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THE CALIFORNIA HEALTHY YOUTH ACT: A POLICY ANALYSIS ON
CALIFORNIA'S COMPREHENSIVE SEX EDUCATION MANDATE

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Public Health

by
Rae Chelle D. Gabriel

June 2020

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ABSTRACT

Background: The California Healthy Youth Act is the policy that mandates California public schools to implement comprehensive sex education in middle and high school. Since its enactment in 2016, sexually transmitted infections have reached its highest rates with young people accounting for half of all new cases. Likewise, teen dating violence and sexual violence (including sex trafficking) continue to burden adolescents, especially among minorities. Policy enhancements are recommended to bridge the gaps in implementation to ensure compliance and sustainability of the policy.

Methods: A policy analysis was conducted using Bardach's 8-fold path and a SWOT analysis. Data was gathered through existing qualitative literature and news articles, and secondary data collected by government agencies.

Results: Results demonstrated that lack of funding was a major contribution for the absence of implementation in the classroom. To address the financial need and increase the proportion of schools that implement the education, additional accountability is recommended to improve the mandate block grant. This will increase the likelihood of implementation and provide sustainable outcomes.

Conclusion: It is a child's basic right to learn about sexual health and the means of protection from adverse sexual health outcomes. The California Healthy Youth Act is a major step forward in ameliorating the disproportionately high rates of sexual health outcomes among adolescent minorities.

Implementation is a challenge, but with federal funding and adequate accountability, this education can teach adolescents how to build healthy relationships and feel empowered to take charge of their sexual health throughout their lifetime.

ACKNOWLEDGEMENTS

To my parents and brother, thank you for always being my number one supporters throughout my academic career. I strive to be my best because of all of you. Rainier, your level of patience throughout grad school reminded me that I couldn't have done this (and life) without you. To my best friends, thank you for your constant love and support and being my ultimate cheerleaders. Thank you to my thesis chair, Dr. Becerra for this opportunity, your guidance, and support throughout the process. To my committee members Prof. Olney and Lidia Carlton, thank you so much for your patience, flexibility, and support. Lastly, a special thank you to Dr. Mshigeni and the MPH faculty for their encouragement, contribution to my education, and dedication to the program. I am so honored to be part of such an influential field and beyond grateful for the impact each and every one of you made in my life.

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CHAPTER ONE

INTRODUCTION

Problem Statement

The World Health Organization (WHO) (2019b) defines sexual health as:

A state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

The WHO recognizes the vulnerability of sexual health and therefore advocates for positivity in all dimensions of the concept. Due to its sensitive nature, the mere absence of a positive approach can result in unsafe sexual experiences such as assault, manipulation and victimization that negatively impacts all aspects of an individual's well-being (UNESCO, 2009).

Additionally, the National Coalition for Sexual Health (NCSH) (2019) also shines a light on sexual positivity by placing a high value on the benefits of sexual health. Benefits like having a pleasurable sex life, feeling good emotionally, and developing healthy relationships. While the focus is primarily positive, the NCSH acknowledges that this also means preventing major health outcomes such as sexually transmitted infections (STIs) and unintended pregnancies.

These two organizations have defined sexual health as a whole however, it is not inclusive to other sexual health related topics such as sexual orientation, gender identity, and gender expression (World Health Organization, 2020a). These definitions also do not include individual differences that are constructed from cultural backgrounds, beliefs, societal influences, and values (Almahbobi, 2012). Since an individual's definition of sexual health is completely subjective, each person may have varying comprehension of sexual health, including their understanding of safety and what sexual positivity looks like. As such, adverse outcomes like sexually transmitted infections (STIs), unintended pregnancy, unhealthy relationships, and sexual violence may result if all elements that surround this topic are not learned, understood and practiced.

In 2018, almost 2.5 million cases of STIs were reported in the United States (US), the most it has ever reached (Centers for Disease Control and Prevention, 2018a). Additionally, young adults between the ages of 15-24 years account for almost half of these cases (Centers for Disease Control and Prevention, 2019b). Young adults are more likely to engage in unprotected sexual acts and have multiple sex partners, which are high-risk factors for contracting STIs, including Human Immunodeficiency Virus (HIV) (Centers for Disease Control and Prevention, 2020a; Subbarao & Akhilesh, 2017). The lack of awareness and inadequate knowledge of sexual health practices contributes to the rates of STI contraction (Reuter et al., 2018). Cunningham et al. (2009) further identified that the social stigma associated with STIs and HIV may hinder

access to sexual health resources or barrier methods, like condoms, negatively affecting overall rates.

Subsequently, the same lack of awareness and engagement of high-risk sexual activity among young adults caused the high rates of unintended pregnancies in the US (Kornides et al., 2015; Reuter et al., 2018). Young women age 20-24 years old account for more than half of all unintended pregnancies in the US (Kornides et al., 2015). In 2011, within the US there were 45 unintended pregnancies per 1,000 women (Guttmacher Institute, 2019a). This is the lowest rate it has ever been since its rise in 2001, but is still highest among other developed nations (Finer & Zolna, 2016; Guttmacher Institute, 2019a).

Other adverse outcomes include various forms of unhealthy relationships and sexual violence. Teen dating violence (TDV) is very common among young people in the US and affects almost 2 million young people every year (Centers for Disease Control and Prevention, 2020e). One in three adolescents have reported being victims of some type of abuse within a dating relationship, with young women between 16-24 years being the most vulnerable (Loveisrespect.org, 2017). A form of violence that can occur within TDV or any close relationship, is sexual violence. Sexual violence occurs when a sexual act, like rape or sexual assault, is forced without consent (National Sexual Violence Resource Center, 2010). The Centers for Disease Control and Prevention (CDC) (2020e) identified that sexual violence occurs frequently, affecting a proportion of both men and women sometime in their life. According to RAINN (2020a), young

people are among the highest risk with 66% of sexual violence victims being between 12-17 years old. While anyone can be a victim of sexual violence, adolescents have been identified to be the most vulnerable, especially among the lesbian, gay, and bisexual (LGB) population (Centers for Disease Control and Prevention, 2010). Lastly, sex trafficking is a form of human trafficking that is a severe form of sexual violence, where victims are forced or coerced into performing commercial sex acts (Centers for Disease Control and Prevention, 2020c). Sex trafficking is a widespread humanitarian concern with over 7,800 reported cases in 2018 within the US (Polaris Project, 2018). According to the 2018 Federal Human Trafficking Report (2019), over half of all active sex trafficking cases were among adolescents. Despite having an actual number of reported cases, the covert nature of this crime often goes underreported especially due to fear of disclosure for victims (Barnert et al., 2017).

The relevance of both TDV and sexual violence also attributes to the overall high rates of STIs and unintended pregnancies with almost a 3 times increased likelihood to contract an STI, and decreased likelihood in consistent contraception use (Offenhauer & Buchalter, 2011). Early implementation of sexual and reproductive health education has been a key component in not only preventing these types of outcomes but also in creating safer and healthier communities (Gutmacher Institute, 2017; Haberland & Rogow, 2014). Strong evidence implies that comprehensive sex education (CSE) helps build healthy relationships, delay sexual activity, and avoid STIs and unintended pregnancies

(Guttmacher Institute, 2016). Whether presenting this education in school or within the community, students will have the opportunity to adopt the skills needed to protect their human rights, sexual health, and well-being (Haberland & Rogow, 2014). In addition, this education centers on building a positive outlook on sexual health, emphasizing healthy sexual development, fostering healthy relationships, and intimacy (Breuner & Mattson, 2016). Furthermore, as written in the Convention on the Rights of the Child document by the United Nations (UN) (2013) it was declared that access to sexuality information is the “child’s right to health” (p. 17). Ultimately, this education serves as an effective way for young people to make informed decisions beyond their sexual health.

As such, a major means to alleviate the burden of STIs, unintended pregnancies, unhealthy relationships and sexual violence, has been the California Healthy Youth Act (CHYA) (California Department of Education, 2019a). Enacted in January 2016, this act mandates California public schools to provide sex education that delivers medically accurate information while maintaining inclusivity at an appropriate age level for adolescents (California Department of Education, 2019a). As indicated by the California Department of Education Website (2019a), the five key purposes are:

1. To provide pupils with the knowledge and skills necessary to protect their sexual and reproductive health from HIV and other sexually transmitted infections and from unintended pregnancy;

2. To provide pupils with the knowledge and skills they need to develop healthy attitudes concerning adolescent growth and development, body image, gender, sexual orientation, relationships, marriage, and family;
3. To promote understanding of sexuality as a normal part of human development;
4. To ensure pupils receive integrated, comprehensive, accurate, and unbiased sexual health and HIV prevention instruction and provide educators with clear tools and guidance to accomplish that end;
5. To provide pupils with the knowledge and skills necessary to have healthy, positive, and safe relationships and behaviors.

Despite the depth at which the CHYA covers sexual health, there remains little evaluation on the efficacy of the CHYA and the barriers to implementation. Just two years after the enactment of the CHYA, California had the highest rates of bacterial STIs compared to all other states with disproportionately higher rates among certain geographical areas (California Department of Public Health, 2018b). For example, in 2018, San Bernardino County reported over 20,000 cases of STIs, while Los Angeles County reported over 96,000 (LA County Department of Public Health, 2019; San Bernardino County, 2019). In Riverside County, incidence rates of chlamydia have drastically increased from 365.1 per 100,000 cases to 474.7 per 100,000 cases between 2016 and 2018 (SHAPE Riverside County, 2018). Further, the burden of STIs fall beyond geographical areas, but also among minority groups with rates consistently affecting people of

color (Centers for Disease Control and Prevention, 2019d). In the same degree, the rates for sexual violence also disproportionately affect minority groups. According to the CDC's 2017 California Youth Risk Behavior Survey (YRBS) (2017a), females and adolescents who identified as lesbian, gay, or bisexual (LGB) reported higher rates of experiencing sexual violence (13.6% and 18.5%). Thus, understanding the scopes of policy enhancement based on the CHYA and making additional implementation measures may help reduce the STI and sexual violence burden among minority groups noted in the state.

Purpose of Study

The purpose of the study is to conduct a policy analysis of the CHYA and make recommendations for novel policy implementations.

Research Questions

1. What are the current scopes of improvement on the CHYA?
2. What policy options ensure sustainability of the CHYA?

Significance to Public Health

Sexual health and its relevance have continued to rise over the years addressing the vital role it plays in public health and the potential of controlling the impact it has on health outcomes (Douglas & Fenton, 2013). Results of this study will provide one of the first insights into whether policy changes can be an effective means to mitigate such a public health issue.

In addition, the following Master of Public Health competencies will be met in the present thesis:

1. Competency: Evaluate policies for their impact on public health and health equity.

The results of this research will identify if the current policy on sexual and reproductive health education is truly effective in its five purposes in improving sexual health knowledge, while decreasing adverse sexual health outcomes, like STIs, unintended pregnancies, unhealthy relationships, and sexual violence among middle and high school adolescents.

2. Competency: Apply negotiation and mediation skills to address organizational or community challenges.

A policy analysis will be conducted on the CHYA to identify barriers in implementing CSE. The proposed novel policy options will address what changes should be executed to overcome organizational challenges.

CHAPTER TWO

LITERATURE REVIEW

What is Sexual Health?

According to research by Douglas and Fenton (2013) sexual health has been an intricate concept involving a multitude of influences, behaviors, attitudes, and societal factors. Douglas and Fenton (2013) also illustrated that sexual health has progressed as a major natural concept of the human race. A concept deemed as a “public health priority” by Ford et al. (2013) that should be addressed to improve well-being (p. 96). This meant focusing on the positive sides of sex as well as, access to sexual health information, education, and reproductive health care (Ford et al., 2013). Anything short of this focus would be a disservice to young people and their sexual and reproductive health, and can lead to preventable health outcomes (Maria et al., 2017).

The WHO describes sexual health as a respectable concept that fully embraces sexual positivity, and further includes pleasure and safe sexual experiences (World Health Organization, 2019b). Achieving these levels of positive experiences depends on an individual’s access to resources. Resources such as sexuality information and education, access to sexual and reproductive health care, and living in an environment that positively supports sexual health (World Health Organization, 2019b). Further, the American Sexual Health Association (ASHA) website (2020b) defines sexual health as “the ability to embrace and enjoy our sexuality throughout our lives. It is an important part of

our physical and emotional health.” Although a less broader definition than the WHO, ASHA succinctly defines sexual health apart from preventing infections and unplanned pregnancies, but rather appreciating sexuality throughout one’s lifetime (American Sexual Health Association, 2020b).

While these organizational definitions have characterized sexual health, each individual’s definition is subjective but do not always include a full understanding of all the risks and responsibilities (Douglas & Fenton, 2013). Sexual health at the individual level is constructed over time by one’s cultures, sub-cultures, beliefs, and values (Almahbobi, 2012; American Sexual Health Association, 2020b). Fortenberry (2013) describes that relationships, experiences, and beliefs can influence an individual’s definition of sexual health, and can also change throughout one’s lifetime. Due to a myriad of influential combinations, there is no one definition that can explain sexual health because of the difficulties in measuring the concept. However, through the support of the CHYA, CSE can ultimately introduce a much more comprehensive definition to youth.

While CSE can provide guidance around this intricate concept, a lack of CSE implementation will affect an individual’s understanding and self-efficacy in advocating for healthy relationships and safer sexual experiences. This is one of the reasons young adults age 15-24 years old make up half of all new STI infections, 21% of HIV cases for 13-24 years old, and almost 180,000 births for 15-19 year olds in 2018 (Centers for Disease Control and Prevention, 2020d).

Further, this reason also influences the TDV and sexual violence experiences that are prevalent among young people, with 21% of females and 10% of males experiencing some form of dating violence by a partner within the last 12 months (Centers for Disease Control and Prevention, 2016). Additionally, the negative stigma that is often connected to sexual health, also influences the rates of these sexual health outcomes (Cunningham et al., 2009). As a result, the California Department of Education (CDE) has taken on the CHYA to be a vital step in building healthy lives among adolescents and working towards ameliorating the burden of adverse sexual health outcomes in California.

Consent

Consent is an essential component to sexual health encompassing the protection of human rights (World Health Organization, 2020b). Prior to any type of engagement of sexual activity, consent must be agreed upon by both or all-participating partners (RAINN, 2020b). According to the Rape, Abuse & Incest National Network (RAINN) website (2020b), “positive consent” looks for communication and occurs every time the level of sexual activity changes. RAINN (2020b) also posits consent needs to be freely given, not coerced, and can be retracted at any given time.

On the other hand, Beres (2014) explored the definition of consent, identifying that there is a fluctuation between varying definitions. The legal definition as defined through literature by Beres (2014), has two main components: an individual’s mental capacity to give consent, and how it is

conveyed or “what counts as consent” (p. 374). Beres (2014) further suggests that consent is often addressed differently between men and women, determined by the length of time of the relationship, and more frequently provided non-verbally. Literature by Archard (1998) and Dripps (1992), express that as long as it is understood and agreed upon, it is considered consent (as cited by Beres, 2014). Furthermore, literature by Hickman and Muehlenhard (1999) and Humphreys (2000) elaborate that consent is something that can take place without force, or “free verbal or nonverbal communication of the feeling of willingness” (as cited by Beres, 2014, p. 375). Regardless of how it is conveyed, the unanimous definition of consent is “some form of agreement to participate in sexual activity” (Beres, 2014, p. 374).

Even with interchangeable definitions of consent, understanding the definition alone does not suggest an individual’s self-efficacy in providing or retracting consent prior or during sexual activity. Research conducted by Mohamed (2019), found that college students were more confident in asking for consent and agreeing to sexual activity, but not declining. While having a more comprehensive definition is important in understanding the concept, Mohamed’s research is indicative of the lack of skills and confidence that can be developed through CSE. As such, it is imperative for youth to receive CSE because an individual’s lack of competence to freely give, decline, or retract consent can lead to serious preventable repercussions, like sexual violence.

Adverse Sexual Health Outcomes

All people, regardless of age, sex, race, and background are at risk of adverse sexual health outcomes, however disparities exist among specific geographical regions and minorities. (Centers for Disease Control and Prevention, 2020d). STIs (including HIV) are major outcomes that can also lead to more serious health concerns, like cancer, pelvic inflammatory disease, and infertility (Ivankovich et al., 2013). Further, unhealthy relationships and all forms of sexual violence can lead to psychological distress like depression and suicidal ideation, unhealthy behaviors like substance abuse, and future unhealthy/abusive relationships (Centers for Disease Control and Prevention, 2020b). However, these outcomes can be completely prevented if young people are receiving adequate health information that will provide them with the knowledge, skills, and resources to make healthy decisions and protect their overall health (Centers for Disease Control and Prevention, 2020a).

Sexually Transmitted Infections. STIs, used interchangeably with STDs (sexually transmitted diseases), are caused by bacteria, viruses or parasites and are most commonly passed through unprotected sexual contact with an infected person (American Sexual Health Association, 2020a; World Health Organization, 2019a). Unfortunately, some of the most common STIs are asymptomatic and are often left untreated. For instance, the CDC (2011), explains that it is common for people to be unaware of their status, especially women, since STIs like chlamydia and gonorrhea do not always present symptoms. Due to its

asymptomatic nature, people are more inclined to think they are not in need of a healthcare visit. In turn, untreated chlamydia and gonorrhea can lead to more severe health conditions, such as infertility and PID (Centers for Disease Control and Prevention, 2019f, 2019g).

STIs do not discriminate by age or other factors but they have been the most prevalent among young people age 15-24 years, with Black and Hispanic/Latino adolescents being more likely to contract an STI than their white peers (Centers for Disease Control and Prevention, 2019d; Healthy People 2020, 2020c). The prevalence among these groups is due to the likelihood of engagement and unique circumstances. For example, the 2017 YRBS found that young people are more likely to engage in high-risk activities including multiple sex partners, unprotected sex, and sex while under the influence (Centers for Disease Control and Prevention, 2020d). These disparities also exist because this age group is also more likely to have barriers that inhibit access to healthcare, like lack of transportation and insurance (Centers for Disease Control and Prevention, 2013). Furthermore, given that racial minorities are limited with opportunities and resources, the systemic issues of discrimination, poverty, and racism play a huge role in the distribution of adverse health outcomes (Healthy People 2020, 2020b). As a result of these reasons in 2018, young adults accounted for half of STI diagnoses and 21% of new HIV diagnoses (Centers for Disease Control and Prevention, 2020a)

Unintended Pregnancies. Unintended pregnancies can be defined as a pregnancy that is accidental, unplanned, or unwanted (Guttmacher Institute, 2019a; Yazdkhasti et al., 2015). Unintended pregnancies pose a number of social and economic risks including an increased likelihood of high school incompleteness and overall poor health (Guttmacher Institute, 2019a; Yazdkhasti et al., 2015). Unintended pregnancies can also compromise the health of both mother and baby, if proper care is not obtained during pregnancy (Centers for Disease Control and Prevention, 2019a; Yazdkhasti et al., 2015). While the unintended pregnancy rates have drastically declined almost 50% between 2008 and 2011, disparities exist among certain groups (Guttmacher Institute, 2019a). According to the CDC (2019a), young non-Hispanic black or African American women age 18-24 years old living below the poverty threshold have higher unintended pregnancy rates than their peers. For the same reasons STIs affect minorities, systemic inequities causes a skewed distribution of education, health, and wellness, negatively impacting health outcomes among women of color (Centers for Disease Control and Prevention, 2018c; Guttmacher Institute, 2019a).

Teen Dating Violence. Cutter-Wilson (2011) defines TDV as any form of physical, psychological, and sexual aggression between any two young individuals age 13-19 years that are dating or in a close relationship. Dosil et al. (2020) describes physical violence as using physical strength such as hitting, punching, or slapping; psychological violence as any type of emotional

manipulation or threats; and sexual violence as forced sexual acts without consent. Dating violence among young people is so highly prevalent that almost half of all victims experience their first form of violence during adolescents (Centers for Disease Control and Prevention, 2020b). A large part of this is because young people are still among developmental stages, where they lack the capacity in identifying what healthy relationships should look and be like (Cutter-Wilson & Richmond, 2011). Due to its seriousness and relative impact, TDV has become a public health concern in recent years and thus should be addressed through CSE.

Sexual Violence. The WHO (n.d.) defines sexual violence as:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work (p. 149).

Sexual violence is a serious crime and health concern that violates an individual's human rights and liberty to consent. Sexual violence includes sexual harassment, sexual abuse, forced abortion, and forced sexual exploitation, such as sex trafficking (World Health Organization, n.d.). The 2017 YRBS results found that nearly 10% of adolescents had been forced into doing "sexual things" unwillingly within the last 12 months (Centers for Disease Control and Prevention, 2018b). In addition, sexual violence were reported higher among

females (15.2%) and LGB (22%) high school adolescents (Centers for Disease Control and Prevention, 2018b).

A form of sexual violence is sexual exploitation, otherwise known as sex trafficking. According to the State's Trafficking Victims Protection Act of 2000 by the Department of State (2000), sex trafficking is defined as "the recruitment, harboring, transportation, provision, obtaining of a person for the purpose of a commercial sex act" (p. 8). Sex trafficking is a form of slavery that damages physical and mental health and puts youth in danger. Anyone can become a victim of sex trafficking, however runaway, homeless, or foster care adolescents are often targets due to their extreme vulnerability, and unstable housing and family situations (Polaris Project, 2018; Youth.gov, n.d.). While getting an accurate number of sex trafficking victims is difficult due to the many cases that go unreported, more than half (51.6%) of the human trafficking cases that were reported were sex trafficking among minors (Human Trafficking Institute, 2019). The 2018 Statistics from the National Human Trafficking Hotline (2018) reported that the most common age that sex trafficking began was between 15-17 years. Based on the traumatic nature of sex trafficking, health problems can arise such as STIs, pregnancy, substance abuse, malnourishment, and bruises from physical attacks from the perpetrator (Department of Health and Human Services Agency, n.d.)

In general, the outcomes of these violent acts are substantial and likely chronic. Adolescents who experience this type trauma are more at risk for future

violent relationships, and also face serious repercussions such as poor academics, substance abuse, and poor mental health (Centers for Disease Control and Prevention, 2020e; Cutter-Wilson & Richmond, 2011). Furthermore, these consequences are generally magnified among LGB adolescent population due to the additional social disconnect and discrimination they experience based on their sexual orientation (Dank et al., 2014). Due to the prevalence of TDV and sexual violence among young people, especially LGB adolescents, primary prevention through CSE is imperative in protecting youth from the dangers of these traumatic life experiences.

Comprehensive Sex Education

To ameliorate concerning adverse health outcomes, CSE has been an important means to save adolescent lives (Advocates for Youth, 2014; Guttmacher Institute, 2017; Haberland & Rogow, 2014). CSE incorporates all of the elements of sex. Comprised of developing and valuing healthy sexuality while learning how to avoid and protect from adverse health outcomes (Advocates for Youth, 2014; Breuner & Mattson, 2016). Adolescents will strengthen their ability to foster healthy relationships, understand what consent looks like, learn how to access reproductive health care, and encourage open communication with parents and partners (Advocates for Youth, 2014; Breuner & Mattson, 2016).

Leung et al. (2019) argues that CSE is a fundamental part of education, as it goes beyond the current standards of anatomy, physiology and the reproductive system. The United Nations Educational, Scientific and Cultural

Organization (UNESCO) (2009) identifies that the goal of sex education is to ensure that young people can navigate their sexual health by utilizing information and skills that can be executed throughout their lifetime. Further, the American Civil Liberties Union (ACLU) (2020) fully supports CSE, acknowledging its effectiveness in protecting sexual health outcomes of young people. As such, this education has high potential in enhancing skills and confidence in making informed decisions about their sexual and reproductive health.

Guidelines and Policy

To build positive views on sexuality and lessen preventable health outcomes, guidelines and policies have been established to ensure young people learn how to protect their sexual health (Leung et al., 2019). For example, the United Kingdom (UK), Mainland China, and the US have all developed policies to warrant implementation of sex education (Leung et al., 2019). In contrast, other countries like Hong Kong, don't have policies but rather guidelines to suggest sexuality education into curriculum (Leung et al., 2019). These guidelines are provided to raise awareness and develop favorable views toward sexual health.

California Healthy Youth Act. Enacted in January of 2016, the CHYA requires CSE and HIV/AIDS instruction for adolescents at least once middle school and once in high school (California Department of Education, 2019a). The primary purposes of this education is for students to build healthy attitudes, body positivity, and healthy relationships, but also develop skills that will protect their sexual and reproductive health (ACLU, 2016; California Department of

Education, 2019a). Formerly known as the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act of 2004, it has since then been revamped to address the evaluated gaps in sex education in California (ACLU, 2016). While the bulk of the content remains the same, the CHYA further strengthens the existing requirements by adding new components that make this law more comprehensive and inclusive of all sexual orientation and genders. (ACLU, 2016)

The new additions provide inclusivity to LGB adolescents—including those who are questioning—in understanding the fluidity of gender, gender identity, and gender expression, while also incorporating same-sex relationship examples, and negative outcomes that arise from gender stereotypes (ACLU, 2016) The addition of these concepts acknowledges the diversity of youth, and will provide an opportunity for LGB youth to feel represented in the classroom. Other new additions include information on sexual assault, relationship abuse, intimate partner violence, sexual harassment, and sex trafficking. Information on these serious topics will raise awareness and also help youth identify unhealthy relationships and foster healthy ones (ACLU, 2016). Moreover, local resources have expanded to strengthen the message of adolescent rights to sexual and reproductive health services and other vital resources (ACLU, 2016). Lastly, encouragement to have open discussions with parents/guardians and trusted adults has also been expanded to continue developing healthy and trusted relationships with an adult.

Furthermore, this addition to the Education Code promotes sexuality as a normal part of human development, which will help in reducing negative stigma associated with sex (California Legislative Information, 2019) With a policy such as the CHYA, it can guide youth in protecting their sexual health while also building skills that will promote advocacy for themselves, their peers, and their communities.

The support of CSE and advancement of the CHYA has been an excellent step forward in improving public education standards. Its five purposes were designed to protect adolescent sexual health through life skills enhancement. However, since this policy is relatively new, there is little evidence if the CHYA is achieving its five purposes and alleviating the life-threatening concerns of teen dating violence, sexual violence and sex trafficking. Like any policy, implications can affect the implementation of the CHYA resulting in barriers among school districts. Thus, this analysis will identify why it is difficult for school districts to adhere to the compliance of this policy.

CHAPTER THREE

METHODS

Study Design

This study conducted a systematic policy analysis on the CHYA based on empirical guidelines (Collins, 2004). Policy analysis focuses on understanding health policies by analyzing its outcomes and the impact it has on the target community (Collins, 2004).

Data Source and Collection

Data for this analysis was obtained through online research from scholarly peer-reviewed articles, public health agencies (California Department of Public Health), sexual health advocates (Planned Parenthood, SIECUS, Guttmacher Institute), public news articles (Los Angeles Times, The Washington Post), government data and information (US Department of Health and Human Services Agency), and the CDC's Youth Risk Behavior Survey.

Measures

While there are several methods that can be used for policy analysis, Bardach's 8-fold path is a simple tool to easily explain a health policy (Collins, 2004). Additionally, a SWOT analysis tool was used to decipher the strengths, weaknesses, opportunities, and threats of each policy option for step 6 of the

path (Klusek, 2020) Additionally, the novel policy outcomes were modeled off of Healthy People 2020 objectives (Healthy People 2020, 2020a).

Data Analysis

All data were collected and qualitatively analyzed based on deductive means. In this process, pre-determined process that entails structural approach to analysis is used (FoodRisc Resource Centre, 2016). For this study, the Bardach's 8-step method was used. The following steps include: "(1) define the problem; (2) assemble the evidence; (3) construct the alternatives; (4) select the criteria; (5) project the outcomes; (6) confront the trade offs; (7) decide; (8) tell your story" (Collins, 2004).

Ethics

This study is not human subject research and thus does not require IRB approval process.

CHAPTER FOUR

RESULTS

Context

Prior to the formulation of the CHYA, a large proportion of the US population and medical organizations were in support of a more CSE in schools regardless of its taboo and controversial nature (Planned Parenthood, 2020c). According to a national poll conducted in July 2014 by Planned Parenthood and New York University's for Latino Adolescent and Family Health (2014), results claimed that majority (90%) of parents believed that sexuality education was important to learn in secondary education. In spite of this impressive parental support of sex education within the US, CSE is not mandated by every state in the nation. However, federal funding, called Title X, had been available for almost 50 years supporting reproductive clinics in providing confidential services, like CSE, contraception, and testing for low-income individuals or those who lack health insurance (Planned Parenthood, 2020b). However, as of March 2019, Title X funding no longer supports CSE and services (US Department of Health & Human Services, 2016). Contrary, Title V, another federally funded program is still available, but dedicated to abstinence-only-until-marriage (AOUM) education for community and faith-based organizations that support AOUM (Santelli et al., 2017).

As of March 2020, there are no national-level mandates on sex education but all states incorporate some type of sex education. Each state's lawmakers

and governor have the autonomy to decide the depth of sex education instruction in public schools; some as minimal as requiring age-appropriate, evidence-based, culturally appropriate, or medically accurate information *if* instruction is implemented (National Conference of State Legislatures, 2020; Planned Parenthood, 2020a; SIECUS, 2020). Some states like Alaska and Nebraska, only require Healthy Relationship Education, while other states, such as Connecticut and Michigan, require HIV and AIDS instruction only (SIECUS, 2020). California on the other hand, encompasses extensive sex education due to the mandate of the CHYA (SIECUS, 2020). Due to the additions of inclusivity, violence awareness, and improved resource content, California has demonstrated to be an overall progressive leader over the years in paving the way for CSE in schools.

The Problem

Young adults (age 15-24 years) have a downward trend in low birth rates, STI cases, and delaying sex than any other previous generation. However, young adults are at a higher risk and continue to constitute half of all new STI infections, with persisting disparities among specific minority groups, such as LGB youth and Black and Hispanic racial backgrounds (California Department of Public Health, 2018b; Centers for Disease Control and Prevention, 2019b). According to the California Department of Public Health (2019), STIs have reached their highest rates in 30 years. On the contrary, California's birth rate have reached a low record for young women 15-19 years, with a rate of 17 per

1,000 females in 2016 (Guttmacher Institute, 2019b). However, disparities show disproportionate rates are among women of color (US Department of Health & Human Services, 2019).

Other pressing concerns among adolescence are the relevance of TDV and sexual violence. TDV is a common concern that has been that can affect anyone, especially during adolescence. Half of all TDV victims had their first experience during their adolescent period (Centers for Disease Control and Prevention, 2020b). However, females and LGB youth are more likely than males and heterosexual peers to experience physical dating violence (Dank et al., 2014). Further, sexual violence and sex trafficking are severe public health concerns and a violation of human rights. According to the Centers for Disease Control and Prevention (2018b), over 10% of all high school adolescents have been a victim of sexual violence. Victims involved in any type of sexual violence often result in a significant health burden of short and long-term consequences like emotional guilt and shame, post-traumatic stress disorder, suicidal ideation, and injuries (National Sexual Violence Resource Center, 2016) These consequences are especially heightened among LGB adolescents who face additional discriminatory stressors due to their sexuality (Meyer, 2003).

At a young age, adolescents should not have to feel unsafe, threatened, or helpless. Instead, they should feel confident and empowered to protect their sexual health and well-being. As such, the CHYA was enacted to bring attention to the needs of adolescents and help mitigate the negative health outcomes they

are most vulnerable to. While passing a law is a huge step to implementing CSE in the classroom, the recent statistics posits questions regarding efficacy, compliance, as well as timeliness of delivery of such an initiative.

Supporting Evidence

According to the CDC's 2017 YRBS (2017b), almost half of all students who have had sex did not use any type of contraception during their most recent sexual act. This type of behavior yields the record high of STI rates in California every year. California's 2018 STD annual report by the CDPH (2018a), found that bacterial STIs made a drastic rise, reaching the highest rates in 30 years, with disparities among young people (California Department of Public Health, 2018a). More specifically, females age 15-24 years have a trend of highest chlamydia rates, while males age 15-24 years have a trend of highest gonorrhea rates (Centers for Disease Control and Prevention, 2019e). In contrast, the birth rate among young people have improved with an 82% decrease rate between 1991 and 2018 (National Vital Statistics Reports, 2019). Even with a substantial reduction of birth rates, a large disparity exists with majority (75%) of all births to females under 20 years old were of Hispanic racial background in 2016 (US Department of Health & Human Services, 2019)

TDV is a widespread issue with the highest rates of intimate partner violence among any other age group (Cutter-Wilson & Richmond, 2011). In California, over 8% of adolescents who were in dating relationships have been physically hurt or injured by their partner (Centers for Disease Control and

Prevention, 2018b). Additionally, the burden of TDV disproportionately affects minority groups. Based on a study conducted by Dank et al. (2014) rates among LGB victims were generally higher than heterosexual victims. For example, 43% of LGB experienced physical dating violence and 59% of experienced psychological dating abuse versus 29% and 46% of heterosexual peers (Dank et al., 2014). Moreover, sexual violence has major impacts on victims and their families due to the psychological, emotional and physical effects it causes (Centers for Disease Control and Prevention, 2020e). According to 2017 California YRBS (2017a), over 10% of adolescents experienced some sort of sexual violence by anyone. Among those who have experienced sexual violence, 13.6% were female and 18.5% were LGB youth (Centers for Disease Control and Prevention, 2017b). Also, sex trafficking is a rising concern in California as human trafficking continues to be an expanding criminal enterprise, devastating the lives of young people. In 2018, there were over 1,200 confirmed sex trafficking cases in California, with more than half of cases among sex trafficking minors (State of California Department of Justice, 2012).

The biggest problem among these health outcomes is the unequal distribution of cases by racial background and sexual identity. According to Luo et al. (2014), adolescents face an abundance of stressors of growth and development at home and in society, and this pressure may be amplified for LGB youth. LGB youth face additional stressors of navigating their identity, along with the outside social stigma and discrimination based on their sexuality. As a result,

this can lead to more vulnerability that can translate into tension in other aspects of their life (Luo et al., 2014). Furthermore, racial minority disparities exist due to societal root causes of racism and discrimination that inhibit equal opportunity. The racism and STD risk: potential theoretical model developed by Heidi Bauer (2007) of the California Department of Public Health, demonstrates how racism influences an individual's outcomes (as cited by California Department of Public Health, 2008) For example, poverty and a lack of educational opportunities can lead to “primary outcomes”, such as lower access to care or access to contraception; this then leads to “secondary outcomes”, such as a missed diagnosis or lower health quality treatment; which in turn leads to “impact on factors that affect STD transmission”, such as a longer duration of infection and increase number of sexual partners and spread (California Department of Public Health, 2008, p. 11).

Due to the major health outcomes that can arise during adolescence, it is vital for students to receive CSE to feel safe, build communication skills, and understand their human rights. However, despite the initiation of the CHYA, not all school districts are putting this law into practice with some factors being the availability of funding, school district policies on curricula, or the conservative level of the district (Advocates for Youth, 2014). According to the CDC's 2018 School Health Profile (2019) only 80% of schools in California (grades 6-12) require health education course instruction. Further, only 40% of these schools—that require health education course instruction—are implementing CSE

according to the CDC's 20 sexual health topic guidelines, that the CHYA adopted (Center for Disease Control and Prevention, 2019). Furthermore, due to the challenges of meeting and measuring the CHYA requirements, the proportion of schools that implement CSE are not always monitored (Advocates for Youth, 2014).

To accommodate the implementation of CSE, a federally funded grant, called mandate block grant (MBG), is available to California school districts to provide fiscal support in implementing mandated programs and activities in the state (California Department of Education, 2019b). This fund is granted by application every fiscal year and is eligible for grades K-12. Funding is based on average daily attendance (ADA) and school districts can receive between 40% to over 100% of reimbursed costs (CSBCA, 2012). As of fiscal year 2019-2020, MBG supports almost 50 state-mandated programs including CSE and HIV/AIDS instruction (California Department of Education, 2019c).

In a Los Angeles Times column written by Myers (2019) a new California state budget is anticipated to increase in statewide operations, yet it is demonstrated that funding for instruction in the classroom are insufficient and cannot meet teacher demands. The Public Policy Institute of California (2012) further claim that California's finance system is "flawed" and fails to set students up for academic success. The amount spent per pupil is relatively low in California at \$9,407, compared to other large states like New York that spend \$18,887 per pupil (Public Policy Institute of California, 2012). On top of that, only

a small fraction (about 5%) of district spending is spent on books and supplies for the classroom (Public Policy Institute of California, 2012).

Furthermore, an article in The Washington Post by Strauss (2019) explained that the California Board of Education (CBE) are reworking the current sexual health guidelines of the Health Education Framework to better support the baseline requirements of the CHYA. This incorporates age-appropriate content as early as kindergarten and includes subjects like gender identity from kindergarten through third grade, sexual feelings and masturbation in fourth through sixth grade, consent and sexual abuse in grades seven through eight, and contraception and healthy relationships throughout the remaining years of high school (Strauss, 2019). While the intention behind this framework is meant to support the CHYA, the instruction itself is not mandatory in elementary school, but is permitted (California Department of Education, 2020).

Policy Options and Projected Outcomes

Adolescents have the right to learn about their reproductive and sexual health that will positively influence overall well-being. As such, it is mandated to implement CSE into curricula for middle and high school students since the enactment of the CHYA. With its five purposes, the CHYA strives to provide an education for pupils that will present an opportunity to build skills to protect their sexual health, while also influencing healthy relationships, positive body image, and destigmatizing the concept of sex and sexuality (California Department of Education, 2019a).

To better support the CHYA and its purposes, a few alternative policy options can be considered to address the gap in the policy. Policy option 1 is to increase accountability for the CHYA through the MBG by the CDE. This funding will serve as an extra form of leverage in securing the implementation since school districts that receive the MBG are legally required to perform all mandated activities as listed in the CDE website (California Department of Education, 2019b).

A projected outcome for policy option 1 includes funding for pupils based on average daily attendance (ADA). Applicants are expected to receive over \$30.00 per ADA for middle school students, and over \$60.00 per ADA for high school students. Receiving the MBG would yield another projected outcome with a 10% improvement of school districts that are compliant with the CHYA by 2030. Funding will aid in the necessary resources for school districts to successfully deliver teacher training in CSE, the purchase of curricula, and additional supplies needed for instruction. While teacher training and curricula are already major budget categories for school districts, it is the school districts responsibility to conduct periodic teacher training for CSE to stay current on relative information (American Association of School Administrators, n.d.; California Department of Education, 2019a). The last projected outcome will save substantial public expenditures due to the sustainability of this policy option. Since the MBG will ensure CSE implementation, the expected savings is just over \$7.00 per public

dollar spent on adverse sexual health outcomes. In retrospect, this option could have helped save over \$13 billion in 2010 (Guttmacher Institute, 2019a).

Policy option 2 is mandating the CHYA as early as grade school. While the CHYA applies to all grade levels, the only current requirement is to implement CSE at least once in middle school and once in high school. Since the relevance of TDV, sexual violence and sex trafficking among adolescent population, instruction of the CHYA prior to middle school will introduce exposure to age-appropriate CSE and ultimately establish a foundation of sexual health knowledge and skills that will build and strengthen throughout their education.

A projected outcome for policy option 2 include a 10% increase in the proportion of adolescents that use any form of birth control/STI prevention method during their most recent sex act by 2030. The number of youth that are ever having sex is substantially lower than in the last decade, however, more than half of those who *are* engaging in sex did not use contraception (Centers for Disease Control and Prevention, 2019c). Another outcome for policy option 2 is a 10% decrease in TDV minority victims by 2030. In relation to this outcome, the third outcome of policy option 2 is a 10% decrease in sexual violence (including sex trafficking) among youth by 2030. The thoroughness of CSE encompasses information on a multitude of adolescent issues that will raise awareness, improve understanding and build self-efficacy. Pupils will also learn more on local resources and how to access them if and when it is needed. As a result of policy option 2, early implementation of CSE will promote awareness of sexuality while

normalizing the conversation around sex, thus reducing stigma and boosting self-efficacy in delaying sex, using contraception, and building healthy relationships with parents/guardians, trusted adults, and others.

Table 1. Policy Options and Outcomes

Policy Option 1: Increase accountability for the CHYA implementation through the MBG by the California Department of Education	Policy Option 2: Mandate the age-appropriate CSE earlier in elementary school
MBG will ensure that California school districts will receive \$32.18 per average daily attendance (ADA) for students in middle school and \$61.94 per ADA for students in high school.	Implementing age-appropriate CSE at an earlier age will result in an increase in awareness of sexual health; this will result in a 10% increase of the proportion of middle and high school adolescents using contraception during their most recent sexual act by 2030.
MBG will result in a 10% improvement in the proportion of school districts that are compliant with the CHYA by 2030. This includes routine teacher training, purchase of curricula, and additional supplies needed for instruction.	Implementing age-appropriate CSE at an earlier age will result in a 10% decrease of TDV among minority youth by 2030.
MBG will ensure students are receiving CSE, resulting in a decrease in public expenditures, saving \$7.09 for every public dollar spent on adverse sexual health outcomes.	Implementing age-appropriate CSE at an earlier age will result in a 10% decrease in sexual violence (including sex trafficking) among youth by 2030.

Strengths, Weaknesses, Opportunities, and Threats Analysis Evaluation

The major strengths of MBG will ensure that California school districts will receive funding and provide thorough implementation of CSE. School districts who are apprehensive or financially burdened to implement the education will be fiscally supported. MBG will advance compliance of the mandate, overall

increasing the proportion of school districts that put the CHYA into practice. Nonetheless, MBG will reduce the economic impact on California and influence productivity of public expenditures.

A weakness of MBG is the individual application process for each district that requests funding. While this funding attends to mandated programs, the funding itself is not mandated to receive. Instead, grants are fulfilled per approved application for each district that applies. If approved, the ADA amount per student may not be sufficient to cover all 49 of the listed mandated programs and activities since reimbursement costs are as low as 40%. Further, by adding the accountability component to MBG, challenges may arise when figuring out logistics for accountability measure (i.e. time, funds, and personnel).

The opportunities of the MBG are the primary emphasis that pupils will be receiving CSE to promote healthy sexuality and improve health outcomes. The MBG provides an opportunity for the CSE to be delivered via instruction every school year regardless of a school district's fiscal challenges. In addition, savings of \$7.09 on every public dollar spent could translate into further investment for California school districts and the quality of education for their students.

The threats however, are the pressure for school districts to be compliant of CSE or the possibility of the MBG ceasing to exist. Existing educational standards already take precedence in classroom expectations, that the CHYA could easily take the lowest priority for several school districts. Further, due to

CSE's controversial disposition, school districts can face potential backlash from parents and members of the community.

Strengths for policy option 2 for lowering the grade level requirement for the CSE to begin are normalizing the conversation around sexuality and increasing understanding of how to protect one's sexual health. When pupils know how to have healthy discussions about sex, they will also feel more confident in delaying sexual activity or taking the necessary precautions to protect themselves. The recurrence of CSE implementation will bring immediate health improvements in California while also reducing stigma around the taboo topic.

However, a lack of funding is a weakness for mandating the CHYA in elementary school. Evidently, while 80% of school districts require a health course in middle and high school, only a fraction of school districts are implementing CSE (Center for Disease Control and Prevention, 2019). Thus, extending the mandate to lower grade levels will generate more challenges in meeting the requirement.

The opportunity this option promotes is an increase in adolescents executing safe sex practices, accessing sexual and reproductive resources, and building trusting relationships with adults. Adolescents will understand the importance of protecting their health, and can take responsibility as early as they deem necessary. Additionally, students will learn how to build healthy relationships and also identify the difference with an unhealthy one. Overall, CSE

in elementary will also build a safe space for LGB adolescents to feel represented and heard in the classroom.

Lastly, the threats to mandating the CHYA in elementary school are the shortfall of sustainability in the unforeseen future. If CSE is implemented as early as elementary school, this will result in a decrease in STIs, unintended pregnancies, TDV, sexual violence and sex trafficking. If statistics are ideal, this may yield a revamp to the CHYA potentially removing vital components of the education, or concluding that the mandate is no longer needed to manage adverse sexual health outcomes.

Weighing the Outcomes

Policy option 1 will greatly increase the proportion of instruction in each school district. Even with the legal obligation, increased accountability will result in a greater likelihood that students will receive CSE. Given that this grant is already operative, it is practical to deepen the accountability. Further, this option promotes sustainability of the CHYA due to its feasibility and ultimately providing socioeconomic relief to the state.

Policy option 2 provides the inclusion of the CHYA to be mandated as early as elementary school. Implementation of the CHYA prior to middle school will yield immediate short-term impact results, lessening the proportion of adverse sexual health outcomes among adolescents. Given that the CDE had made adjustments on sexual health guidelines for the Health Education Framework to further support the CHYA for all grade levels, this policy option

isn't completely improbable. However, mandating the CHYA sooner in the education system will need the same financial investment and support to successfully deliver. In spite of which option is more suitable, fiscal support is imperative in the implementation the CHYA regardless of what grade level the education starts.

Decision

The outcomes that either policy options present will ultimately provide a solution in mitigating the high prevalence of adverse sexual health outcomes and the disparities among adolescents. Both policy options are in full support of adolescent education and health promotion, and provide outcomes that will benefit both the well-being of all people and the economy. Despite the challenges in getting school district applications and logistics for the changes, the best policy option is to increase accountability for the CHYA in the MBG. The changes to the MBG will not be substantial, and school districts struggling to implement the CHYA will continue to have the financial means to do so. Overall, the addition of accountability in the MBG is a realistic and sustainable step forward in reducing the rates of sexual health outcomes and saving California public expenditures in the long run.

CHAPTER FIVE

DISCUSSION

As of 2016, the CHYA had been an active policy and yet California has reached its highest peak in STIs and continued to denote sexual health disparities among adolescents (California Department of Public Health, 2019). It has been reported that a number of school districts do not implement CSE—let alone any type of health course—which is a disservice to adolescents of their own health rights (Center for Disease Control and Prevention, 2019; United Nations, 2013). UNESCO (2018) describes CSE as promotion of respectful and healthy sexual behavior that brings positive health outcomes throughout an individual’s lifetime. While policy option 2 is an excellent way in introducing sexual health concepts early, it would be much harder to sustain due to a lack of funding and the controversial issues that may arise. For these reasons, adopting policy option 1 into the CHYA framework is critical in pushing the seriousness of CSE. Through the MBG, the number of students receiving CSE in schools will increase. Student’s that receive CSE will feel empowered to communicate about sexual health with their parents and partners and make healthy decisions about their sexual and reproductive health.

The increase in accountability to the MBG is the best option in ameliorating the devastating health statistics among adolescents. Due to the substantial economic cost of adverse sexual health outcomes, this approach is

the most cost-effective. Implementing CSE to students will save billions of dollars in public expenditures (Guttmacher Institute, 2019a), and can be allocated to other student investments or other major public health concerns. With a projected outcome of an increased proportion of school districts implementing CSE, CSE can enhance disease control and prevention and truly make a difference in community health.

Strengths and Limitations

Since the CHYA is a new policy, this research brings recognition in whether the mandate has been influential in mitigating STIs, unintended pregnancies, unhealthy relationships, and sexual violence. Conducting a policy analysis on the CHYA helped in understanding adolescent vulnerability, and the underlying systemic issues that prevent minority adolescents from adequate education and health care. The results of this research will raise awareness on the CHYA, while influencing other public health professionals on the importance of investing in adolescent education to ultimately reduce disparities among LGB youth and people of color. Moreover, this policy analysis may lead to an enhancement of the current policy based on the presented novel solutions.

The results of this policy analysis should be interpreted in the context of its limitations. As noted by Ghimire (2004), policy analysis is distinct based on the socio-economic status of a country. Unlike in developing countries where extensive discussions and consultations occur, developed nations, such as the US, rarely employ such practices and there remain little to no evaluation

procedures for policies and alternatives, with little feedback from target audience. As such, identifying alternates to replace or enhance a policy can be subjective and conducting an exhaustive list of alternates for the CHYA is well beyond the scope of this project. Likewise, as further highlighted by Ghimire (2004), context plays a critical role in critical evaluation of alternatives and can be impacted by timing, affected parties, etc. These factors can all lead to subjective interpretation of policy options presented in this analysis and thus, additional options remain to be evaluated.

Recommendations for Research and Practice

Further research is needed on comprehensive quantitative evaluation of whether CHYA have been effective in reducing STIs, unintended pregnancy, TDV, and sexual violence, as well as increase sexual health knowledge. Further characterizations of such changes by socio-economic and demographic stratifications are needed. Cost-benefit analysis of the recommended policy option(s) is further needed.

The results of this analysis are indicative of a lack of implementation of CSE. While some school districts are implementing the CHYA, it is important for school districts to require some type of health course to ensure all adolescents have an opportunity to receive adequate information to build competence in navigating their sexual health. Additionally, the conversation of sex should also be provided at home if the circumstances are ideal. With a lack of implementation in schools, and the disproportion of health outcomes affecting LGB youth and

young people of color, it would be ideal for adolescents to learn about sexual health and healthy relationships first-hand from their families (Ashcraft & Murray, 2017). Regardless of where the information is addressed, adolescents will gain an understanding of how to protect and navigate their sexual and reproductive health.

Conclusion

In conclusion, the CHYA serves as an investment for an adolescent's future. It is a child's right to understand sexual health and the necessary information to make informed decisions regarding their health. When provided with CSE in school, young people are immediately equipped with sexual health knowledge and skills that can protect and improve their quality of life. However, the results of this analysis demonstrate that several school districts are not putting the CHYA into practice (Center for Disease Control and Prevention, 2019). Due to the budget challenges that teachers currently face, there is an essential need for financial support to fully comply with the CSE mandate. By increasing the accountability to the existing MBG, it will improve overall implementation among school districts across the state. This funding will provide the necessary means to successfully deliver CSE in the classroom. Moreover, the projected outcomes of this approach positively influence the direction of STIs, unintended pregnancies, unhealthy relationships, sexual violence, and public expenditures. Ultimately, the allocated fiscal support and additional accountability

will aid in CSE sustainability to continue helping adolescent's lead healthy lives for years to come.

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