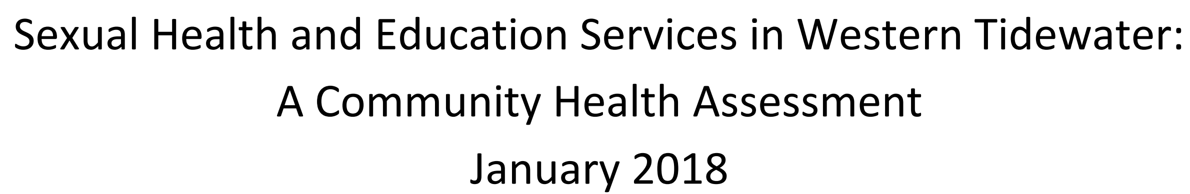
Sexual Health and Education Services in Western Tidewater:
A Community Health Assessment
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Table of Contents

Executive Summary……..3

Virginia League for Planned Parenthood Overview..5

Community Assessment……………………………………………………...............................7

National Sexual Health Overview…………………………...10

Community Health Indicators for Western Tidewater………………………………..17

Sexual Health in Western Tidewater…………………………………..……………………23

Next Steps in Western Tidewater………………………………………………………….....34

Appendices…………………………………………………………………………………………………36

Executive Summary

In recent years, there has been a steady decline in both pregnancy and birth rates among teens in the United States. Experts attribute the declining rates to a substantial increase in the use of contraceptives by sexually active teens, and a decrease in sexual activity among adolescents[1]. Even with these declines, the United States continues to have the highest teen birth rate among all industrial nations[2]. These same trends in teen pregnancy are reflected at a local level in Western Tidewater. While this is a positive trend, teen pregnancy and STI rates are considerably higher in the lower income and rural localities in Western Tidewater.

There is a general assumption that educational, social, medical, and economic difficulties experienced by parenting teens and their children are the result of teenage pregnancy[3]. However, research illustrates that economic and social disadvantages are also among the causes of teenage pregnancy.

The declining trends in adolescent sexual activity are encouraging. However, to effectively reduce rates of STIs and unintended pregnancy and births, there must be an investment in age appropriate, medically accurate, and comprehensive sexual health education. Within Western Tidewater, sexual health education is primarily concentrated in the school health and family life curricula. These curricula do not always include comprehensive sex education strategies. If offered, sexuality health education programs in the region target school-aged youth. However, older teens (ages 18-19) and young adults (ages 20-24) consistently experience the highest rates of unintended pregnancy. Therefore, expanding education services to youth and young adults is necessary to improve health outcomes in the region.

Previous research indicates that comprehensive sexual health education, that includes information about both abstinence and contraception, can delay the onset of sex. Furthermore, these programs can increase the use of contraception by sexually active teens and limit their number of sexual partners. Additionally, sexual health education is supported by an overwhelming majority of the American public. In surveys conducted over the past 20 years at the local, state, and national level, 80 to 85 percent of parents consistently indicate that they

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[1] Centers for Disease Control and Prevention (CDC). (2016). Contraceptive use. Retrieved from http://www.cdc.gov/reproductivehealth/contraception.
[2] McDevitt, T. (1996). Trends in adolescents' fertility and contraceptive use in the developing world. U.S Bureau of the Census. Washington, DC.
[3] Kirby, D. (1997). No easy answers: Research findings on programs to reduce teen pregnancy. National Campaign to Prevent Teen Pregnancy.

want their children to receive “comprehensive, medically accurate, and age appropriate sex education”[4].

This community assessment underscores the need for comprehensive sexual health education programming in Western Tidewater. Youth and young adults in this region deserve effective sexual health education programming that utilizes best practices as determined by evaluation and research. The Virginia League for Planned Parenthood (VLPP) believes programs such as these will significantly improve the sexual health outcomes for youth and young adults in Western Tidewater.

[4] Huberman, B. (Ed). (2002). Parents as advocates for comprehensive sex education in schools. Advocates for Youth. Retrieved from http://www.advocatesforyouth.org/component/content/article/158-parents.

Virginia League for Planned Parenthood Overview

Mission

The Virginia League for Planned Parenthood (VLPP) is a 501(c)3 organization whose mission is to ensure individuals and families have the freedom, information, and ability to make their own informed reproductive choices.

VLPP believes that each individual has a basic right to control their reproductive health, and that individual control will lead to a better quality of life and stronger families and communities. VLPP provides a variety of health services, including primary care, well-women exams, breast cancer screenings, cervical cancer screenings, treatment of precancerous cervical conditions, birth control information and supplies, emergency contraception, pregnancy testing, options counseling, abortion services, transgender healthcare services, and STI testing and treatment.

Vision

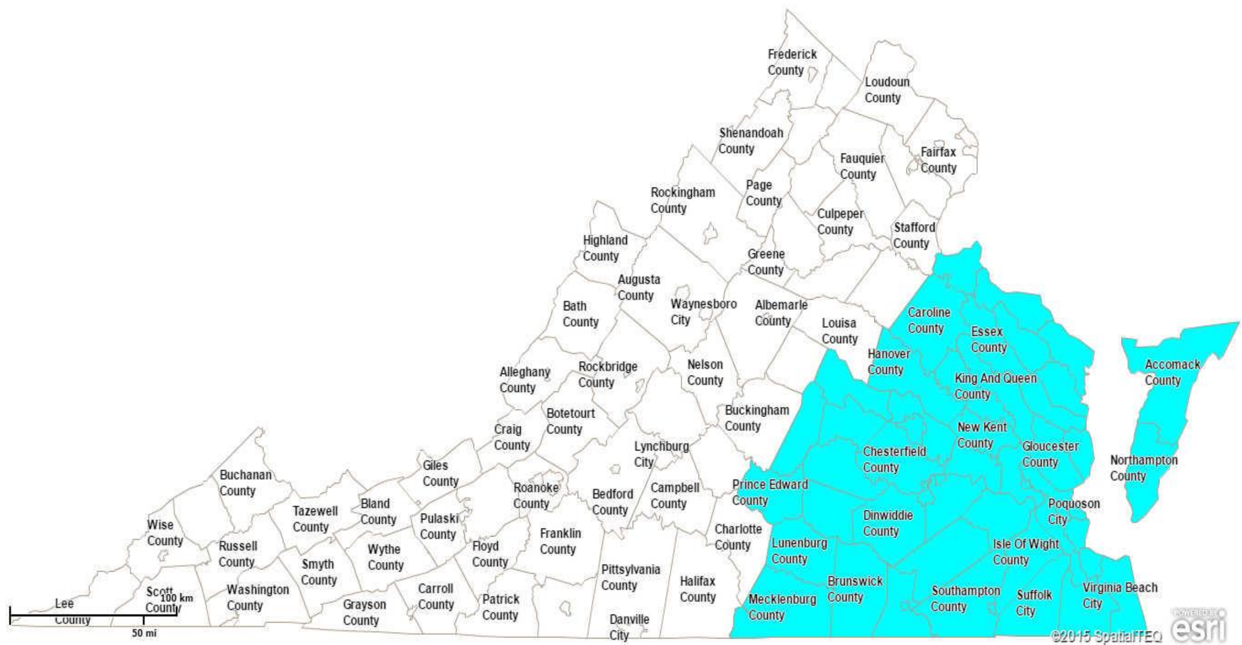
VLPP envisions a future where there is universal understanding and support for the right of each person to responsibly manage their sexual and reproductive health. A person's freedom, equality, and health will be enhanced by access to a full range of health planning options. When the right to family planning is accepted as fundamental and mainstream, there is the potential for each person to fulfill their own dreams. VLPP further envisions a future where laws will guarantee these rights and ensure access to quality health care, education, and advocacy services. These services should be readily available in safe settings that preserve and protect the privacy and right of each individual regardless of income, age, gender, marital status, race, ethnicity, or sexual orientation.

VLPP works collaboratively within a broad network that includes schools, community organizations, parents, elected officials, and policy makers to encourage and promote strong families and communities. These partnerships work toward creating a future where laws and funding will be based on the health needs of individuals and the desire to achieve positive health outcomes. In this climate, policy makers will be incentivized to embrace prevention initiatives, and there will be broad support for family planning, sexuality education, and freedom of choice.

Service Area

VLPP serves the Greater Richmond Metro and Greater Hampton Roads Metro areas with three health centers located in Richmond, Hampton, and Virginia Beach. This community assessment focuses on the area served by the Western Tidewater Healthy Youth Initiative which includes the cities of Suffolk and Franklin, and Isle of Wight County (Figure 1).

Figure 1. Virginia League for Planned Parenthood Service Area



Community Assessment

This report is intended to serve as a resource for providers who are planning and implementing comprehensive sexual health education programs in Western Tidewater. This assessment can be used as a tool to inform organizations about current trends and best practices which will allow them to utilize resources effectively in order to maximize community impact. VLPP believes that empowering individuals to create and maintain healthy relationships with their intimate partners and educating them on how to avoid unintended pregnancy and STIs can lay the foundation for healthy sexuality over a lifetime.

Rationale for Comprehensive Sexual Health Education

Decades of research has stressed the need to provide comprehensive, medically accurate sexuality education to young people. While there has been a national decline in teen pregnancy over the last decade, the US still has the highest teen pregnancy rates in the industrialized world. Every year in the US, more than half a million teens between the ages of 15-19 become pregnant. Of that number, 75% are described as unintended pregnancies[5]. Youth are also adversely impacted by STIs. Young adults between the ages of 15-25 make up one-quarter of the sexually active population in the US, yet they contract roughly half of the 20 million STIs contracted each year. In the US, one in four young people between the ages of 15-24 contracts a STI each year[6].

Evaluations of comprehensive sexuality education programs, as opposed to programs that only focus on abstinence, show that a comprehensive approach encourages youth to delay the onset of sexual activity. Furthermore, these programs can reduce the frequency of sexual activity, reduce the number of sexual partners, and increase condom and contraceptive use[7]. While researching the impact of sexuality education on sexual risk taking for teen 15-19, the National Survey of Family growth found that teens who received comprehensive sexuality education were 50% less likely to report a pregnancy than those receiving abstinence only education[8].

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[5] Future of Sex Education Initiative. (2012). National sexuality education standards: Core content and skills, K-12. [A special publication of the *Journal of School Health*].
[6] CDC. (2012). Sexually transmitted disease surveillance 2011. U.S. Department of Health and Human Services. Atlanta, GA. Retrieved from https://www.cdc.gov/std/stats11/surv2011.pdf
[7] Kirby, D. (2007). Sex and HIV programs: Their impact on sexual behaviors of young people throughout the world. *Journal of Adolescent Health*, 40, 206-217.
[8] Future of Sex Education Initiative. (2012). National Sexuality Education Standards: Core Content and Skills, K-12 [a special publication of the *Journal of School Health*].

Comprehensive Sexuality Education in Virginia

In the Virginia Department of Education's Standards of Learning (SOL), all content related to sexuality, reproductive anatomy, healthy relationships, abstinence, puberty, and sexual violence prevention falls under the Family Life Education (FLE) standards. Although there are FLE standards for grades K-12, school districts are not required to teach FLE. This means that many students attending public schools in Virginia get no information related to sexual health during their entire academic career. If school districts do implement FLE programs, they must meet or exceed the requirements outlined in the SOL[9].

If students do get sexuality education during their time in Virginia public schools, the programs often employ an abstinence-only-until-marriage approach[i]. Abstinence-only programs have yet to show any long-term positive impact on sexual health behaviors such as sexual initiation, frequency of vaginal sex, number of partners, condom use, or the incidence of unprotected vaginal sex[10]. Despite this, the Virginia Department of Health has continued to administer Title V Abstinence-Only Education funding to local health departments[11].

Such abstinence-only programs have been implemented in Suffolk Public Schools. Ninth and tenth grade students currently participate in a program called 'Choosing the Best', which includes eight, 50-minute lessons. These lessons encourage students to delay sexual activity until marriage and present pre-marital sex as morally unacceptable. 'Choosing the Best' promotes their program as an opportunity for teenagers to "learn about the negative emotional effects of casual sex and how sexual delay provides freedom: freedom from physical and emotional risks and the freedom to pursue dreams and personal goals. After evaluating the options for themselves, students are given the opportunity to commit to delaying sex until marriage"[12]. This abstinence-only approach has been shown through decades of research to be ineffective at reducing teen pregnancy and reducing STI rates among youth.

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[9] VA. Code Ann. §22.1-253.13:1 (c), http://law.lis.virginia.gov/vacode/tot;e22.1/chapter13.2/section22.1-253.13:1/

[10] Underhill, K., Operario, D., & Montgomery, P. (2007). Abstinence-only programs for HIV infection prevention in high-income countries. *The Cochrane Database of Systematic Reviews*, (4), CD005421.

[11] Information provided by Sherika Eskridge, Abstinence Education Program Coordinator, Virginia Department of Health, May 31, 2016.

[12] Choosing the Best Publishing. (2017). Retrieved from http://www.choosingthebest.com/journey

[i] Abstinence-Only-Until-Marriage: A form of sex education that teaches abstinence from sexual activity outside of marriage as the only acceptable sexual behavior for youth. This approach often excludes other types of sexual health education topics, such as birth control and condom use.

Western Tidewater Healthy Youth Initiative

This report is intended to serve as a resource for providers who are planning and implementing comprehensive sex education programs within the Western Tidewater region. The Western Tidewater Healthy Youth Initiative seeks to build partnerships with youth-serving organizations in Suffolk, Franklin, and Isle of Wight in order to provide comprehensive, medically accurate sexual health education programs. These programs will prioritize youth who are at high risk for unintended pregnancy and STIs. As such, these programs will be free of cost and held in locations which are accessible to the participants. The Western Tidewater Healthy Youth Initiative also has the capacity to provide technical assistance and workshops for professionals, parents, and community members who are interested in learning more about how to improve sexual health outcomes for youth in the region.

Note about the Data

Data used in this report is from a variety of sources, including the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), Virginia Department of Health, Kids Count, and the Guttmacher Institute. The most recent statistics available are included in this report.

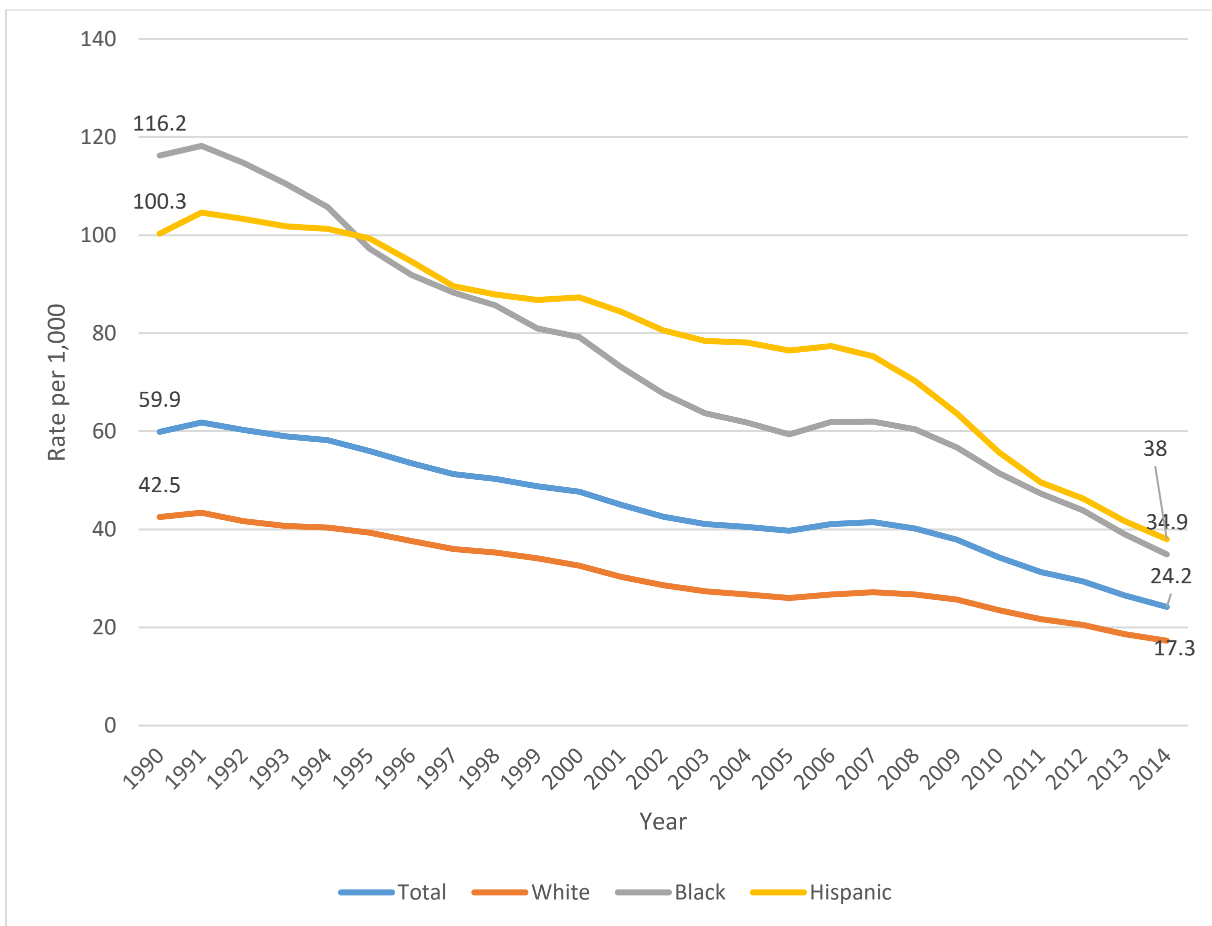
These data sources use a variety of data collection techniques. For example, the U.S. Census Bureau and the CDC use sample data, which means they use information about a group of community members to estimate the prevalence of disease or unplanned pregnancy for an entire population. In contrast, data from the Virginia Department of Health includes exact rates and percentages about disease prevalence and unplanned pregnancy for a particular area.

National Adolescent Sexual Health Overview

Teen Pregnancy

Teen pregnancy rates have been declining in the United States for the past 20 years. In 2014, there were 24.2 births for every 1,000 adolescents ages 15-19[13]. Though this decline has been observed across racial/ethnic groups, disparities persist. Hispanic teens have the highest teen birth rates followed by African American teens (Figure 1). Additionally, individuals without a high school diploma had the highest rates of unintended pregnancies among all education levels[1].

Figure 1. Birth Rates Ages 15-19, by Race/Ethnicity 1990-2014[14]



[13] Martin, J.A., Hamilton, B.E., & Ventura, S. J. (2015). Births: Final data for 2014. National Center for Health Statistics.
[14] Ibid.

Though teen pregnancy rates are declining overall, many of the pregnancies that do occur are unintended. An unintended pregnancy is defined as a pregnancy that is either mistimed or unwanted. In 2015, there were 3.9 million total pregnancies in the United States, and nearly half were unintended[15, 16]. Unintended pregnancies or closely spaced pregnancies can contribute to negative maternal and child health outcomes, including inadequate prenatal care, preterm birth, economic strain, and adverse physical and mental health outcomes for both mother and child[1]. Moreover, unintended pregnancy rates are highest among poor and low income individuals, and adolescents account for 75% of unintended pregnancies each year. Those in their late teens and twenties have higher rates of unintended pregnancy than any other age group[17].

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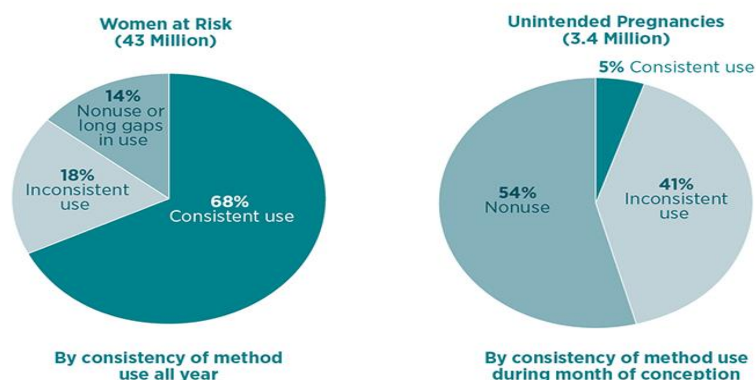
[15] Guttmacher Institute (2016). Unintended Pregnancy in the United States. Retrieved from https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
[16] CDC. (2017). Births and natality. Retrieved from http://www.cdc.gov/nchs/fastats/births.htm.
[17] The National Campaign to Prevent Teen and Unintended Pregnancy. (2017). Key Information about Virginia. Retrieved from https://powertodecide.org/what-we-do/information/resource-library/key-information-about-us-states.

Contraceptive Use

While disparities based on race, ethnicity, and income exist, the largest predictor of someone becoming pregnant is contraceptive use. Approximately 43 million individuals are at risk of unintended pregnancy if either they or their partner fail to use a contraceptive method correctly and consistently. Ten percent of people at risk of unintended pregnancy are not currently using any contraceptive methods[18]. In 2013, approximately 2.5 million teens reported being sexually active and of these youth, only 55% used condoms, 35% used oral contraceptives, 20% used withdrawal, 8% used non-pill hormonal methods (e.g. the ring, the shot, the patch, etc.), and 3% used an IUD[19].

When used correctly, modern contraceptives are very effective at preventing pregnancy. A study from 2008 showed that nearly 68% of U.S. individuals who are at risk of unintended pregnancy use contraceptives consistently and correctly. These individuals make up 5% of total unintended pregnancies in the United States. By contrast, inconsistent contraceptive users account for 41% of unintended pregnancies, and those who do not use any contraceptive method account for 54% of unintended pregnancies[20] (Figure 2).

Figure 2. Contraceptive Use and Unintended Pregnancy, 2008



[18] Lindberg L, Santelli J, and Desai S. (2016). Understanding the decline in adolescent fertility in the United States, 2007–2012, *Journal of Adolescent Health*.

[19] Ibid.

[20] Sonfield A, Hassetedt K, and Gold RB. (2014). Moving forward: Family planning in the era of health reform. Guttmacher Institute.

Sexually Transmitted Infections

In the US, there are 20 million new STIs each year. Most infections do not have long-lasting negative effects on an individual's health if the person receives adequate medical treatment. However, some STIs can lead to serious health consequences when left untreated[21]. Young people are disproportionately affected by sexually transmitted infections, accounting for half of all new STI cases[22]. With regard to HIV specifically, over 1.2 million people are living with HIV in the United States with approximately 50,000 people newly infected each year. According to 2015 data from the Centers for Disease Control and Prevention (CDC), approximately 15% of individuals with HIV do not know they are infected[23].

The three most effective ways to prevent STI transmission are:

1. To abstain from all sexual contact;

2. To maintain a mutually monogamous relationship with someone who does not have an STI; and

3. To use condoms or other barrier methods consistently and correctly (when used correctly and consistently condoms can be 98%[ii] effective at preventing pregnancy[24]).

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[21] CDC. (2013). Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States. Retrieved from http://www.cdc.gov/std/stats/STI-estimates-fact-sheet-feb-2013.pdf.

[22] CDC. (2015). HIV in the United States: At a glance. Retrieved from http://www.cdc.gov/hiv/statistics/basics/ataglance.html.

[23] Dailey A, Hoots B, Hall, H, et al. (2017). Vital signs: Human immunodeficiency virus testing and diagnosis delays – United States. MMWR, CDC. Retrieved from https://wwwhttps://www.cdc.gov/mmwr/volumes/66/wr/mm6647e1.htm

[24] Planned Parenthood Federation of America. (2017). How effective are condoms? Retrieved from https://www.plannedparenthood.org/learn/birth-control/condom/how-effective-are-condoms.

Relationship Violence

There is a pressing need to address harassment, bullying, and relationship violence. These issues have a significant impact on the emotional and physical well-being and academic success of youth and young adults. Teen relationship violence is an issue that is continuously underreported. It is estimated that ten percent of teens are physically harmed by their partners in a given year[25]. When a person experiences relationship violence, they are less likely to be able to follow through with behaviors that will prevent unintended pregnancy and sexually transmitted infections[26]. The Youth Risk Behavior Survey (YRBS) conducted by the CDC in 2013 found[27]:

- 10.4% of students had been kissed, touched, or physically forced to have sexual intercourse when they did not want to by someone they were dating
- Prevalence of sexual dating violence was higher among female (14.4%) than male (6.2%) students
- Prevalence of physical dating violence was higher among female (13.0%) than male (7.4%) students
- 1 in 3 teens has experienced abuse in a relationship (physical, sexual, emotional, and verbal)
- 40% of pregnant people that have experienced abuse state that their pregnancy was unintended, compared to 8% of pregnant persons who have not experienced abuse
- Girls experiencing violence are eight times more likely to be pressured to become pregnant
- Approximately 1 in 5 women have experienced pregnancy coercion, and 1 in 7 women have experienced active interference with contraception

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[25] Future of Sex Education Initiative. (2012). National sexuality education standards: Core content and skills, K-12. [A special publication of the *Journal of School Health*].
[26] Ibid.
[ii] With typical use, condoms are 85% effective. In other words, 15 out of 100 people who use condoms as their only birth control method will get pregnant each year.
[27] Kan L, Kinchen S, Shanklin SL, et.al. (2013). Youth risk behavior surveillance—United States. MMWR, CDC. Retrieved from https://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf.

Vulnerable Populations: Youth in Foster Care and LGBTQ Youth

Youth in foster care are particularly vulnerable and are more likely to experience teen pregnancy and STIs than general population youth[28]. While research of sexual behaviors among youth in foster care varies, there is some evidence that foster youth (on average) first engage in sex at a younger age than other adolescents. Furthermore, there is an issue with access to sexual health education, comprehensive or otherwise. Foster youth miss out on school-based sex education (even when offered), because of changes in foster placements, which can result in lapses in school attendance. Additionally, there is some indication that foster care adolescents may not always have permission to participate in these classes due to religious views of their caseworker or caregivers[29].

Like foster youth, adolescents that identify as lesbian, gay, bisexual, transgender, and queer (LGBTQ) are particularly vulnerable to higher risks of teen pregnancy and sexually transmitted infections. In 2010, adolescent males ages 12-19 accounted for approximately 91% of diagnosed HIV infections[30]. LGBTQ youth are more likely than their heterosexual peers to engage in risky sexual behaviors, including earlier age of initiating sex, drinking alcohol or using drugs prior to sexual activity, and are less likely to use a condom during sex[31]. Lastly, LGBTQ youth are more likely to be harassed, and experience a higher prevalence of dating violence and forced sexual intercourse[32]. Considering the increased risk for poor sexual health among LGBTQ youth, curricula that is inclusive to all genders and sexual orientations is essential. Not only will this approach help youth to connect to important messages related to pregnancy and STI prevention, but it will help to de-stigmatize sexual orientations and genders in an effort to curb bullying and harassment.

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[28] Love LT, McIntosh J, Rosst M, & Tertzakian K. (2005). Fostering hope: Preventing teen pregnancy among youth in foster care. The National Campaign to Prevent Teen Pregnancy.

[29] Boonstra, H. D. (2011). Teen pregnancy among young women in foster care: A primer. Guttmacher Institute. Retrieved from hhttp://www.guttmacher.org/gpr/20112011/06/teen-pregnancy-among-young-women-foster-care-primer.

[30] CDC. (2012). Diagnoses of HIV infection and AIDS among adolescents and young adults in the United States and 5 U.S. dependent areas, 2006–2009. HIV Surveillance Supplemental Report. Retrieved from http://www.cdc.gov/hiv/pdf/statistics_2009_HIV_Surveillance_Report_vol_17_no2.pdf

[15] Blake SM, Ledsky R, Lehman MA, Goodenow C, Sawyer R, Hack T. (2001). Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: the benefits of gay-sensitive HIV instruction in schools. *American Journal of Public Health*; 91(6):940–946.

[16] CDC. (2011). Sexual identify, sex of sexual contacts, and health-risk behaviors among students in grades 9-12 — youth risk behavior surveillance, selected sites, United States, 2001–2009. *MMWR Early Release*; 60[June 6]:1–133.

Youth Risk Behavior Surveillance

The Youth Risk Behavior Surveillance System (YRBSS) is a survey created by the CDC that is administered to students in 9th through 12th grade. The survey collects information about health risk behaviors such as alcohol and drug use, tobacco use, diet, physical activity, sexual activity, and behaviors that contribute to unintentional injuries and violence. While many school districts throughout the United States choose not to participate, the YRBSS is useful when considering what types of prevention programming might be necessary for high school students.

According to the 2015 YRBSS survey:

- 41.2% of all high school students have ever had sex
- 30.1% of all high school students are currently sexually active
- Among those sexually active, 56.9% use condoms
- Among those sexually active, 18.2% use birth control pills
- Less than 10% of all sexually active students used both condoms and hormonal methods of birth control
- Almost 14% of sexually active students did not use any method to prevent pregnancy
- Almost 4% have had sex before the age of 13
- Almost 12% of all students have had sex with four or more persons
- Nationwide 10.2% of all students had ever been tested for HIV

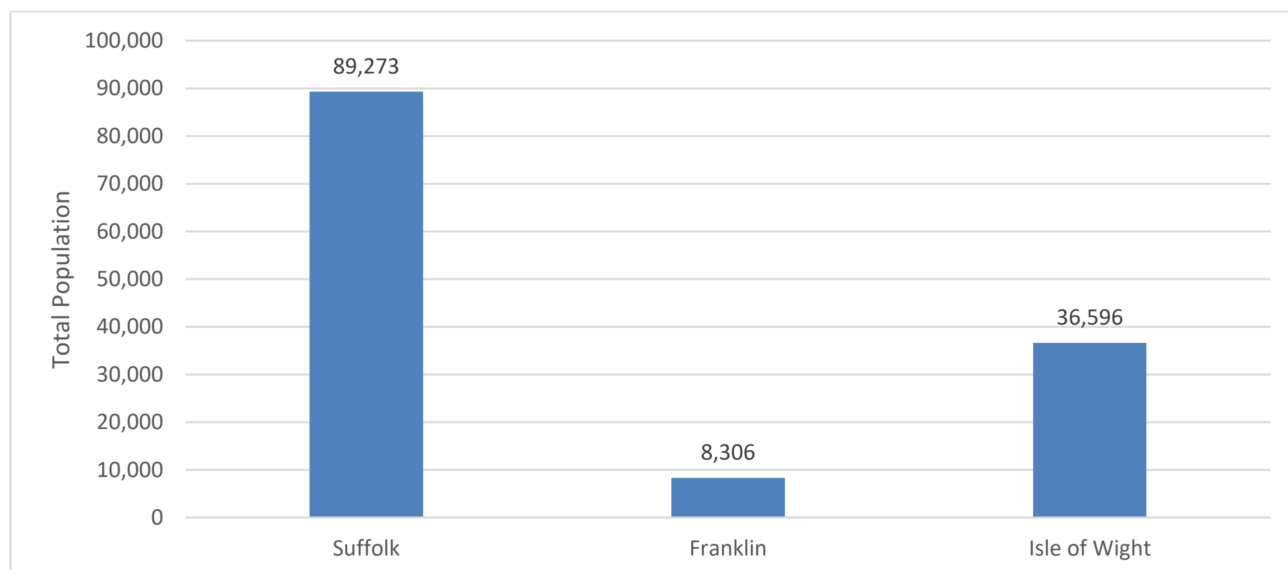
Community Health Indicators for Western Tidewater

The following section highlights demographic information, poverty, education, and health insurance status in Western Tidewater. These indicators (sometimes called the "Social Determinants of Health") are relevant because the physical and social environment in which an individual lives, works, or goes to school affects their health outcomes. Examining these indicators will shed light on existing health disparities among people of different socioeconomic backgrounds, genders, and races/ethnicities.

Demographics

In 2016, the City of Suffolk, City of Franklin, and Isle of Wight County make up just under 2% of the total population of Virginia (8,411,808 individuals). The most populated area in Western Tidewater is the City of Suffolk, while Isle of Wight County is the second most populated (Figure 3).

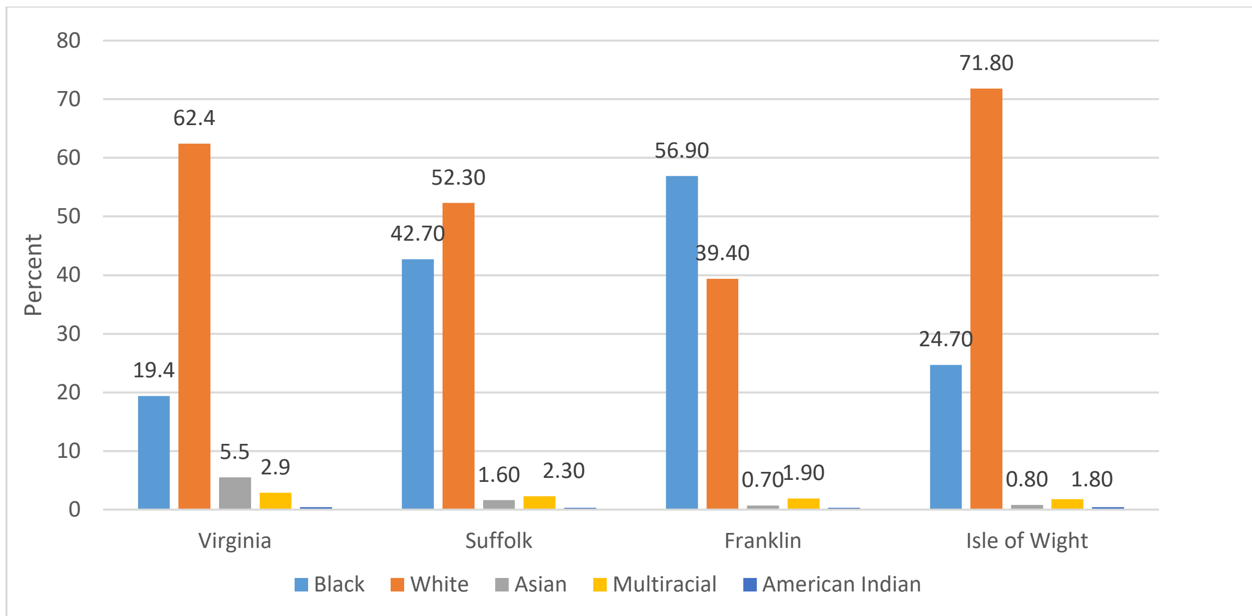
Figure 3. Total Population Western Tidewater, 2016[33]



The City of Franklin is unique as it has the smallest total population, but the majority of the population are people of color. In Franklin, the majority of residents are Black, Asian, or Multiracial. In Suffolk City and Isle of Wight, the majority of residents are White (Figure 4).

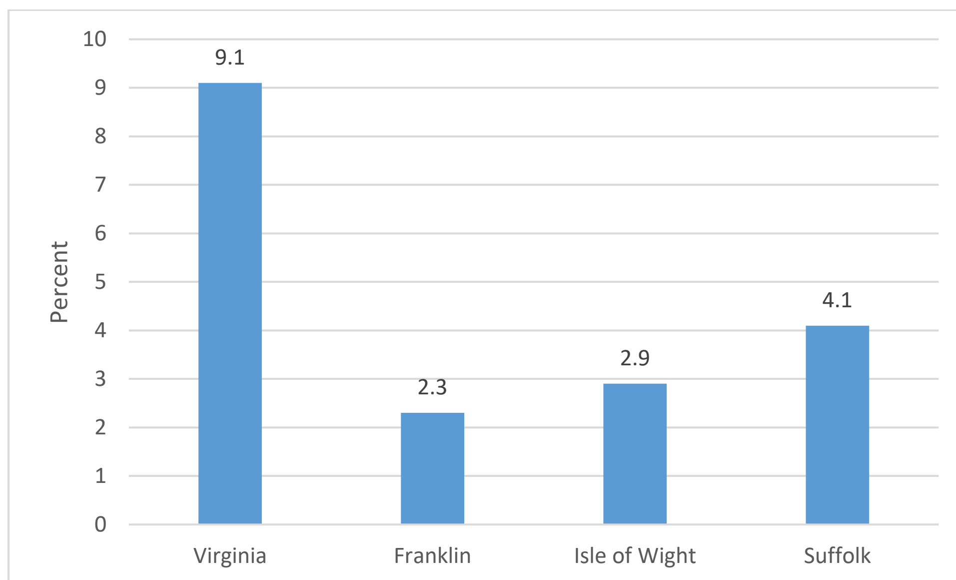
[33] Claritas. (2016).

Figure 4. Population of Western Tidewater by Race, 2016[34]



While Suffolk has a slightly higher percentage of individuals of Hispanic or Latino origin than Franklin and Isle of Wight, the percent of Hispanic or Latino residents in Suffolk is half the state average of 9.1% (Figure 5).

Figure 5. Population of Western Tidewater by Hispanic/Latino Origin, 2016[35]

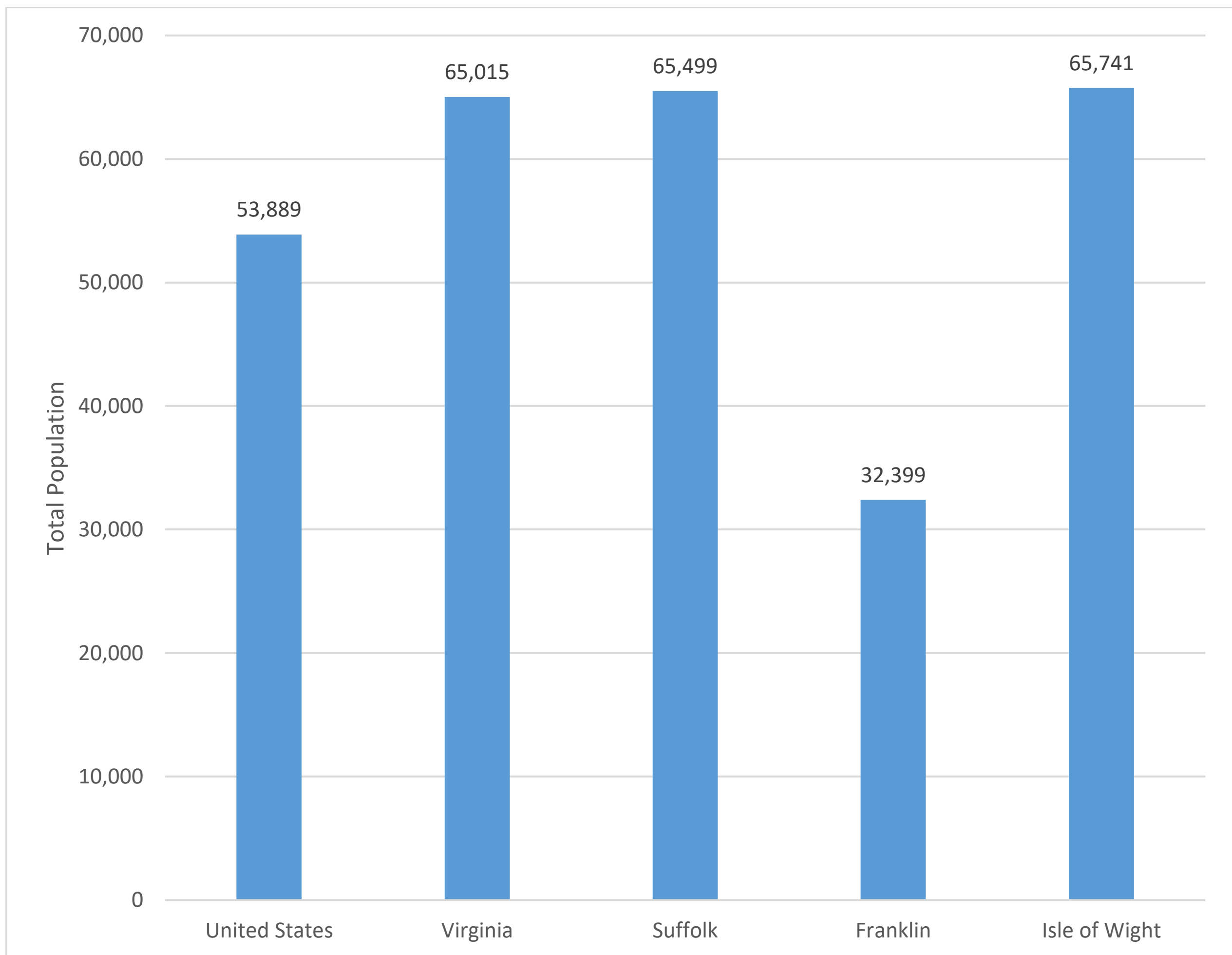


[34] Ibid.
[35] Ibid.

Poverty

The City of Suffolk and Isle of Wight County have median incomes consistent with the Virginia State average. However, Franklin has a considerably lower median income than the surrounding areas (Figure 6). Franklin also has the highest rate of unemployment in the region at 6.7% compared to Suffolk (5%) and Isle of Wight (4.6%)[36].

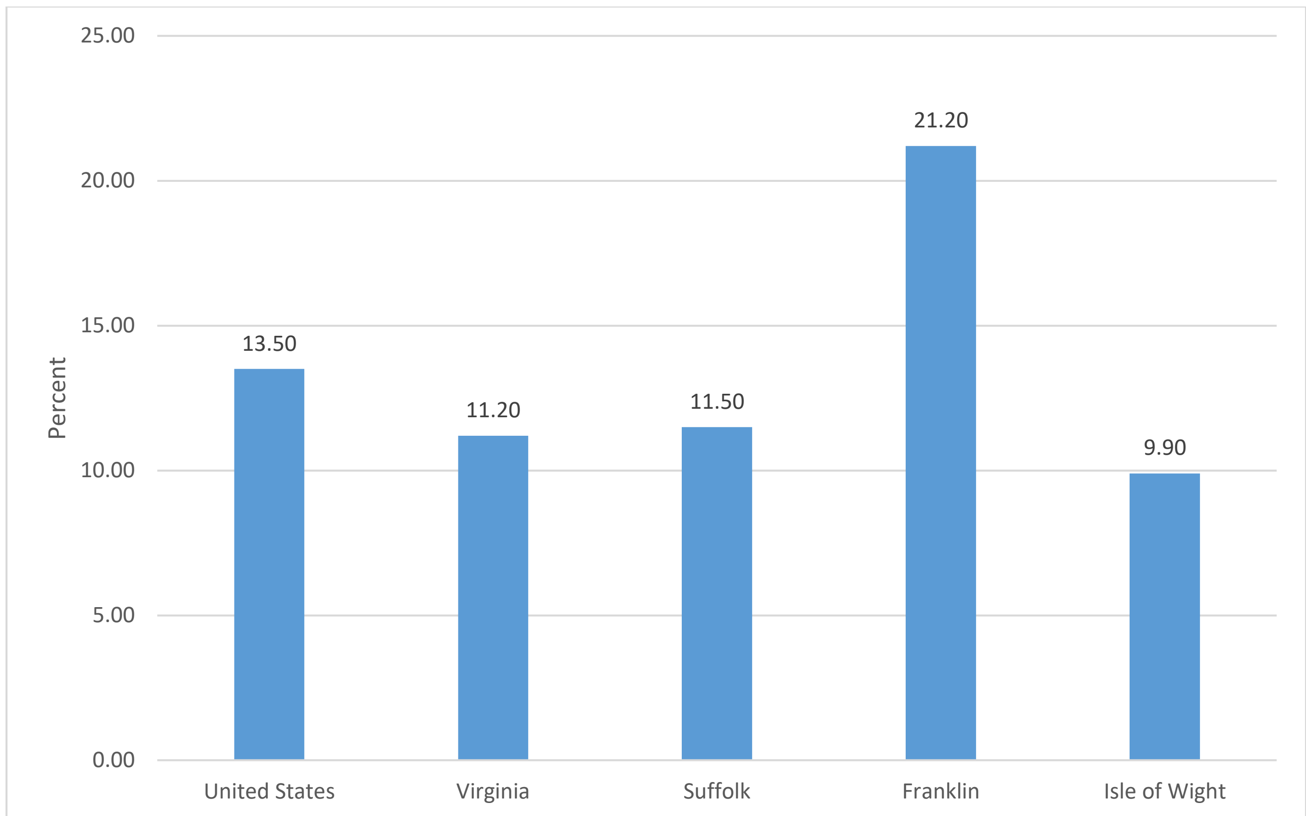
Figure 6. Median Household Income, 2015[37]



[36] U.S. Census. (2016).
[37] U.S. Census. (2015).

Due to high rates of unemployment and low median incomes, Franklin has the highest rates of people and children living in poverty. In 2016, the poverty rate in Franklin (over 20%) was nearly two times the poverty rate in Isle of Wight or Suffolk (Figure 7).

Figure 7. Individuals Living in Poverty, 2016[38]



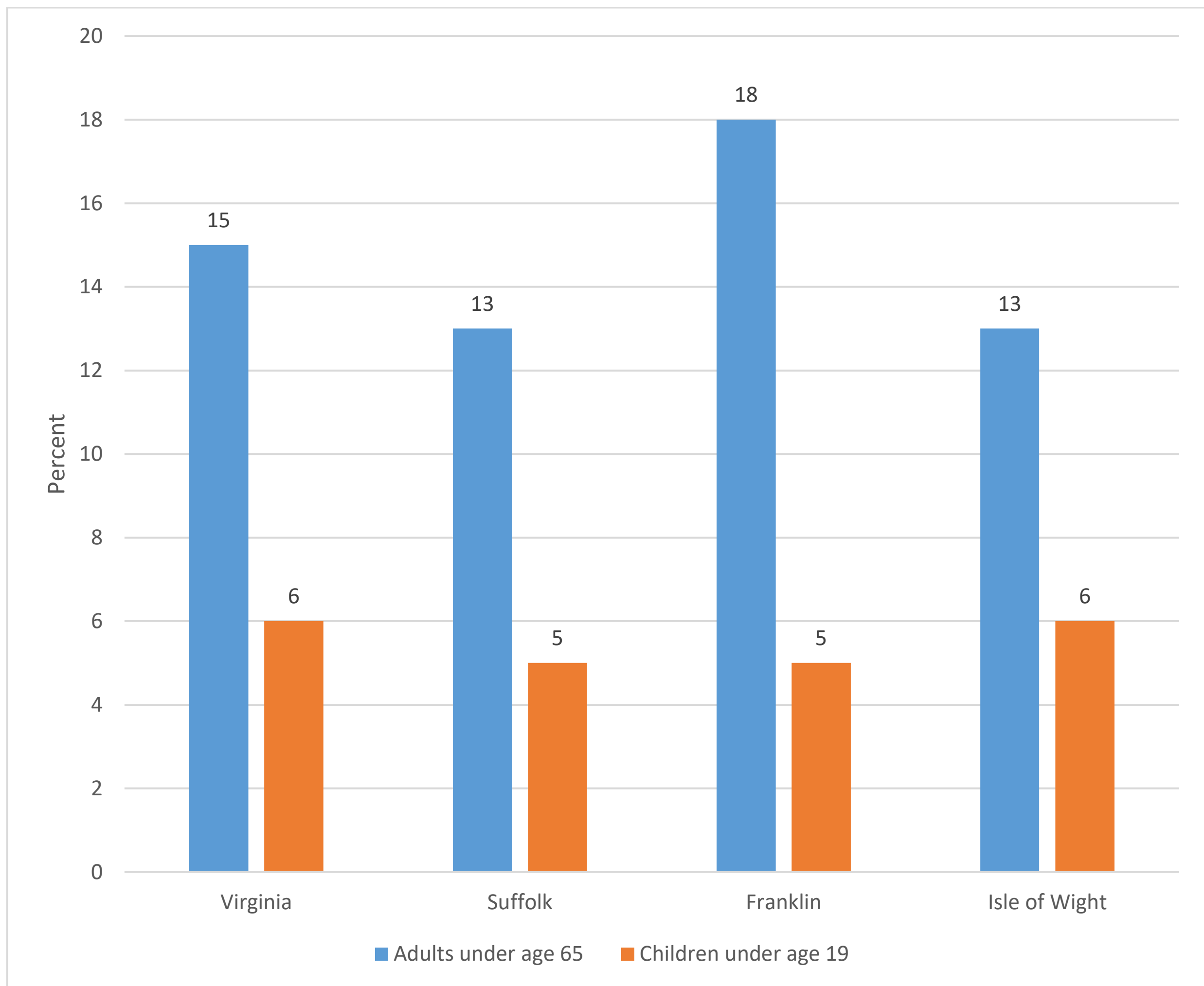
When poverty is analyzed by age, the impact of poverty on children is dramatic. According to 2015 data, 94% of children living in Franklin were at or below the federal poverty line. This is almost twice the rate of poverty as children in Suffolk (47%) and Isle of Wight (37%)[39].

[38] U.S. Census. (2016).
[39] Kids Count. (2015).

Health Insurance Status

In Virginia, 15% of adults are living without any form of health insurance. Rates of uninsured adults in Suffolk and Isle of Wight are slightly lower at 13%. However, due to some of the aforementioned indicators, the uninsured rate among adults in Franklin is higher at 18%. Despite high rates of poverty, children in Western Tidewater are at rates in line with the Virginia state average (Figure 8).

Figure 8. Uninsured Adults and Children, 2014[40]



[40] County Health Rankings. (2017).

Education

In Western Tidewater, high school graduation rates for all students are either at or slightly below the Virginia state average (92.2%). While regional graduation rates are mostly consistent with state rates, disparities based on race, gender, income status, and intellectual disabilities persist. In both Virginia and Western Tidewater, female students are more likely to graduate on time than male students. However, if a teenager becomes pregnant or gets someone else pregnant during high school, the likelihood they will graduate significantly declines. Approximately half of teen parents (male and female) get a high school diploma or GED by age 22[41]. Statewide, Asian students have a higher on-time graduation percentage than other students. The graduation rate in Isle of Wight is consistent with the Virginia state average, while the overall rates of on-time graduation in Suffolk (-5%) and Franklin (-3%) are below the state average. White students show a slightly higher graduation percentage than Black and multiracial students at the state and local level (Figure 9).

Figure 9. On Time High School Graduation (Percent), 2016[42]

	All Students	Female	Male	Black	Hispanic	White	Asian	Two or More Races	Economic Disadvantage Anytime	Disability, Anytime
Virginia	92.2	94.16	90.43	89.83	83.82	94.54	96.98	93.57	89.67	87.47
Suffolk	87	91.1	83.2	86	91.3	88.7	75	87	85.1	75.4
Franklin	88.9	91.7	86.1	87.7	N/A	91.7	N/A	N/A	90	91.7
Isle of Wight	92.7	95.8	89.8	89.9	100	93.3	N/A	93.3	88.4	69.6

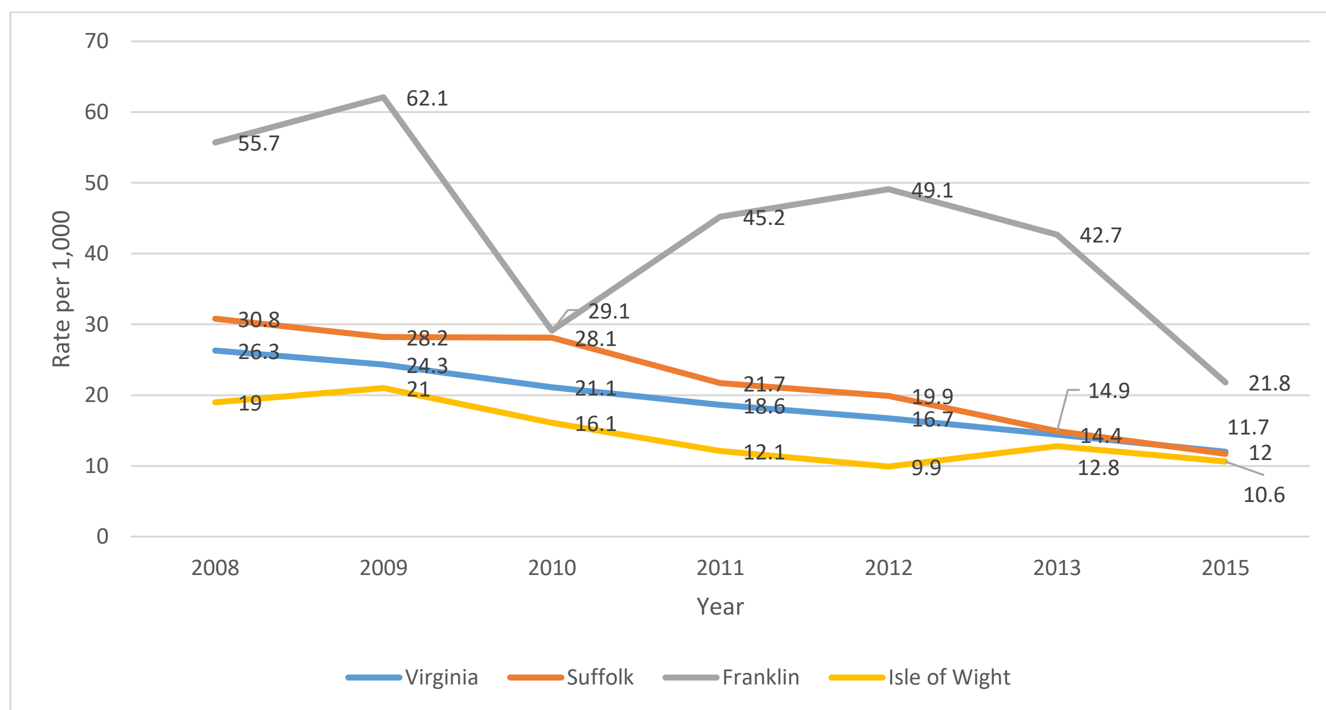
41 Bureau of Labor Statistics, U.S. Department of Labor. (1997). National longitudinal survey of youth. Retrieved from http://www.bls.gov/nls/nlsy97.htm.
42 Virginia Department of Education. (2016).

Sexual Health in Western Tidewater

Teen Pregnancy

In Virginia, more than half (54%) of all pregnancies are described as unplanned. In past years, public spending in Virginia for unplanned pregnancies reached an estimated $507 million[43]. Over the past decade, total rates of teen pregnancy have continued to decline in Virginia and in Western Tidewater. As indicated earlier, this decline is consistent with national trends (Figure 10).

Figure 10. Teen Pregnancy Rate Trend, Ages 10-19, 2008-2015[44]

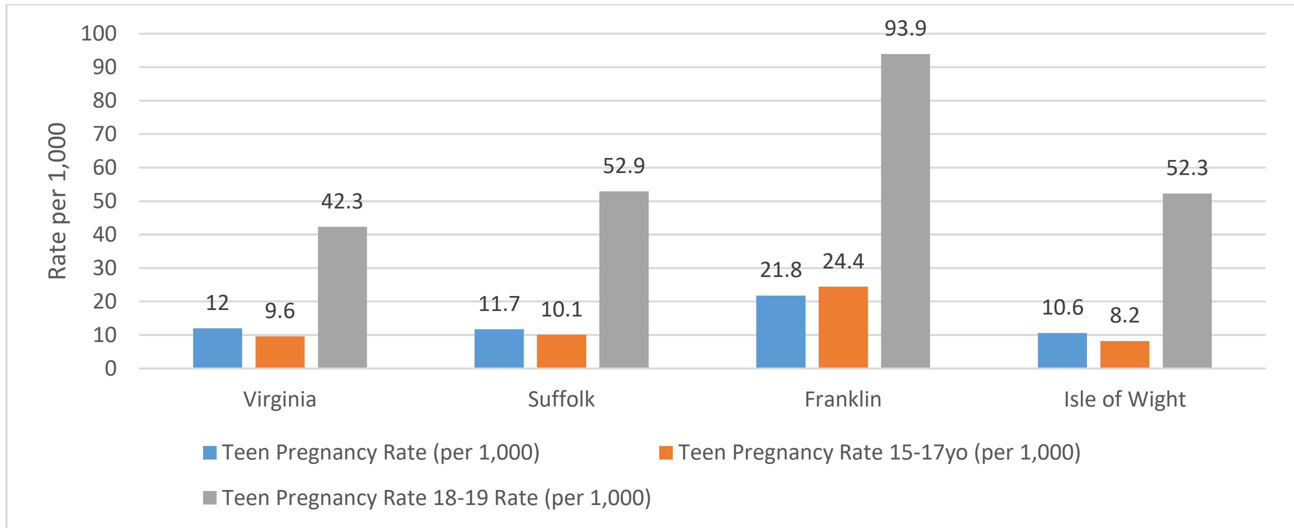


Suffolk and Isle of Wight have teen pregnancy rates somewhat consistent with the Virginia state average. However, teens in Franklin have a rate of pregnancy almost twice the state average (21.8 per 1,000 teens). Teens ages 18-19 become pregnant at significantly higher rates in Virginia and in each region of Western Tidewater than other teen age groups. In Suffolk and Isle of Wight, the rate of pregnancy among teens ages 18-19 is slightly higher than the state

[43]Guttmacher Institute (2016). Unintended Pregnancy in the United States. Retrieved from https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
[44] Virginia Department of Health. (2016).

average of 42.3 per 1,000. Again, Franklin shows a disproportionately high rate of pregnancy among older teens, with a rate more than twice the state average (Figure 11).

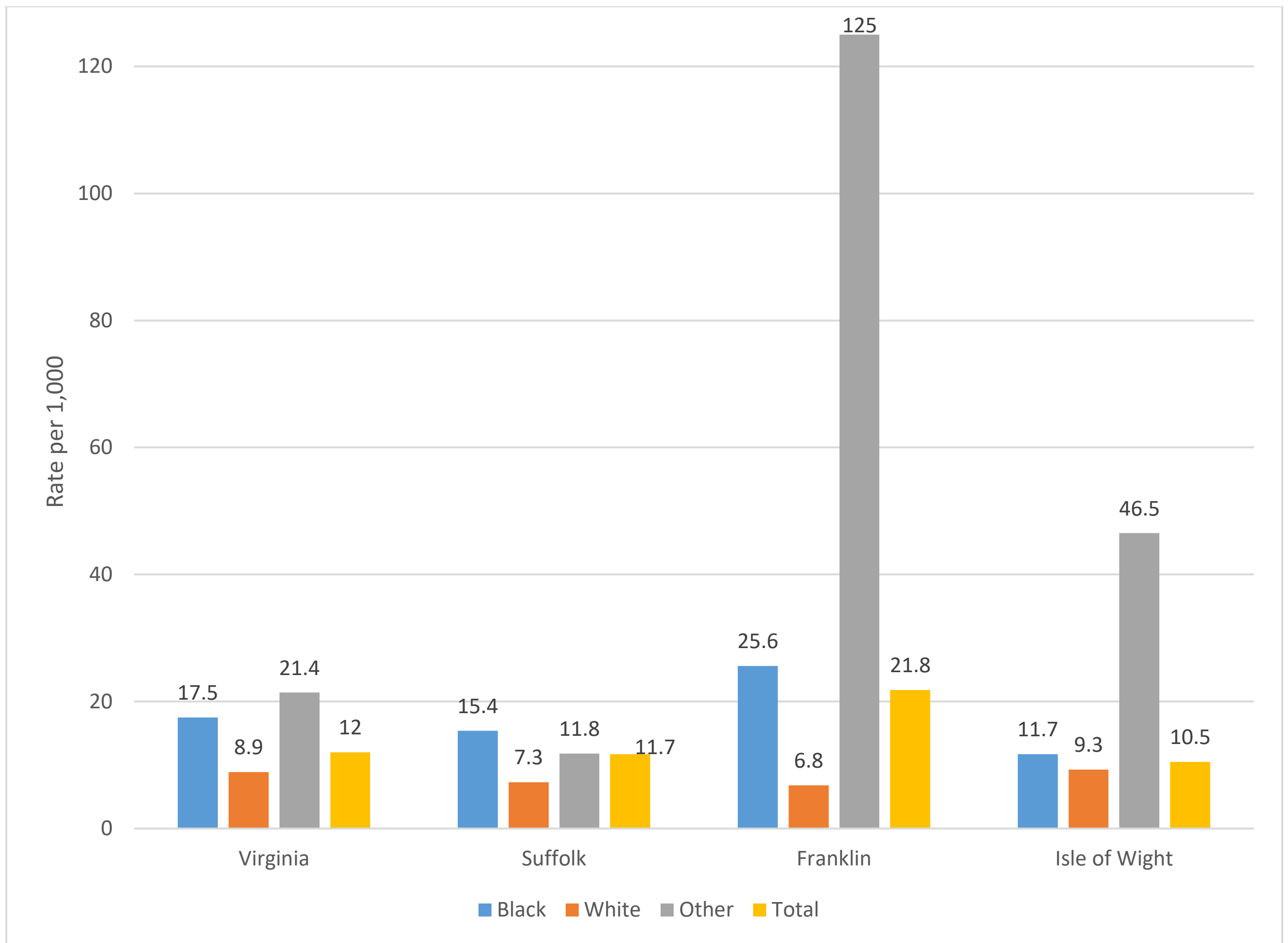
Figure 11. Teen Pregnancy Rate, 2015[45]



Consistent with national teen pregnancy trends, disparities based on race and ethnicity exist in Western Tidewater. In Virginia, youth who did not indicate their race or who checked “Other” represented the highest rates of pregnancy, at 21.4 per 1,000. Statewide, Black teens become pregnant at almost twice the rate of White teens (17.5 and 8.9 per 1,000, respectively). In Western Tidewater, Black teens are also disproportionately affected by teen pregnancy in every location (Figure 12).

[45] Virginia Department of Health. (2015).

Figure 12. Teen Pregnancy by Race, Ages 10-19, 2015[46]

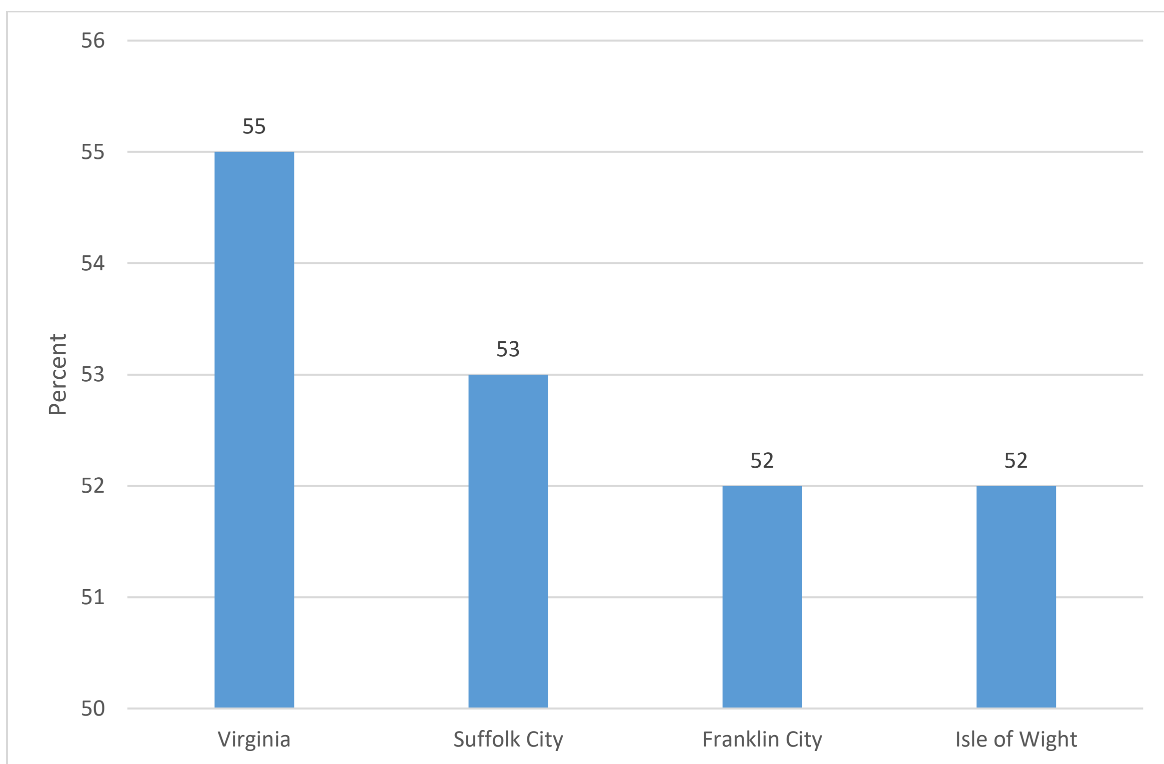


46 Ibid.

Contraceptive Use

There are few publicly funded clinics in the Western Tidewater area that provide affordable reproductive health services (see Appendix A). Suffolk, which has the largest total population, has four publicly funded clinics, Franklin has two publicly funded clinics, and Isle of Wight has one publicly funded clinic[47]. However, all three geographic areas have one clinic that receives Title X funding. Title X is a national funding source which provides individuals with affordable comprehensive family planning and preventative reproductive health services. While there is one publically funded clinic in each location, there is still an overall need for publically funded contraceptive services and supplies in Western Tidewater. According to data collected by the Guttmacher Institute in 2010, over half of women ages 13-44 in each location are in need. This is relatively the same as the Virginia state average (Figure 13).

Figure 13. Women Ages 13-44 in Need of Publicly Funded Contraceptive Services and Supplies, 2010[48]



[47] Frost J, Frohwirth L, Blades N, et.al. (2015). Publicly funded contraceptive services at U.S. clinics. Guttmacher Institute. Retrieved from https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.
[48] Guttmacher Data Center. (2014). Retrieved from https://data.guttmacher.org/counties.

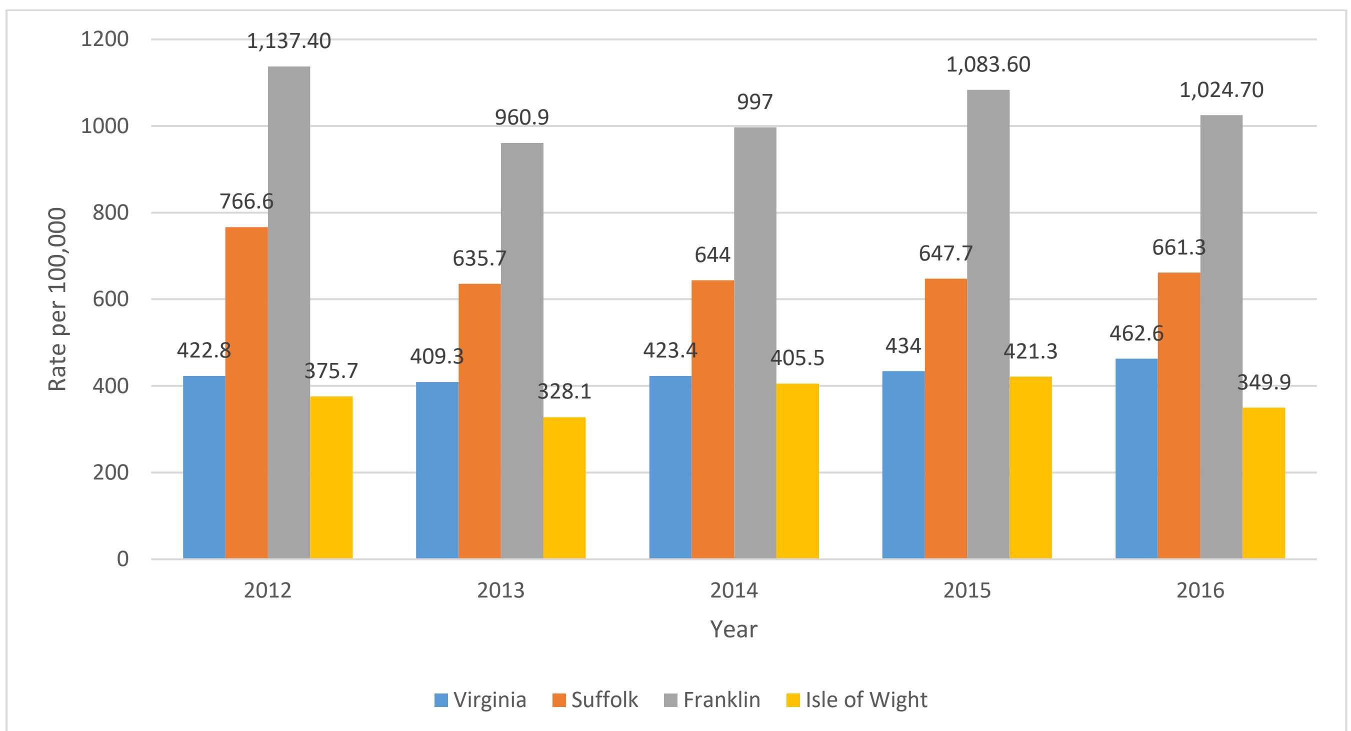
Sexually Transmitted Infections

In both Virginia and Western Tidewater, chlamydia is the most commonly diagnosed STI. During the past five years, both Suffolk and Franklin have consistently had STI incidence rates above the state average for chlamydia, gonorrhea, and HIV. Conversely, Isle of Wight has consistently reported rates for chlamydia, gonorrhea, and HIV below the state average.

Chlamydia

While the rates of chlamydia in Virginia have increased during the past five years, rates in Western Tidewater are decreasing slightly in all locations. This positive trend in reduced rates of chlamydia may be due to actual decrease in incidence or due to lack of testing (Figure 14).

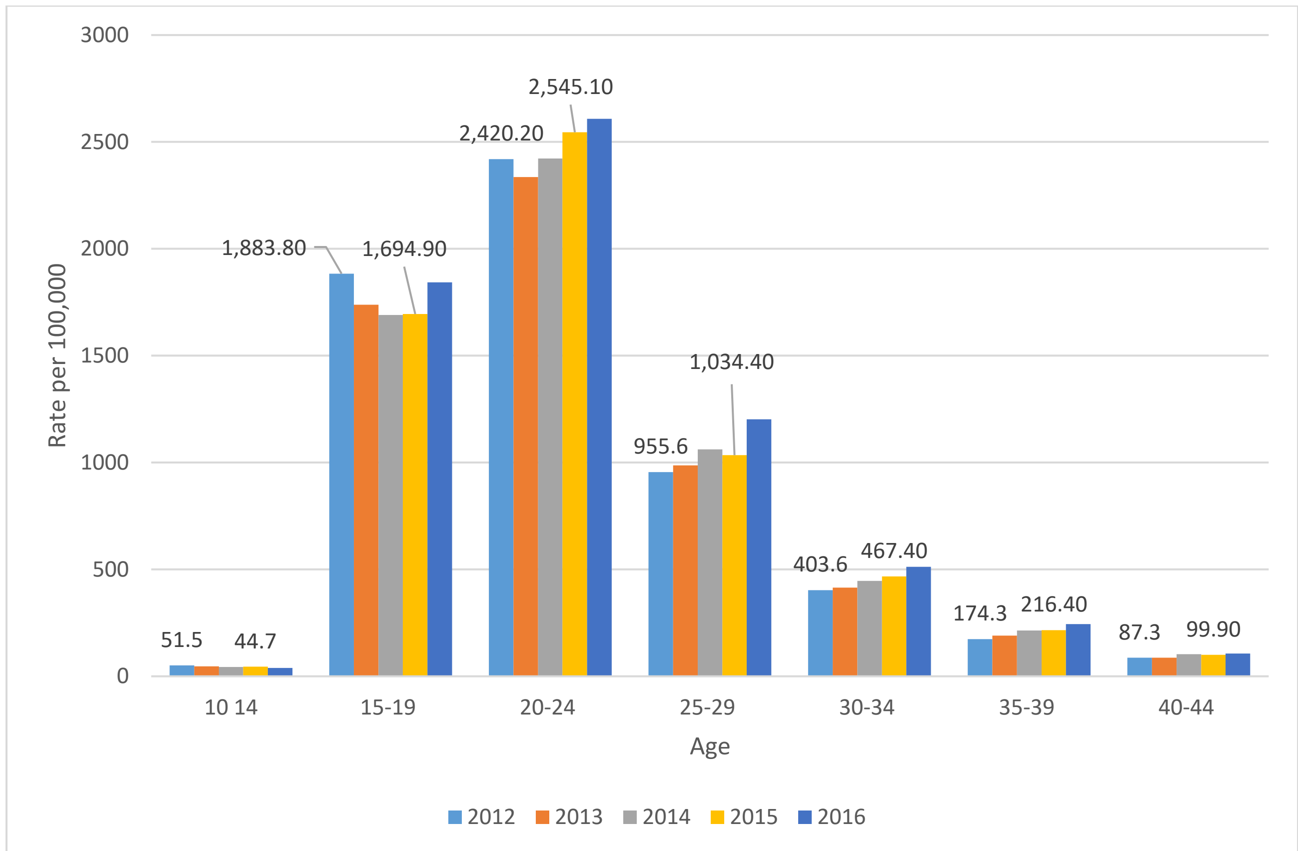
Figure 14. Chlamydia Incidence Rate, 2012-2016[49]



[49] Virginia Department of Health. (2016).

While there has been a slight decrease overall in diagnosis of chlamydia in Western Tidewater, young people are diagnosed at higher rates than other age groups. Consistent with national trends, youth ages 15-24 in Virginia are diagnosed with chlamydia at a disproportionately high rate (Figure 15).

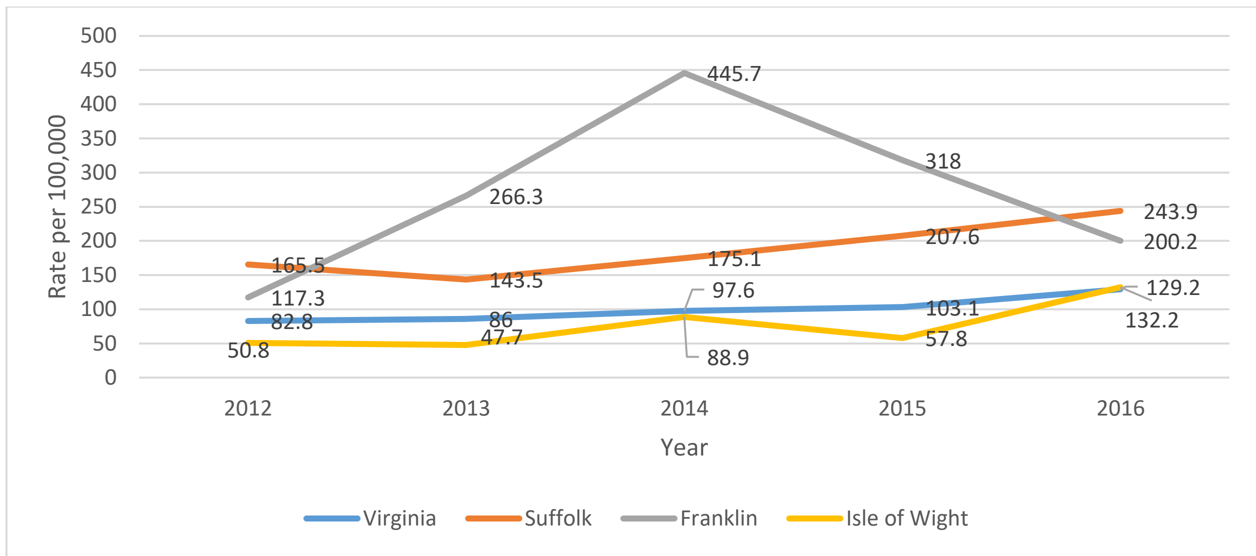
Figure 15. Virginia Chlamydia Incidence Rate: Ages 10-44, 2012-2016



Gonorrhea

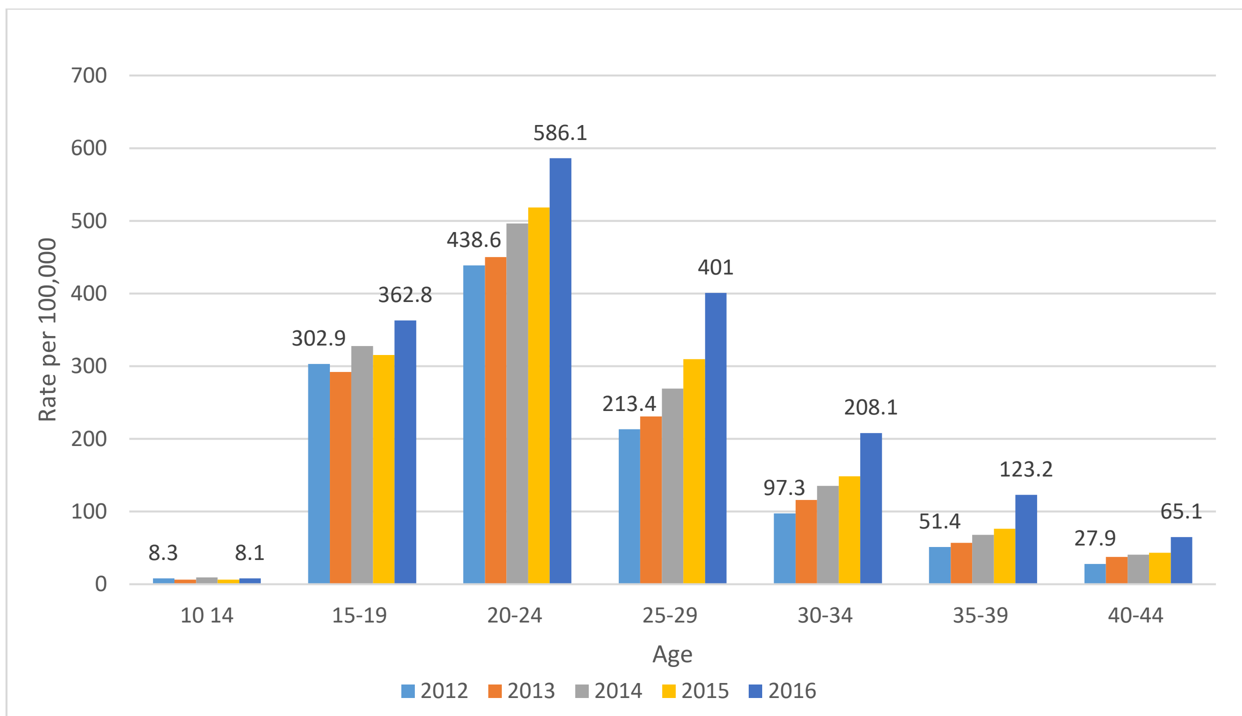
While rates of chlamydia diagnosis are decreasing, gonorrhea rates are increasing in Virginia and in all locations within Western Tidewater. From 2012-2016, gonorrhea diagnoses increased 56%. Diagnosis rates in Suffolk increased at a slightly lower rate than the state average; however, rates increased in Franklin 70%. While rates of gonorrhea in Isle of Wight remain close to the state average, there has been a 160% increase in diagnoses during the past five years (Figure 16).

Figure 16. Gonorrhea Incidence Rate, 2012-2016[50]



Similarly to chlamydia, rates of gonorrhea disproportionately affect youth ages 15-24 in Virginia (Figure 17).

Figure 17. Virginia Gonorrhea Incidence Rate: Ages 10-44, 2012-2016[51]



[50] Ibid.

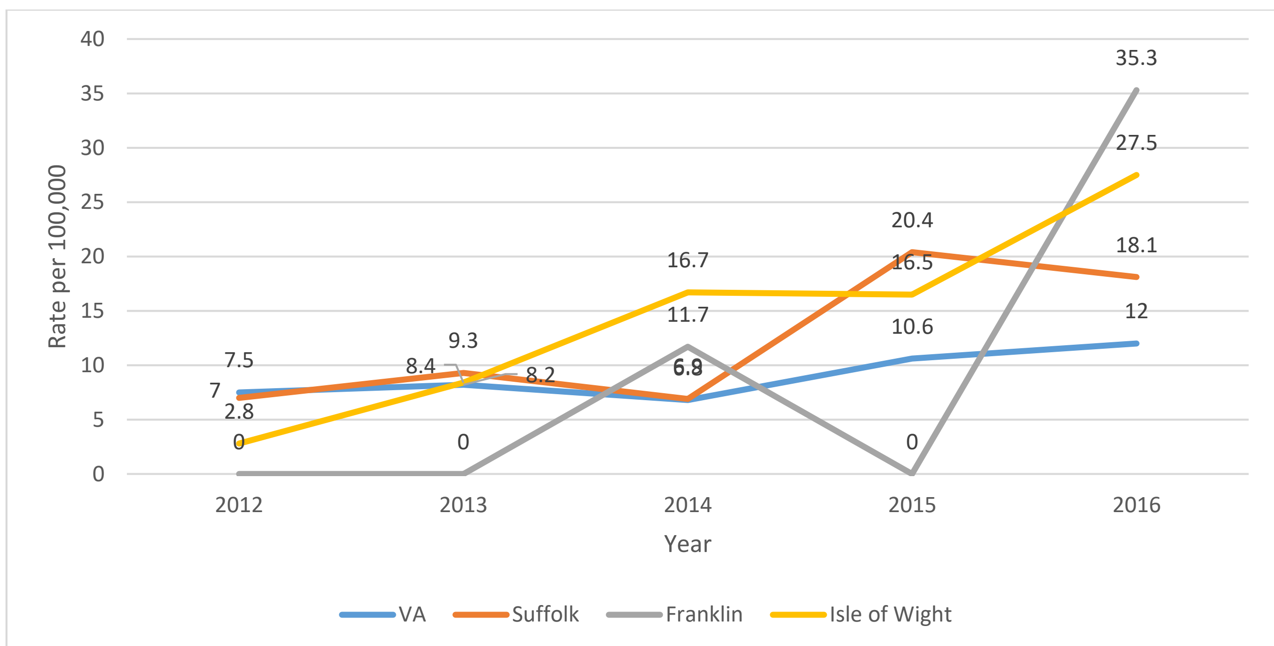
[51] Ibid.

Syphilis

Syphilis is a STI caused by a bacterium that can cause serious health consequences if not treated[52]. Early syphilis can appear as a painless chancre, and usually lasts 3-6 weeks regardless of whether a person is treated or not. However, if the infected person does not receive treatment, the infection will progress to the secondary stage.

Rates of early syphilis have increased at an alarming rate across Virginia and in Western Tidewater. In Virginia, there has been a 60% increase in diagnosis. While Suffolk, Franklin, and Isle of Wight have all shown a dramatic increase in rates of diagnosis, it is essential to keep the total population of each city/county in perspective. For instance, while in Franklin the diagnosis rate was 35.3 in 2016, only three patients were diagnosed that year. In 2016, ten patients were diagnosed with syphilis in Isle of Wight, and sixteen were diagnosed in Suffolk (Figure 18).

Figure 18. Early Syphilis Incidence Rate, 2012-2016[53]

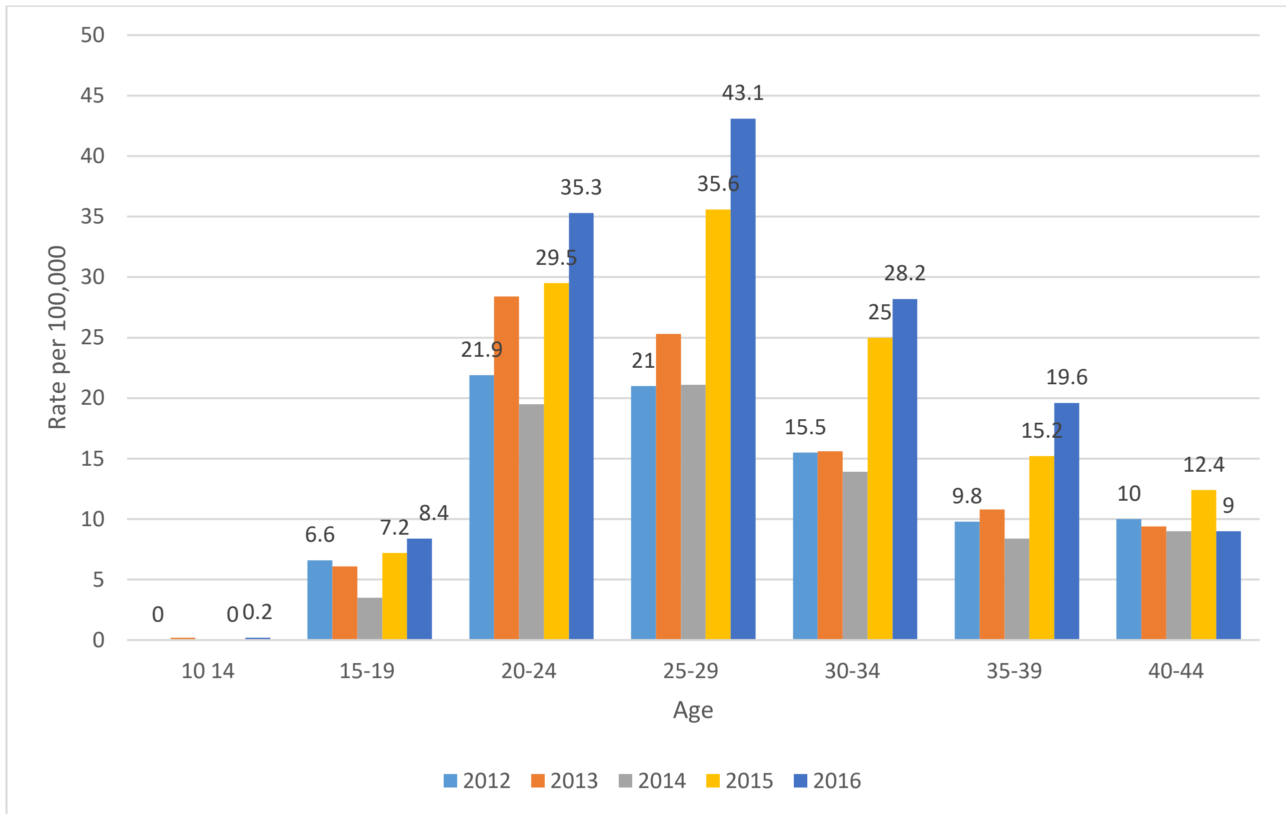


While diagnosis rates of early syphilis impact many age groups across Virginia, the sharpest increases in incidence during the past five years have been among slightly older individuals in their twenties (Figure 19). This is noteworthy considering that this is also the age range in which most females who decide to give birth do so. Research from the CDC indicates up to 40% of

[52] CDC. (2017). Syphilis fact sheet (detailed). Retrieved from https://www.cdc.gov/std/syphilis/stdfact-syphilis.htm.
[53] Ibid.

babies born to females with untreated syphilis may be stillborn, or die from the infection as a newborn[54].

Figure 19. Virginia Early Syphilis Diagnosis Rate: Ages 10-44, 2012-2016[55]



HIV/AIDS

In Virginia, the rate of newly diagnosed HIV cases has declined slightly from 11.4 per 1,000 in 2012 to 10.0 per 1,000 in 2016. While there have been sharp increases and decrease in newly diagnosed HIV cases in Suffolk and Isle of Wight, both locations also indicate a slight downward trend. Franklin, on the other hand, is showing an increasing trend in HIV diagnoses overall. This is largely due to a spike in diagnoses in 2013 and 2015 (Figure 20).

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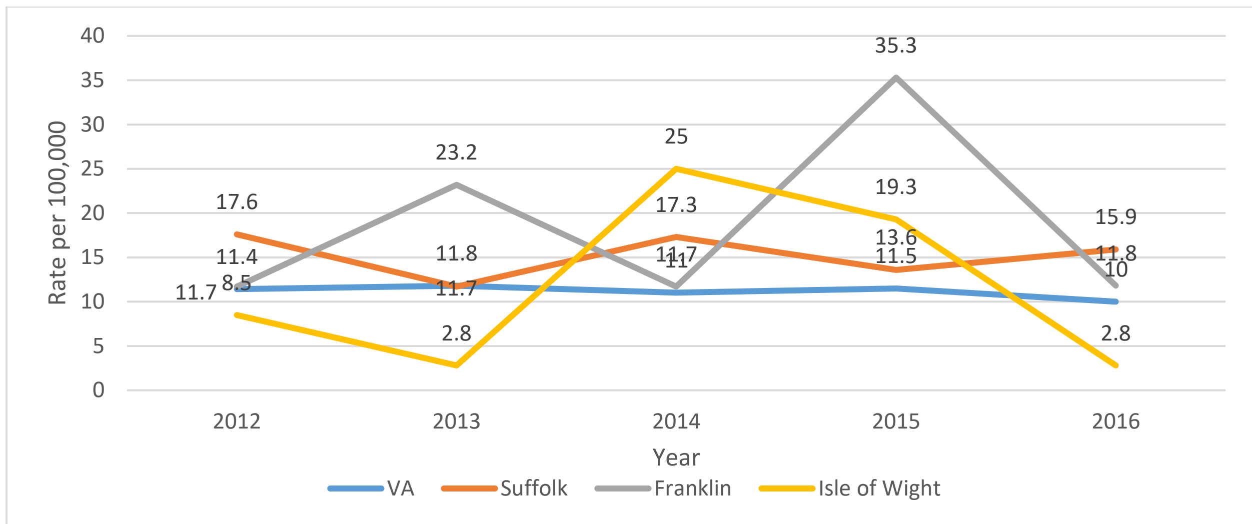
[54] Ibid.

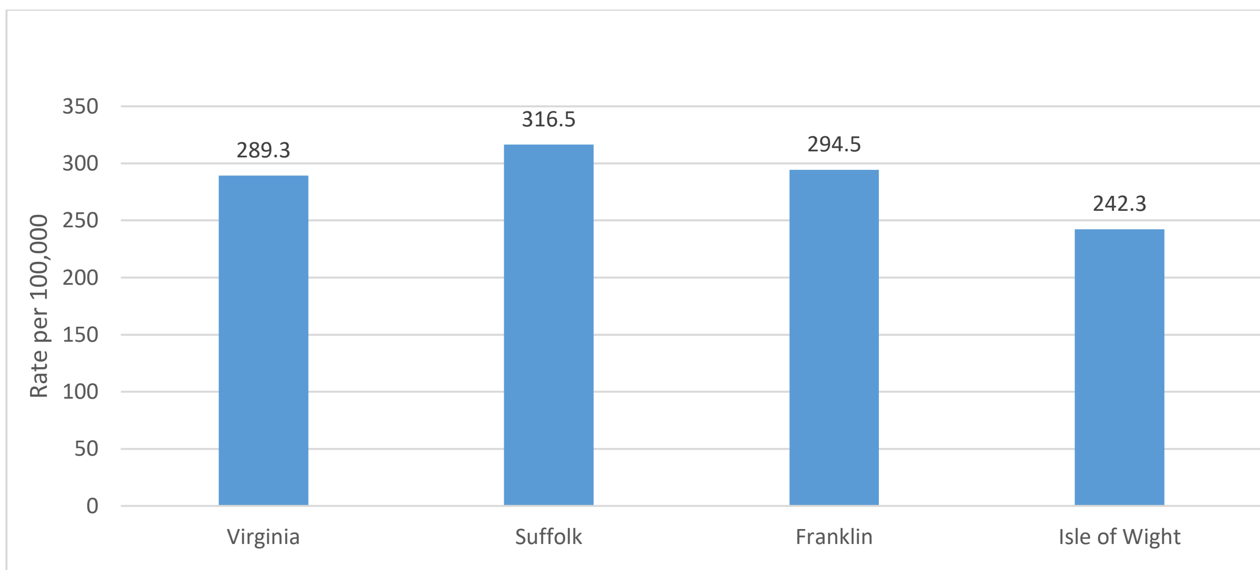
[55] Virginia Department of Health. (2016).

Figure 20. Newly Diagnosed cases of HIV, 2012-2016[56]



In addition to rates of diagnosis, prevalence rates are also relevant. When discussing prevalence, the rate describes the proportion of a population who have the specific disease (i.e. HIV) in a given period of time. Isle of Wight experiences lower prevalence rates of HIV/AIDS compared to Virginia, Suffolk and Franklin. Suffolk has the highest rate of people living with HIV/AIDS (Figure 21).

Figure 21. Individuals living with HIV/AIDS, 2016[57]



[56] Ibid.
[57] Ibid.

Local Opinions about Sexual Health

Sentara Obici Hospital prepared a community health needs assessment in which they provided community insight on specific health targets affecting the Western Tidewater service area. The community insight component of the assessment consisted of two methodologies: an online community stakeholder survey conducted by the Strategy Department, and a series of more in-depth community focus groups carried out by the hospital. The community stakeholder survey was conducted jointly with all Sentara hospitals in South Hampton Roads.

In June of 2016, 121 individual stakeholders completed the survey. Participants were asked, "What are the most serious health problems in our community?" These health problems were then ranked on a scale of 1 to 35, with 1 being the most serious health problem. The survey results revealed the following:

- 33% of participants ranked teen pregnancy at 19;
- 31% of participants ranked sexually transmitted infections at 21; and
- 18% of participants ranked HIV/AIDS at 31.

Participants were then asked, "Which community health services need strengthening?" Thirty-five choices were included in the survey. In this response, family planning services were ranked number 26, with 16% of respondents selecting this item[58].

[58] Sentara Obici Hospital. (2016). Community health needs assessment. Retrieved from http://www.sentara.com/assets/pdf/about-us/community-health-needs-assessments/soh-2016-community-health-needs-assessment-report.pdf.

Next Steps in Western Tidewater

Comprehensive, medically-accurate sexual health curricula are not prevalent in Western Tidewater. Incorporating contraceptive education could further empower communities to protect themselves from unintended pregnancies and sexually transmitted infections. By expanding comprehensive sexuality education programs into areas of high need, especially in areas where few, if any, services exist, the Western Tidewater Healthy Youth Initiative could make a positive impact on community health. Also, individuals in their older teens and early twenties, who experience higher rates of unintended pregnancy than any other group, do not appear to have as many opportunities for sexuality education as younger youth. Expanding educational programming in the Western Tidewater area to those most at risk is necessary in order to improve population health outcomes.

Targeted programming of comprehensive sexual health education in areas where abstinence-only programming is currently offered may be advantageous to youth and young adults. There are claims that suggest abstinence-only/abstinence-until-marriage programs delay sexual activity and reduces teen pregnancy. However, federally-funded evaluations of these programs show that youth enrolled in the programs are no more likely than those not enrolled in the programs to delay sexual initiation, to have fewer sex partners, or to abstain entirely from sex. These programs have shown some negative impact on adolescents' willingness to use contraceptives, including condoms, to prevent negative sexual health outcomes[59].

Strategy

Given the large number of older teens and young adults who experience unintended pregnancy and STIs, both nationally and in this region, education programs that target both youth and adults would be necessary in order to address poor sexual health outcomes. Because this region is rural, with small populations in each locality, convening large groups of youth may be difficult, if not impossible. There is a remarkable absence of youth-serving organizations in this region, with the YMCAs in Suffolk and Franklin appearing to be some of the few organizations offering youth programs in this area.

For this reason, education programs should aim to make a strong impact by reaching small numbers of youth and adults who are at high risk for unintended pregnancy and STIs. Risk factors include but are not limited to living in areas with high poverty, unintended pregnancy,

[59] Trenholm C, et al. (2007). Impacts of four Title V, Section 510 abstinence education programs final report. Mathematic Policy Research. Submitted to U.S. Dept. Health & Human Services, Assistant Secretary for Planning and Evaluation.

or STI rates; having experienced family violence; and living in out-of-home care. Ensuring that programs offered in this region are accessible to all people, regardless of ability to pay or access to transportation, will be crucial in ensuring program success.

While there appear to be a variety of services available in Suffolk, services are limited in the surrounding localities. The Western Tidewater Healthy Youth Initiative plans to build relationships with service providers in Suffolk, Franklin, and Isle of Wight to provide comprehensive sexual health programming to youth-serving organizations.

Potential Partners: Western Tidewater Healthy Youth Initiative

Partnerships Underway

- Suffolk Department of Parks and Recreation
- Boys and Girls Clubs of Southeastern Virginia—Suffolk Unit

Short-Term Partnership Opportunities

- Local redevelopment and housing offices
- Local departments of social services
- Genieve Women's Shelter
- Family Violence and Sexual Assault Unit
- Up Center (Suffolk)
- James L. Camp Jr. Family YMCA
- Suffolk Family YMCA

Long-Term Partnership Opportunities

- Franklin City Public Schools
- Suffolk Public Schools

Not Potential Partners

- Isle of Wight Public Schools: Have stated that they are satisfied with current family life education program
- Healthy People, Healthy Suffolk: Focus on obesity and obesity prevention, rather than sexual health

Appendices

Appendix A: Reproductive Health Services Available in Western Tidewater

Organization	Type of Organization	Location(s)	Service Area (if defined)	Services	Hours of Operation
Western Tidewater Health District	Health Department	Suffolk Isle of Wight Franklin Southampton	Suffolk Isle of Wight Franklin Southampton	Family planning, immunizations, STI treatment, home health and personal care services	Monday-Friday 8:00am-4:30pm
Main Street Physicians	FQHC	Suffolk		Primary care, dental services, referral services	Weekdays (except Tuesday) 8:00am-5:00pm Tuesday 8:00am-7:00pm
Western Tidewater Free Clinic*	Free Clinic	Suffolk	Suffolk, Franklin, Isle of Wight, Southampton	Dental care, medical services, mental health counseling, mammograms, pap smears, referrals	Monday 9:00am-4:00pm Tuesday 12:00pm-8:00pm Wednesday 8:00am-4:00pm Thursday 9:00am-4:00pm Friday 9:00am-1:00pm

Organization	Type of Organization	Location(s)	Service Area (if defined)	Services	Hours of Operation
Sentara Obici Hospital	Hospital	Suffolk		Behavioral health, occupational medicine, emergency department, women's health services, neurosciences, outpatient surgery, laboratory services	24 hours
Southampton Memorial Hospital	Hospital	Franklin		Emergency department, cardiac care, diagnostic imaging, rehabilitation services, laboratory services, nursing home, skilled nursing care facility, women's health services (obstetrics, gynecology)	24 hours
Western Tidewater Community Services Board	Community Services Board	Suffolk	Franklin Suffolk Isle of Wight Southampton	Case management, crisis intervention, child and adolescent prevention services	Monday-Friday 8:30am-5:00pm
Whaleyville Community Center	Community Center	Suffolk		Fitness center	Monday-Friday 6:00am-8:00pm Saturday 8:00am-12:00pm
James L. Camp Jr Family YMCA	Community Center	Franklin		Fitness center, childcare, day camps	Monday-Thursday 5:00am-9:00pm Friday 5:00am-8:00pm

Organization	Type of Organization	Location(s)	Service Area (if defined)	Services	Hours of Operation
					Saturday 8:00am-5:00pm Sunday 1:00pm-6:00pm
Suffolk Family YMCA	Community Center	Suffolk		Fitness center, childcare, day camps	Monday-Friday 5:00am-10:00pm Saturday 8:00am-6:00pm Sunday 11:00am-6:00pm
Genieve Women's Shelter	Domestic Violence Service Center	Suffolk	Isle of Wight Smithfield Southampton Suffolk Surry	24-hour hotline, individual and group counseling, court accompaniment, case management, emergency shelter, permanent supportive housing, children's services, mentoring, life skills program, employment program, adolescent advocacy outreach program, children's program, support groups and recreational activities	Monday-Friday 9:00-5:00

Appendix B: Virginia League for Planned Parenthood Multi-Session, Comprehensive Sexuality Education Programs

These programs are often designed to be short, focused and targeted for specific populations of teens in schools, out-of-home facilities, and in community settings. All of the following programs are medically accurate and research-based:

Curriculum	Age Group	Number of Sessions	Description
All Together Now	14 +	5	This curriculum was developed by Planned Parenthood and emphasizes pregnancy prevention, STI prevention, condom use, contraception, decision making, and accessing sexual health services. *All Together Now* also includes optional follow-up activities to do with a trusted adult after each session. Research on this curriculum shows statistically significant increases in knowledge about contraceptives, the ability to use condoms consistently and correctly, and greater intention to use family planning services.
All Together Now + Safe Dates	14 +	6 - 10	*Safe Dates* is a research-based, intimate partner violence prevention program for teens. *Safe Dates* aims to increase awareness about healthy and unhealthy relationships and give participants the skills they need to develop healthy relationships and to help friends who are in abusive relationships. When the six sessions of *Safe Dates* are paired with *All Together Now*, this series also includes information about pregnancy prevention, STI prevention, condom use, contraception, decision making, and accessing sexual health services.
Family Life and Sexual Health (FLASH): Middle School	11 – 14	7 +	*FLASH: Middle School* is an evidence-informed program released by the Family Planning Program at the Seattle & King County Department of Public Health. The goals of FLASH are to assist in the development of persons who are knowledgeable about human development and reproduction; who respect and appreciate themselves, their families and all persons; and who will neither exploit others nor allow themselves to be exploited. Based on the Theory of Planned Behavior, *FLASH* lessons include a variety of strategies designed to help students choose and succeed in these behaviors.

Curriculum	Age Group	Number of Sessions	Description
FLASH High School	14 – 18	8 +	*FLASH: High School* is similar to FLASH: Middle School (description above) with more developmentally-appropriate material for older students including emphasizing abstinence, condoms, consent, communication, contraception, and STI prevention.
FLASH Special Education	11 – 18	6 +	*FLASH: Special Education* aims to assist in the development of persons who are knowledgeable about human development and reproduction; who respect and appreciate themselves, their families and all persons; and who will neither exploit others nor allow themselves to be exploited. This curriculum is tailored to meet the needs of youth with intellectual disabilities in a self-contained, exceptional children classroom.
** Get REAL: Middle School*	11-14	5 to 9	*Get REAL Middle School* is designed to delay sex and to increase correct and consistent use of protection methods when a person becomes sexually active. Get REAL views sexuality in the context of relationships and focuses on social and emotional skills as a key component of making responsible and healthy decisions.
** Get REAL: High School*	14-18	6 to 11	*Get REAL High School* is an evidence-based intervention designed to help students develop the skills needed to delay sex and to encourage correct and consistent use of protection methods when they become sexually active. The curriculum approaches sexuality education with a focus on the central role of communication in relationships and with parents. It also provides students with age-appropriate skills for avoiding STIs, including HIV, and unplanned pregnancy, and for accessing sexual health care.
** Making Proud Choices!: An Adaptation for Youth in Out-of-Home Care*	14 – 18	5 to 10	*Making Proud Choices!* is an interactive, evidence-based program that has been adapted for youth in out-of-home care. *MPC* aims to empower youth to choose behaviors that will reduce their chances of experiencing an unintended pregnancy or sexually transmitted infection. *MPC* uses a trauma-informed approach and includes information about healthy relationships, abstinence, birth control, condom use, sexually transmitted infections, and ways to stay safe in the digital age.

Curriculum	Age Group	Number of Sessions	Description
*** *Reducing the Risk***	14 +	8 to 16	*Reducing the Risk (RTR)* is an evidence-based sex education program designed for schools. *RTR* focuses on empowering youth to develop attitudes and skills that will allow them to prevent pregnancy and STIs, including HIV. The program includes information about healthy communication, abstinence, STIs, contraception, and helps youth develop delay and refusal skills. Research shows that *RTR* increases participants' knowledge about sexual health and makes participants more likely to communicate with their parents, delay having sex, and use protection when having sex.
*** *Sexual Health and Adolescent Risk Prevention (SHARP)***	14 +	1	*SHARP* is an intensive, interactive single-session STI/HIV prevention intervention lasting 4 hours. This curriculum was designed specifically for high-risk adolescents in temporary juvenile detention facilities and clinical settings (both in-patient and community-based). The session encourages condom use, goal setting, contraception use, and STI prevention among participants through group activities, videos, and condom use demonstrations. The groups are organized by gender, either all males or all females, with no more than 10 per group. This program has been shown to increase consistent condom use among participants.
The Power to Decide	14 – 16	5	This curriculum was created by VLPP and designed to increase knowledge about pregnancy prevention, healthy relationships, relationship safety, pregnancy, and parenting. This evidence-informed program was designed for? VLPP public high school students. Youth who participate in this program will learn communication skills that will allow them to advocate for themselves in a relationship. Topics include healthy relationships, dating violence prevention, healthy decision-making, and pregnancy.

** Indicates an Evidence-Based Teen Pregnancy Prevention Program recommended by the Office of Adolescent Health*