approach** that acknowledges the intersections of all students' identities
- **Standards based on best practices** established not only from public health experts but through intentionally bringing to the table Black women who are experts in the field and Black girls to voice their needs, concerns, and perspectives, and ensuring that they occupy prominent leadership roles
- **Approaches that specifically and intentionally focus on the positive aspects** of Black girls' identities, using strengths-based methods to help combat the often negative and stigmatizing scare tactics and stereotypes that are lobbied against Black girls
- **Representation of Black girls' identities** in the sex education classroom, starting with ensuring that Black educators from a spectrum of gender identities are teaching sex education and that the materials used in sex education classrooms, including lesson plans, anatomy pictures and models, and educational videos are relatable to Black girls' experience
- **Approaches** that are not only trauma-informed, but also designed with an understanding of oppression, the intersections of oppression, structural racism, misogyny, homophobia, transphobia, and any other discriminating or stigmatizing forces that act on girls in their lives
- **Curricula designed by and for Black girls and women**, as well as well-researched and established approaches to adapting existing curricula to be culturally congruent for Black girls
- **Research and evaluation metrics** that take a much broader view of measuring effectiveness in sex education programming, moving beyond data about teen birth and STIs to study outcomes that matter for Black girls themselves and that more accurately reflect the depth and breadth of their lived experiences

²⁵ <https://siecus.org/sex-ed-is-a-vehicle-for-racial-justice/>

Short-term Recommendations for Pittsburgh and Allegheny County

With these findings and broad recommendations in mind, the BGEA Health and Wellness working group recommends the following steps be taken by communities, organizations, and school districts locally to work towards implementation of high quality sexuality education for Black girls and femmes in our region:

- **Conduct a neighborhood listening tour** in Black communities to ask for each community's thoughts, concerns, and ideas about reproductive health and to make the case for sex education.
- **Create an alliance of stakeholders** including youth and trusted adults, in particular Black girls and adults, to come together around sex ed. This alliance should be:
 - facilitated by a paid professional organizer;
 - supported by youth-serving and public health professionals, with families taking the lead; and,
 - tasked with formulating a plan to elicit buy-in from funders, school districts, and legislators around the importance of implementing high quality sex ed in our schools, particularly for Black girls.

- **Assemble a task force of sex education professionals**, as advised by the community alliance, to outline a set of standards for K-12 that would establish best practices in Allegheny County for:
 - age- and stage-appropriate topics and medically accurate, culturally congruent curricula based on the SIECUS guidelines;
 - instruction in the sex education classroom, including: how to determine an educator's readiness to teach sex education, when to utilize external educators for sex education, and capacity-building for teachers who feel or who are demonstrated to be unable to adequately provide sex education;
 - required ongoing professional development for teachers, including on sex ed topics, anti-racism, implicit bias, SOGIE topics, cultural competency in sex ed, and reproductive justice; and,

- communication with parents about the sex education offered by the schools and how to provide supports for talking with their children about sex and sexuality, including a centralized resource like a website maintained in accordance with these standards.

- **Schools and community organizations should partner** to improve access to reproductive health resources, services, and referrals within schools in order to normalize and support the reproductive health of Black girls. This should include (and not be limited to): providing menstrual supplies and condoms, and broader services such as STI testing, mental health services, and legal support.
- **Secure funding** to support these activities, as well as next steps and long-term recommendations.

Long-term Recommendations for Pittsburgh and Allegheny County (K-12)

- **Adopt task force standards** widely in school districts in the City of Pittsburgh and Allegheny County.
- **Train support staff** in each district and/or school who can act as a point person on sex education for parents and educators.
- **Establish mechanisms by which sex education is evaluated and monitored** continuously and schools and districts are held accountable to the standards they have adopted.
- **Create and carry out a plan for advocacy** both at the local and state level that pushes for mandated comprehensive sex education and government funding streams that support its continued implementation.



For more information about the
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Additional Resources:

Planned Parenthood of Western PA
<https://www.plannedparenthood.org/plannedparenthood-western-pennsylvania>

New Voices for Reproductive Justice
<http://www.newvoicespittsburgh.org/about/>



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