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ABSTRACT

This paper will take the strategies of leadership proposed by Bennis and Nanus (1985) in application to sexual education in schools. The severity and significance of the sexual health of youth will be shown, with an emphasis on contributing risk behaviors and ideologies. An overview of the current state of teenage pregnancy and sexual disease incidence will be included. Next, the factors that contribute to the disparities of sexual health in youth will be addressed. These factors include: race, parental and peer support, participation in a sexual education program, and current policies on sexual education. A discussion about the relation of the factors to participation in risky sexual behavior will be included. The paper will conclude by applying the leadership strategies of Bennis and Nanus to develop innovative and effective sexual education in schools. The four strategies proposed are attention through vision, meaning through communication, trust through positioning, and deployment of self through positive self-regard and the Wallenda factor. Applications for future health educators will be discussed to help assist in development of sexual education programs.

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Background

Sexual health in youth is a controversial and highly debated topic that needs to be addressed. Adolescent pregnancy has become a widely publicized topic with shows like "Teen Mom" and "16 and Pregnant" presenting a glamorized portrayal of the experience. Over 105 of births in world are to adolescent mothers, with higher rates of maternal mortality in youth and up to 4.4 million girls aged 15-19 seeking abortion. In addition to pregnancy, sexually transmitted infections have risen greatly in the past ten years. At least 111 million new cases of curable sexually transmitted infection (STIs) develop year, half of which are among young people (Braken, Shand, & Silva, 2010). This paper will review factors that contribute to adolescent pregnancy and development of STIs and HIV/AIDS in youth according to factors such as race, social support from parents and/or peers, and participation in a sexual education program. Then, it will address how health educators can improve the sexual health of youth using the four leadership strategies presented by William Bennis and Burt Nanus (1985). By utilizing components of the media, the result of the educational campaign will not only unify youth but also eventually reduce adolescent pregnancy and prevalence of sexually transmitted infections, HIV/AIDS, and other STDs.

Significance of the Problem

The rising number of unintended health outcomes like adolescent pregnancy and development of STIs and HIV/AIDS is due primarily to the large proportion of youth that engage in unsafe sexual risk behaviors. The CDC states that 46% of US high school students stated that they had sexual intercourse in their life. Thirty-nine percent did not use a condom and 77% did not use birth control of those that had recently had sexual intercourse (in the past 3 months). Because unsafe sexual behavior increases risk for unintended pregnancy, HIV, other sexually transmitted diseases, and sexually transmitted infections, more cases are reported in youth (CDC, 2011).

Three out of ten young women become pregnant before they reach the age of 20 CDC, 2011). There were 410,000 births to teens age 15-19 in 2009 in the United States, with the highest teen birth rate of all the countries. Teen birth rates in the United States have declined but remain high at 39.1 per 1,000 births, with higher rates in the southern states and in black and Hispanic teens. Adolescent pregnancy contributes to disadvantages in the affected youth with less mothers finishing high school. The children of adolescent mothers are also affected by preterm birth, low birth weight, and infant death. In addition to future negative consequences like likely to have low school achievement, drop out of high school, and become parents themselves as teens (Pazol, 2011). According to the National Campaign to Prevent Teen and Unwanted Pregnancy, teen childbearing accounts for 10.9 billion dollars in taxpayer money in 2009. The majority of the cost is associated with the children of the adolescent mothers, due to increase cost of health care, foster care, incarceration, and lost tax revenue. In Florida alone, adolescent childbearing account for 551 million dollars in taxpayer dollars. This large sum of money is substantially less then it could have been due to the decline in the teen birth rate (*The Public Cost of Teen Pregnancy*). The goal should be to continue to reduce to teen birth rate not only for the wellbeing of

the young mothers and children, but also to save millions of dollars annually.

Participation in unprotected sexual intercourse or using injected drugs increase ones risk for HIV/AIDS or STDs. Despite the recent media coverage on the prevalence of sexual intercourse, there has been a decrease in the amount of U.S. high school students who have ever had sexual intercourse, the number of partners, and current sexually activity. These results were obtained by conducting a cross-sectional national survey of students with an anonymous, self-reported questionnaire on risk behaviors (Eaton, Lowry, & Brener, 2011). Even with the decrease in sexual behaviors, youth and young adults still have the highest rates of STDs. Nearly half of the 19 million new STDs each year are to youth. An estimated 3,300 adolescents age 13-24 had reported to CDC that they had a HIV infection in 2009 (Pazol, 2011). One of the main contributors to these alarming statistics is the decrease of condom use among sexually active black and Hispanic youth in high school. These risky behaviors and consequences need to be addressed through interventions that are designed specifically for the target audience. Health education on HIV/AIDS and sexually transmitted diseases has also decreased and gotten worse over the past ten years. There has been a decrease in health education on STD prevention from 92.2% in 2000 to 80% in 2006. Currently, only 38.5% of high school teachers taught students how to correctly use a condom in at least one required course, with an average of 2.2 total hours required for HIV prevention education (CDC, 2011). Studies have shown that the program should focus on creating a strong family and school environment, with a positive outlook on future opportunities and goals of youth (Eaton, Lowry, & Brener, 2011).

What is the solution to combating the health risk behaviors that increase adolescent pregnancy and the incidence of HIV, STDs and STIs? Possibly it is creating an innovative, inspiring health education program based on the leadership model by William Bennis and Burt Nanus (1985). The program should be modeled to not condone youth who participate in sexual activity, but challenge youth to set personal expectation for themselves related to their behavior. The model will require an unorthodox approach to sexual education which could create a negative reaction from people that are accustomed to a more traditional approach.

Factors Related to or Affecting the Problem

As previously addressed, there are several social and behavioral factors that are contributed to adolescent pregnancy, HIV/AIDS, and sexually transmitted diseases and infections. The first one is racial disparity and its relationship to the incidence of sexual risk behaviors and likelihood of pregnancy and/or sexually transmitted diseases or infections. Despite the strides made in reducing teen sexual activity and increasing contraceptive use, the rate for minorities have remained the same and/or reversed. Rates of teen pregnancy (pregnant before the age of 20) for Latina teens and African American girls are 52% and 50%, respectively. Comparing these rates to those of non-Hispanic white teenage girls at only 19% portrays the wide gap between racial differences. The difference is also seen in rates of sexual behavior with black high school students reporting the highest rates of ever having sex, as well as the lowest rates of using birth control (less than half as frequent as white girls) (*The Public Cost of Teen Pregnancy*). The relationship between racial disparities in sexual diseases is complex and affected by many factors. The focus of previous research has been on changing individual behaviors (i.e., increase condom use, reduce number of partners, and increase sexual disease testing) and intervening through biomedical programs (i.e., screenings, vaccines, and treatments). The results of previous interventions have been shown to prevent or decrease the spread and complications of sexual diseases. There are several factors that link racial disparities in STD rates: racism, poverty, education, and policies. Racism can affect health status through lack of economic opportunity, delivery of inadequate medical care, and deficiency in immune function due to acute and chronic stress. Low socioeconomic status and poverty are strongly correlated with high rates of sexual disease, with more proportion of racial/ethnic groups affected by greater prevalence of poverty. Education provides opportunities for employment and increases positive hopes for the future, thus influencing how they protect themselves against sexual diseases. Policies need to be developed that provide resources including: more STD testing, education and condoms to youth and young adults, and more research on the racial disparities and prevention that reduces rates of sexual disease (Mocello, Samuel, & Smith, 2008).

The parents' role of decision-making is underestimated- parents have a significant role on the choices that their children make. Nearly 80% of youth indicate that their decisions about sex are influenced by what their parents tell them, with only 32% seeking out advice from parents regarding sex. There is a correlation with less sexual experience and positive relationship between mother and child, as well as poor communication in the relationship leading to higher rates of risky sexual behavior. In relation to social support from peers, teens are most likely to seek out information from their peers about sex. During middle adolescence, pressure to have sex increases but it is related to the similarity of friend groups (i.e., youth who have friends that are abstinent are more likely to be abstinent themselves) (Clark, 2001).

On a broader scale, schools have the opportunity to implement education programs that can reduce teenage pregnancy and sexual diseases in youth.

Higher sexual risk behavior is related to lack of sufficient education. Young women are more likely to become pregnant if they have dropped out of school or are less successful. On a political note, the main focus of sexual education in schools has been directed to abstinence-only intervention (Clark, 2001). The narrow focus has shaped what students are being taught with a "one size fits all approach". Moral controversy shapes what programs are implemented in certain state, with apparent differences in the Southeastern states with more conservative, traditional approach in the past. A need for a more comprehensive sexual education (including abstinence, contraceptive use, pregnancy prevention, STDs, and HIV/AIDS) is the majority belief of Americans today (Clark, 2001).

Changing the traditionally outdated system of health education will not come easy in America. It is difficult to make drastic changes in the school system because it depends on the political climate, funding, and advocacy of persons to make a change. Future health education programs should incorporate the social and behavioral factors in the design phase. Implementation should be designed around individual needs of youth, and focused on preventing teenage pregnancy and sexual disease in youth.

Implications for Leadership

The book, *Leaders: the Strategies for Taking Charge*, presents a witty, inspiring portrayal of the strategies of successful leaders. There are four main strategies that leadership behavior embodies: attention through vision, meaning through communication, trust through positioning, and deployment of self through positive self-regard and the Wallenda factor (Bennis & Nanus, 1985, p.26). These four strategies can be applied to the need of leadership in developing and implementing sexual education programs in schools.

The first strategy proposed by Bennis and Nanus is attention through vision. What exactly does vision mean? It is not a radical, dramatic solution that receives the most attention. The driving factor of a vision is creating a focus. Results are what need to be seen; therefore a successful leader will be results oriented (Bennis & Nanus, 1985, p.28). In relation to teen pregnancy and sexual disease, sexual education needs to switch focus to be outcome-oriented. Commitment to lowering the rates of teenage pregnancy and sexual diseases should be the ultimate goal of any sexual education program. Accomplishing the goals cannot outweigh the people being served. Emphasis needs to be placed on developing a transactional relationship between leaders and followers (Bennis & Nanus, 1985, p.32). Students and leaders need to be unified toward a common goal in order for it to get accomplished. Sexual education programs should utilize the youth when developing programs to incorporate their needs. The problem with current sexual education is that they are not designed with realistic expectations of the behaviors of youth, and not focused on provided a comprehensive, individualized approach. Every teenager is different-shouldn't sexual education be different too?

Meaning through communication is the next strategy that can improve sexual education in schools. After a vision is created, how do you communicate your vision to followers? Communication is the key to becoming an effective leader (Bennis & Nanus, 1985, p.32). It begins with shared meaning and expectations of reality to inspire actions. In order to lower rates of adolescent pregnancy and sexual diseases, adolescents must also acknowledge that there is a problem that needs to be addressed. While sexual education is a controversial and uncomfortable subject, there needs to be a clear explanation that provides knowledge and focus. Even though the information taught in sexual education is boring, techniques and methodology needs to be incorporated that depicts it in a relatable and creative way. More youth will be willing to participate if sexual education programs were delivered by leaders they respect and to whom they can relate.

The next strategy is trust through communication. Once you develop a vision and communicate the meaning, a leader must consistently and clearly continue to stick to the position. Accountability, predictability, and reliability encompass what trust is according to Bennis and Nanus (1985, p. 46). How does a leader inspire trust? A leader develops trust by positioning the actions that implement the vision. A leader must encompass to vision and act as a role model at all times. The leaders of sexual education programs cannot be "friends" to the youth served, they must be open to communicate but have clear and consistent boundaries set that establish authority. Sexual education programs should not manipulate or "scare" youth to abstain from sexual behavior, but inspire youth by creating achievable and challenging expectations.

Deployment of self through positive self-regard is the final strategy proposed by Bennis and Nanus. The importance of interpersonal relationships is often overlooked in corporate and university settings. Leaders must have positive self regard, in that they trust their ability to accomplish the vision. First, a leader must recognize strengths and weaknesses, and then nurture skills with discipline to achieve positive self–regard. When designing sexual education programs, an emphasis should be placed on creating role models with a strong sense of identity. By having leaders that are sure of themselves, it will serve as an inspiration to participating youth (Bennis & Nanus, 1985, p.61). Leaders are role models at all times, so the saying "practice what you preach" should be followed accordingly. The second approach to deployment of self is through the Wallenda factor, which is that fear

of failing, destines one to fail. Leaders need to stay on track with knowing what they are worth, developing skills, and never giving up (Bennis & Nanus, 1985, p.72). The youth in sexual education programs focused not on whether they can abstain from certain behavior, but on meeting personal expectations and standards. Decision-making needs to be self-sufficient when they are faced with decisions. Would my chances of going to college be affected if I became pregnant? What would developing a sexual disease do to my future basketball career? Empowerment needs to be the key message sent to youth in sexual education programs. It's your body, and your responsibility. A sense of control by today's youth will help reduce sexual risk behaviors, prevent teenage pregnancy and sexual diseases.

Conclusion

Leadership encompasses a variety of characteristics, strategies, and techniques. There comes a time when a leader must relinquish the role and let the followers make their own way. It is time for the youth of the United States to become leaders. Teens need to be encouraged to communicate what they want to learn about sex. Parents and social support systems need to be open to different approaches to sexual education depending on each adolescent. Schools and political constructs need change outdated sexual education to individualized, comprehensive education in all states. Leadership does not define who one is but it is the vision to succeed in whatever one endeavors to accomplish.

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