Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

	05/02/2023
_____	_____
Angie Joanna Nunez Rodriguez	Date

Black Mexican Matters: History, Human Rights, & Health Education for Adolescents in Houston, Texas: A Special Studies Project

By
Angie Joanna Nunez Rodriguez
MPH
Hubert Department of Global Health

A. Cornelius Baker, BA
Advisor

Black Mexican Matters: History, Human Rights, & Health Education for Adolescents in Houston, Texas: A Special Studies Project

By

Angie Joanna Nunez Rodriguez, BA
Bachelor of Arts in Anthropology and Sociology
The University of Texas at Austin
2020

Thesis Advisor: A. Cornelius Baker, BA

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2023

Abstract

Black Mexican Matters: History, Human Rights, & Health Education for Adolescents in Houston, Texas: A Special Studies Project

By Angie Joanna Nunez Rodriguez

STIs are extremely common under the age of 25 since youth are more likely to be sexually active and engage in unprotected sex (CDC, 2020; Texas Children's Hospital, 2023). Adolescents (aged 15-24) account for approximately 25 percent of the sexually active population in the country, "but account for half of the 20 million new [STI] cases" each year (Texas DSHS, 2020). The U.S. has higher rates of sexually transmitted infections (STIs) and adolescent pregnancy than most developed countries, and the burden of sexual reproductive health (SRH) inequity is experienced more by racial, ethnic, and gender minorities (like transgender and non-binary persons). Furthermore, African American and Latin American youth living in counties along the U.S.-Mexico border have the highest rates of STIs and unintended pregnancy in the state (Hubach et al., 2022). To address this problem, school education, health services, legislation, and social norms need to be reformed with a human rights perspective that does not disregard or harm any person. Moreover, the U.S. and Mexico share a long and painful history colonialism, cultural, religious and political theories of white supremacy, and legal, economic and social systemic racism that has disproportionately affected the health and prosperity of Black and Indigenous people on both sides of the Rio Grande. Therefore, this thesis focuses on Black Mexicans, especially in Texas, which was once Mexico, then an independent republic (1836-1846), and is now the most diverse, and second largest, state in the U.S. The first objective is to present the contributions and needs of a traditionally overlooked population with a positive human rights perspective. The second objective is to deliver a comprehensive, medically accurate and culturally congruent SRH eBook curriculum for Houston adolescents. The subsequent research and deliverable (Chapter 3) are designed with a Social Ecological Reproductive Justice (SERJ) model, and the pure intention to help young people facilitate meaningful and productive discussions about their autonomy, anatomy, sexuality, safety, fertility, and family planning rights. The goal is to promote informed decision making (IDM), all-inclusive SRH access, the eradication of all forms of violence, and, ultimately, the global protection of all underrepresented and underserved populations, in and outside, of the African diaspora.

Black Mexican Matters: History, Human Rights, & Health Education for Adolescents in Houston, Texas: A Special Studies Project

By

Angie Joanna Nunez Rodriguez, BA
Bachelor of Arts in Anthropology and Sociology
The University of Texas at Austin
2020

Thesis Advisor: A. Cornelius Baker, BA

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2023

Acknowledgements

To the people who supported me and the completion of this project, thank you.

Table of Contents

Introduction and Literature Review

Statement of the Problem

According to the Centers for Disease Control and Prevention (CDC), adolescents account for approximately 25 percent of the sexually active population in the country, "but account for half of the 20 million new [STI] cases" each year (2020). The United States (U.S.) has higher rates of sexually transmitted infections (STIs) and adolescent pregnancy than most developed countries, and the burden of sexual reproductive health (SRH) inequity is experienced more by racial, ethnic, gender, and sexual minority populations. In fact, African American and Latin American youth living in counties along the U.S.-Mexico border have the highest rates of STIs and unintended pregnancy (Hubach et al., 2022). Sex is a normal part of human life; therefore, STIs affect everyone and are extremely common, especially persons under 25 since adolescents and young adults are more likely to be sexually active and engage in unprotected sex (CDC, 2020; Texas Children's Hospital, 2023). The most common STIs in Texas, and the U.S., are chlamydia and gonorrhea (Texas Department of State Health Services, 2020; CDC, 2021). When left untreated, chlamydia and gonorrhea infections lead to long-term health concerns, including infertility and blindness in newborn babies (Texas Department of State Services, 2020). Since 2010, chlamydia and gonorrhea rates have increased by 31% and 80%, respectively, affecting all genders, and most prevalent among 15–24-year-olds (Texas Department of State Health Services, 2020). Currently, access to SRH is increasingly limited due to transphobic and anti-abortion legislations like TX SB14 and TX SB8. To address this major public health crisis, SRH education, services, and policies need to be reformed from a human rights perspective.

In addition to poor SRH access and service delivery, the U.S. and Mexico share a long and painful history of colonialism, white supremacy (i.e., the parent of colorism, skin-tone based

discrimination) and structural racism[1]. These historical institutions have disproportionately affected the health and prosperity of Black and Indigenous people on both sides of the Rio Grande. Therefore, this thesis focuses on Black Mexicans, with specific attention on families living in Texas, which was once Mexico, then an independent republic (1836-1846), and is currently the most diverse and second largest state in the U.S.

The first objective is to present the historical contributions and public health needs of a traditionally overlooked population (Black Mexicans) with a human rights and health equity perspective. The second objective is to deliver a comprehensive and culturally congruent SRH eBook for adolescents in Houston, Texas. The SRH curriculum also includes key information of neglected history relevant to various groups of the African diaspora, especially those in the southern regions of the U.S. and Mexico. The subsequent research and deliverable are designed with a Social-Ecological Reproductive Justice[2] (SERJ) model, and the pure intention to help young people facilitate meaningful and productive discussions about autonomy, anatomy, sexuality, safety, fertility, and family planning. This thesis promotes informed decision making, SRH services use, the eradication of structural racism and all other forms of violence, and, ultimately, the global empowerment of underrepresented and underserved populations in and outside the African diaspora.

[1] Structural racism, or "the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems…that in turn reinforce discriminatory beliefs, values, and distribution of resources,' reflected in history, culture, and interconnected institutions", is a recent topic of discussion in the field of public health documented in the 19th century by social epidemiologist, W.E.B. DuBois, and has been a concern to Indigenous people for the "past 600 years" (Wien et al., 2023).

[2] SisterSong, Inc., the largest national multi-ethnic reproductive justice collective, coined and defined reproductive justice as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" in 1994.

History of the Problem

According to Cuban historians, the last consignment of "ebony merchandise" landed in April 1873, and was sent to the Juraguá sugar mill in south Cuba (Rodríguez Mitchell and Pérez Rojas, 2015). Excluding the number of Africans that arrived autonomously before and after these periods, for almost 400 years the transatlantic slave trade brought millions of Africans to the Americas (Rodríguez Mitchell and Pérez Rojas, 2015). On November 8th, 1519, Spanish colonizer, Hernan Cortés, walked the streets of Tenochtitlan for the first time, and along came his army, including Juan Sedeño, Spanish soldier, and Juan Cortés (Figure 1), the first African slave in present-day Mexico (Vaughn, 2016), according to Spanish archaeological records (Gallaga Murrieta and Vera, 2013).

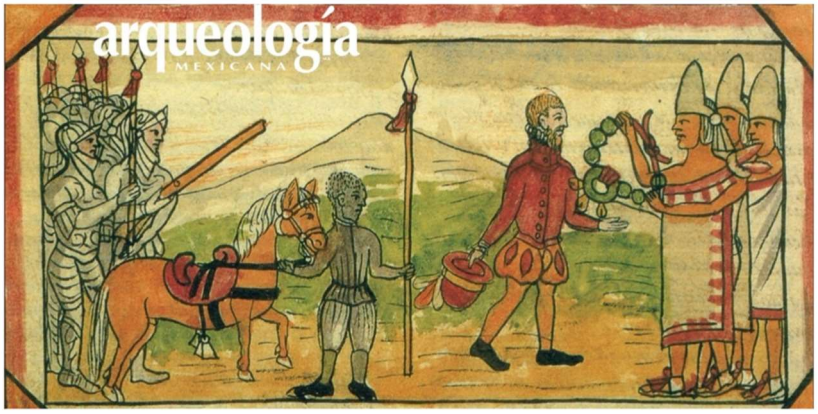


Figure 1. Juan Cortés, left center, was perceived as a god by Indigenous people because he was a dark-skinned person. Juan Cortés was likely not part of bozales (i.e., vessels of unchristianized men, women, and children stolen directly from Africa for slave labor in the Americas) like most after 1519, when King Carlos V issued mass asientos, or contracts between the crown and private slave owners, including other European nations (Vaughn, 2016). Instead, it is understood that he was taken from Africa, then transported to Sevilla, where learned Spanish and was christianized (Vaughn, 2016).

Image available on the Internet and published in "La arqueología y el pasado afromexicano" by Emiliano Gallaga Murrieta and Tiesler Vera in *Arqueología Mexicana*, Núm. 119, pp. 24-27, 2013.

Between 1519 and 1640, approximately 90% of the Indigenous population died due to multiannual epidemics, including smallpox (1520), measles (1531), typhus (1545) and hemorrhagic fever (1576) transported by Europeans; and it is estimated that hemorrhagic fever alone killed 2 million persons (Vaughn, 2023). Thus, the immoral trade of African slaves was

used to birth Spanish America (Mexico), especially since Europeans rarely immigrated to the colony before 1810 (Vaughn, 2016). The Spanish quickly joined forces with Portugal to expedite the transatlantic slave trade with nations like Great Britain, France, and the Netherlands. In 1619, when a Portuguese vessel, "The White Lion" brought the first recorded African slaves to the English American Colony of Virginia, more than half a million people were already slaves in Portuguese America (Brazil), and African slaves in Spanish America had already outnumbered Europeans in 1570 by three to one, by two to five in 1646, and continued to do so in 1742 (The Colonial Williamsburg Foundation, 2023; Vaugh, 2016). Today, the descendants of these African slaves are 2% of Mexico's population. According to the census data collected in the 2020 (Figure 2), there are 2,576,213 Black Mexicans, meaning two Black persons for every 100 persons living in the country (Aguilar Rangel, 2022).

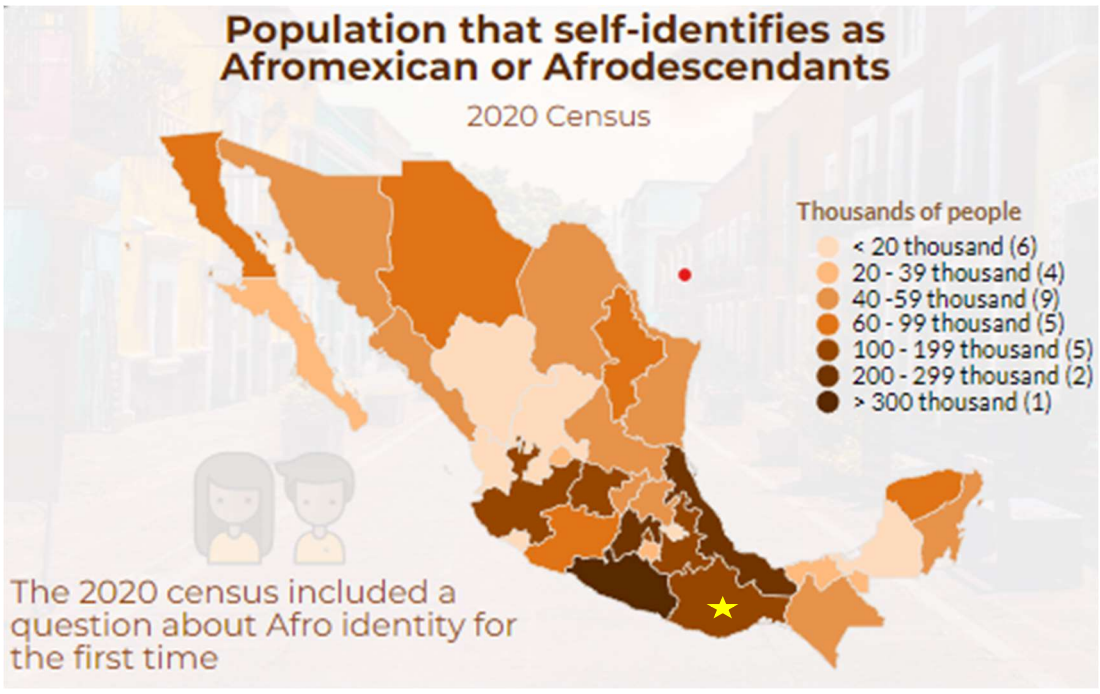


Figure 2. A map showing the geographical location of the Black Mexican population as of 2020. More than half of the population is concentrated in the South. When slavery was abolished by President Vicente Ramón Guerrero (1782-1831) on September 16th, 1829, emancipation was granted to slaves nationwide, except in the Isthmus of Tehuantepec region of Oaxaca (starred).
Infographic available on the Internet by Jazmín Aguilar Rangel for Mexico Institute, 2022.

In 1821, Moses Austin (1761-1821), an empresario and slave owner from Connecticut, was the first person to secure an asiento, or contract, from the Spanish government that protected colonists' property rights, including the possession of humans, in Spanish America. He planned to bring colonist from Louisiana (annexed by the U.S. on April 30, 1812) to establish the first Anglo American settlement in present-day Texas. He died before this could happen. As his dying wish, he pleaded his son and heir, Stephen Fuller Austin (known as "the father of [Anglo-American] Texas") to fulfill his colonizer dream. Following independence from Spain (1810-1821), in 1824, Mexico passed the General Colonization Law to attract colonial immigrants and promote economic growth as a new nation (Gracy, 2023). Between 1830 and 1836, the most significant empresarios and landowners were Lorenzo de Zavala (Mexican and later Tejano, or Hispanic Texan) and Stephen Fuller Austin (Secretaría de la Defensa Nacional del Gobierno de Mexico, 2019). Hence, why they lead the Texas Revolution (1835-1836) against the regime of Antonio López de Santa Anna (1794-1876), dictator of Mexico at the time. On August 30th, 1836, the city of Houston was founded six months after Texas declared its independence from Mexico (Gracy, 2023). The founders were brothers Augustus and John Allen,

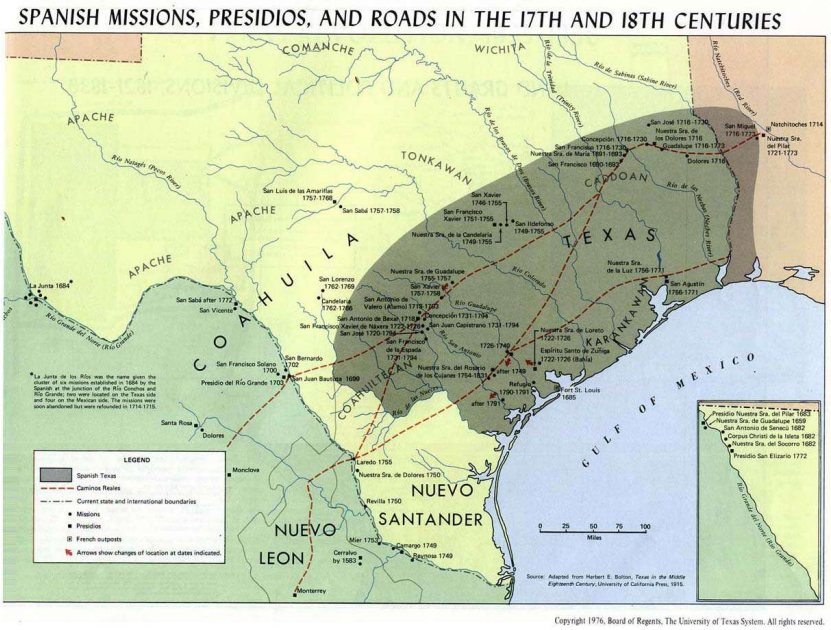


Image of Spanish Texas available on the Internet and included in accordance with Title 17 U.S.C. Section 107.

who purchased 6,642 acres City of Houston, 2023; Greater Houston Partnership, 2023). For reference, the purchasing power of $1 in 1836 is $32.46 today (Official Inflation Data, 2023).

Today, Houston is home to 2,264,876 persons (World Population Review, 2023). The city, built on the land of various Indigenous nations, is the largest metropolis in the state and the Southern U.S., the fourth largest in the country, and the sixth-most populous in North America (United States Census Bureau, 2023). In 2020, census workers recorded 2, 300,027 Houstonians, "spanning over 672 miles [with] a population density of 3,538 persons per square mile" (World Population Review, 2023; United States Census Bureau, 2022). According to the largest chamber of commerce in Greater Houston (Houston–The Woodlands–Sugar Land), "Houston's birth coincided with Texas' battle for independence as the new town struggles to create and identity" (Greater Houston Partnership, 2023). A recent study ranked Houston 10th on a list of large U.S. cities with increasing ethnic diversity (McCann, 2023). The racial composition of the city is 25% white, 22.8% Black, 6.7% Asian, 1.3% mixed, and the largest ethnic group is Hispanic (44.5%) (Statistical Atlas, 2023). The racial breakdown among Hispanics is 74.9% white, 1% Black, 1.7% mixed, and 21.8% other (Statistical Atlas, 2023). Furthermore, researchers found that Harris County (most of Houston) is where more immigrant families live in extreme poverty compared to U.S.-born families (Sanborn et al. 2023). Additionally, the Environmental Integrity Project discovered that five industrial companies in Harris County are responsible for 45 of the 119 "excessive" emissions occurrences reported to the Texas Commission on Environmental Quality between September 2016 and August 2022 (Zuvanich, 2023). Increased public and governmental understanding of environmental protection issues is required since poor air quality has serious health implications, including infertility and interrupted development in children and young adults (Gatimel et al., 2017). It is important to highlight that environmental justice

literature has documented disproportionate residential hazard exposures based on disadvantaged race, ethnicity, and gender status (such as among households headed by women). Until recently, no published studies investigating disproportionate environmental health risks based on minority sexual orientation existed. To close this gap, Collins et al. examined the spatial relationships between same-sex partner households and cumulative cancer risk from exposure to hazardous air pollutants (HAPs) emitted by all ambient emission sources in Greater Houston using data from the U.S. Census, American Community Survey, and Environmental Protection Agency at the 2010 census tract level (2017). Neighborhoods with a high percentage of gay men families had a significantly higher risk of cancer-causing HAP exposure, whereas those with high percentages of gay women families have a significantly lower risk (Collins et al., 2023). These findings imply that health concerns linked to harmful exposures to air toxics in Houston exacerbate pre-existing comorbidities and health equity for LGBTQ+ populations, including children and young adults, is critical and a public health priority. children and young adults, is critical and a public health priority.

> "We had a young lady come in who had abnormal bleeding, and we wanted to prescribe contraception to help control that bleeding. And we couldn't do it because she was 16. The patient had said her mother would not understand, believing that her daughter was 'going to go out and have sex and she just didn't want to go there'." —Carolena Cogdill, CEO of Haven Health, commenting on family health laws in Texas, 2023. (Varney, 2023).

Like environmental health, SRH in Texas is heavily limited and urgently needed. On June 16th, 2021, the state adopted an "opt-in" policy, meaning that by "default children will not learn about sexual health, puberty and reproduction, unless parents" authorize schools to do so (SEX ED FOR SOCIAL CHANGE (SIECUS), 2021; Varney, 2023). The U.S. Department of Health and Human Services reports a nationwide decline in teen birth rates since 2007 (Hamilton, 2020). According to CDC statistics, however, Texas consistently ranks among the top

ten states with the highest rate of teen births, with “22.4 teen births per 1000 females aged 15 to 19 compared to Vermont's rate of 7 per 1000 and California's rate of 11” (CDC WONDER, 2019). In 2022, Texas updated its abstinence-first curriculum to include information on STIs and contraceptives, but failed to include instructions on consent, sexuality, gender, and LGBTQ+ topics, reflecting the social, cultural and political attitudes of a government that continuously bans trans youth healthcare and more books that any other state (Lopez, 2022). Access to SRH and education has significantly decreased as a result of the COVID-19 pandemic (SIECUS, 2021; Varney, 2023). Due to concerns about teaching sex education in a virtual environment, some districts, “including those that were improving their sex education curriculum,” reported stopping all sex education programming (SIECUS, 2021). Nonetheless, activists claim that online education and advocacy have made progress in the advancement of more comprehensive SRH curriculums (SIECUS, 2021). Accordingly, improved, medically accurate, and accessible education about barrier methods and contraceptives is the solution to mitigate high rates of STIs, adolescent pregnancy, and unintended parenthood.

Methods

This special studies project uses a Social-Ecological Reproductive Justice (SERJ) methodological framework and includes written and visual data from peer-review articles, books, archives, newspapers, digitized maps, social media (Instagram) traffic, and participant observations. SERJ combines the four-level Social-Ecological Model, which considers the multifaceted links between (1) individual, (2) relationship, (3) community and (4) societal factors in violence prevention (CDC, 2022), and the Reproductive Justice Framework, which consists of three human rights: “[1]the right to have a child, [2] the right to not have a child, and [3] the right

to parent a child or children in safe and healthy environments" (SisterLove, Inc., 1994). The SRH curriculum (eBook) was created on Canva.

Deliverable

See Appendix.

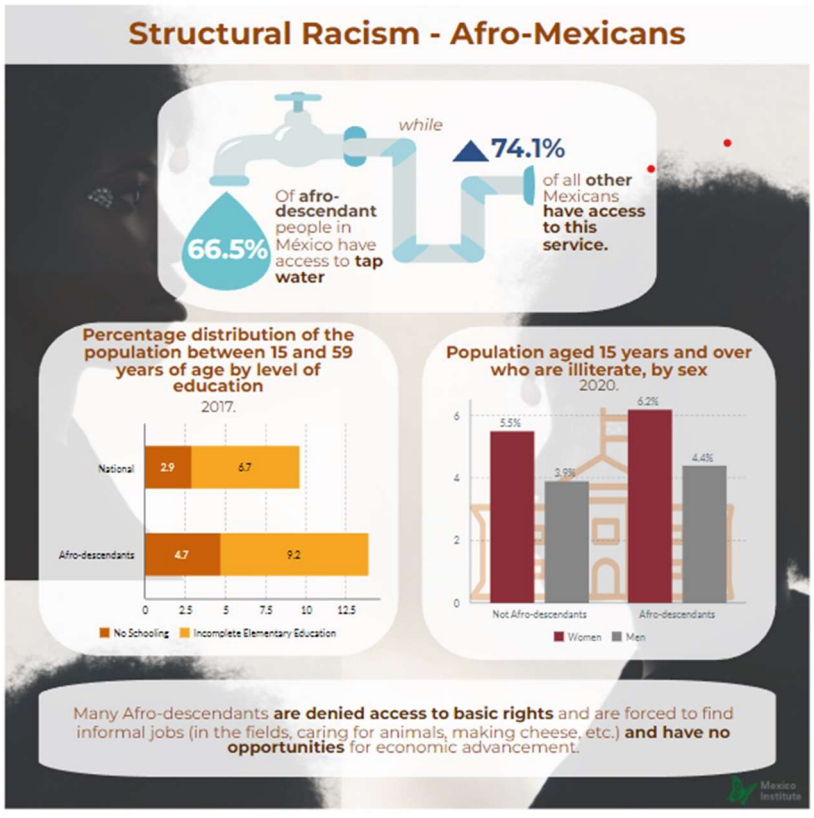
Discussion

For 366 years, European colonizers traded, transported, sold, and enslaved nearly 12.5 million African people, and approximately 11 million survived and reached the Americas (The Colonial Williamsburg Foundation, 2023). Almost 70% of them worked on plantations that produced sugar, rum, molasses, coffee, cacao, cotton, and other byproducts (The Colonial Williamsburg Foundation, 2023). Profits from the transatlantic slave trade at the expense of Africans and their descendants allowed for the establishment of economic and political expansion in the Americas, Europe, and Asia, whose trade of local and international goods with colonial port cities (like Liverpool (U.K.) and New Port (U.S.)) helped European traders generate "capital to sustain the trade of African captives" (The Colonial Williamsburg Foundation, 2023). These profits and slavery-generated products, including products like art, food, and culture, continue to fund modern-day capitalism, which directly impacts population health and the management of public health systems globally.

The World Health Organization (WHO) defines public health as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society" (Acheson, 1988; WHO). The Centers for Disease Control and Prevention Foundation (CDC) says it is "the science of protecting and improving people's and communities' health by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and responding to infectious diseases" (citation). With similar rhetoric, the American

Public Health Association (APHA), the primary membership organization for public health professionals in the United States (U.S.), states the discipline "promotes and protects the health of people and the communities where they live, learn, work, and play". Formal definitions differ within the field, and yet, ultimately, the authority of international organizations and historical events have informed disease prevention, scientific advancements, and healthcare in and outside the U.S.

On June 25th, 1945, for instance, the United Nations (UN) was officially signed into existence during World War II (1939-1945) via a "111-article Charter adopted unanimously", after the Yalta Conference on February 11th, when U.S. President Roosevelt, British Prime Minister Churchill and Russian Premier Joseph Stalin agreed to "a general international organization to maintain peace and security" (United Nations, n.d.). The UN was originally composed of 50 countries; and, on October 15th, 1945, Poland became the 51st member (United Nations, n.d.). In 2015, the UN, whose motto is "peace, dignity and equality on a healthy planet", funded the Sustainable Development Goals (SDGs), a common agenda in public health studies, with the objective "to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity" (United Nations Development Programme, 2023). The SDGs are "(1) no



Infographic available on the Internet by Jazmín Aguilar Rangel for Mexico Institute, 2022.

poverty, (2) zero hunger, (3) good health and well-being, (4) quality education, (5) gender equality, (6) clean water and sanitation, (7) affordable and clean energy, (8) decent work and economic growth, (9) industry, innovation and infrastructure, (10) reduced inequalities, (11) sustainable cities and communities, (12) responsible consumption and production, (13) climate action [to limit global warming], (14) life below water, (15) life on land, (16) peace, justice and strong institutions, [and] (17) partnerships for the goals" (United Nations Development Programme, 2023). The same year the UN published the SDGs, around 736 million people lived on less than $1.90 per day, many without food, safe drinking water, and sanitation facilities (United Nations Development Programme, 2023). Since then, progress has been slow in regions like South Asia and Sub-Saharan Africa, which are home to 80 percent of people living in extreme poverty (United Nations Development Programme, 2023). It is worth noting that, globally, women, and other gender minorities, are more likely than men to be impoverished since they are allocated less paid work, education, and property ownership.

In addition to poverty, violence, and climate change, the COVID-19 pandemic has increased health insecurity and decreased economic growth that disproportionately marginalized and medically underserved populations worldwide. Also, it is possible to draw the conclusion that "no progress has been made" toward universal access to quality care based on data from the national reports on SDGs in the 10 nations with the greatest absolute number of maternal fatalities (Kurjak et al., 2022; Hammonds and Ooms, 2014). The UN's SDGs are a recent approach to address complex public health issues, but history confirms that robust interventions were dire and necessary long before 2015, especially the 16th goal, which I would revise as "peace, justice and strong, equitable institutions" to protect the human rights of all people and health of the most marginalized parts of the world. Still, with all the available literature on global

health disparities, grassroots efforts like the Black Lives Matter and Black Indigenous Liberation Movements, and given that the outbreak of World War II, which the UN considers a primary reason for its inception (United Nations, n.d..), was led by European instability, Nazi Germany and Adolf Hitler, who in 1923, consumed by Aryanism (i.e., white supremacy), wrote that a mostly European war would yield "the extermination of the Jewish race in Germany" (Mađerek 2017), it difficult to rationalize why "ending white supremacy and structural racism" is not *at least* the 18th SDG, if not an addendum to goal number three.

While the history of white supremacy and structural racism, of course, does not begin nor end with the Jewish Holocaust, it does begin in Europe with detail origins in Germany. In 1776, the same year the thirteen British colonies settled in North America declared independence, Johann Friedrich Blumenbach (1752-1840), a German naturalist, physician and anthropologist declared the skull of a "Georgian female" from the Caucasus Mountains the "most handsome and becoming" (Bhopal 2007). Although Blumenbach expressed "abolitionist ideas [at the time] and believed in the 'unity of humanity (including equal potential)'" (Bhopal 2007), he created and continuously revised a "scientific" model that ranked and "identified five varieties of humans relating to five geographical regions" (Bhopal 2007) as: "Caucasian, the 'white' race; Mongolian, the 'yellow' race; Malayan, the 'brown' race, Ethiopian, the 'black' race, and American, the 'red' race" (Williams 2016). Blumenbach placed his self-made and self-assigned racial category at the top based on personal ideas about beauty and intelligence and his studies of comparative human anatomy. Like other white supremacists in science at the time, the "father of physical anthropology" was inspired by Carolus Linnaeus, a Swedish botanist, zoologist, and physician, known as "the father of modern taxonomy", and his book "Systema Naturae" (1735), in which he "proposed a classification of humankind into four distinct races: Europaeus

albesc[ens], Americanus rubesc[ens], Asiaticus fuscus, Africanus nigr[iculus]" (Muller-Wille 2015). Alas, Europeans make themselves white and begin using phrenology, the pseudoscientific study of cranium morphology to predict mental capacity, to justify slavery and human experimentations, such as the Tuskegee Syphilis Study (1932) by the United States Public Health Services (USPHS) that resulted killed 128 Black men from syphilis or related complications, infected 40 women, and 19 children (Equal Justice Initiative, 2020).

Almost 100 years prior, James Marion Sims (1813-1883), a physician, now dubbed "the father of modern gynecology", "practiced" and "perfected" vesicovaginal fistula surgical techniques on Black women slaves in his backyard hospital in Montgomery, Alabama (Grant, 2006; Wall, 2006). In 1845, Sims was "summoned" by a plantation owner (Grant, 2006) who was concerned with the health of his profits because post-partum women who developed a vesicovaginal fistula—a dire pregnancy complication that results from injury to pelvic soft tissues during obstructed labor where the fetus usually dies of asphyxiation—were causing a decrease in plantation production. Available records do not name all the women Sims practiced and experimented on, but it is known that at least 30 surgeries on a young woman named Anarcha were performed without anesthesia (Zhang, 2018) when ether and chloroform were introduced in the 1840s (Brown, 2017). Sims had no experience with sexual reproductive health care (Grant, 2006); and, he had never touched a patient's genitalia because at the time it was not socially acceptable for doctors to do so until he treated Anarcha and the other women (Grant, 2006). Today, debates in support of and against Sims' ethics persist among obstetrics and gynecology (OBGYN) scholars (Wall, 2006). Regardless, Black and Indigenous women are three to four times more likely than white women to experience a pregnancy-related death (López et al., 2021). While there are numerous solutions to address these gaps, the main one is to

increase the diversity of medical professionals in the field because studies show that patient-physician racial-ethnic concordance is related to higher levels of patient trust and satisfaction (Lopez et al., 2021).

The year Sims died, Francis Galton (1822-1911) (English), geographer and statistician, created the term ‘‘eugenics’’ to mean “the science of improving racial stock” (Aubert-Marson, 2009). Galton was the cousin of Charles Darwin (1809-1882), who “argued that race was an inaccurate concept” (Basil L., n.d.) and genocide an “even graver evil than slavery—as a progressive force in human evolution” (Weikart, 2022). Galton was heavily influenced by his cousin’s evolutionary theory of “survival of the fittest” and used Darwinian analogies to promote “getting rid of its [society’s] ‘undesirables’ while multiplying its [society’s] ‘desirables’” (Kevles, 2000). Almost immediately, social and political leaders adopted eugenics by means of scholarship and policy, and various other forms of governmental intervention (e.g., state-sponsored discrimination, forced sterilization, and genocide) at a time when the science of genetics was not even slightly understood (Kevles, 2000).

In 1926, the U.S. was a world leader in eugenics and ethnic cleansing, the systematic sterilization, removal and killing of ethnically (i.e., culturally) racialized groups (e.g., Jews, Italians, Mexicans, African Americans, etc.) by a more powerful group with the intent of making a society “racially” homogeneous, and thus, allegedly, “better”, “whiter”, and “purer”. Nearly seventeen years prior to the Jewish Holocaust, in the border town of El Paso, Texas, USPHS opened “bath houses” as disinfecting stations explicitly designed for “dirty lousey destitute Mexicans” (Dorado Romo, 2005).

> “Hundreds [of] dirty lousey [sic] destitute Mexicans arriving at El Paso daily will undoubtedly bring and spread typhus unless a quarantine is placed at once. The City of El Paso backed by its medical board and state federal and militia officials feel that the

> government should put on a quarantine."—Telegram from El Paso Mayor Tom Lea to the U.S. Surgeon General, 1916.
>
> ***
>
> "It is the high birth rate that makes Mexican peon (pee-on) immigration such a menace. Peons multiply like rabbits."—Letter from Charles Goethe, a prominent American eugenist, to Harry Laughlin, director of the Eugenics Record Office, 1935.

The chambers used toxic fumigants, including gasoline, kerosene, sulfuric acid, DDT (an insect pesticide) and, after 1929, they began using Zyklon-B (hydrocyanic acid)—the same gas used in the Holocaust death camps (Dorado Romo, 2005). After learning about the U.S. treatment of Mexicans and praising their use of Zyklon-B, Gerhard Peters, a Nazi and German chemist, wrote an article in a pest science journal that encouraged its use in Germany's own desinfektionskammern, or disinfection chambers, providing the blueprint of El Paso's chambers as evidence and inspiration (Dorado Romo, 2005). Peters later became director of Degesch, Inc, which supplied Zyklon-B to the Nazi concentration camps. This history is well hidden, and yet it remains blatantly relevant to current public health programming, study recruitment methods, and health disparities, and especially south of the Bible Belt and along the U.S.-Mexico border. Evidence shows that white and non-Hispanic people are overrepresented in clinical trials, as it was the case during the early SARS-CoV-2 vaccine clinical trials and the 2009 pandemic H1N1 vaccination clinical trials (Khalil et al., 2022). Clinical research, however, must include participants that accurately represent the composition of the general population, especially when findings suggest that underrepresented racial, ethnic, and gender minorities are at higher risks of morbidity and mortality and may respond differently to some drugs and vaccines (Khalil et al., 2022). These complex inequalities must be resolved with multifaceted methods, regulations, and educational initiatives rooted in human rights and health equity. This is especially important at a time when politicians in states like Mississippi and Louisiana are leading the backwards race to

re-instate Jim Crow legislature like House Bill 1020 and blood purity laws to undermine the Black population and violate their civil right (e.g., voting).

Public Health Implications

For 247 years, the U.S. has been shaped by perspectives from systems and institutions of power created by predominantly white European actors with racist tendencies and a distorted understanding of human genetic variation. According to the World Health Organization (WHO), the maternal mortality ratio[3] (MMR) is an "indicator of the overall health of a population, of the status of women in society, and of the functioning of the health system" (WHO, 2006). In the U.S, the National Vital Statistics System (NVSS) has periodically experienced coding, publication, and data release changes that limit the accurate collection and dissemination of information on maternal deaths[4] (Hoyert and Miniño, 2020). While experts say data of maternal mortality and morbidity "should rely on population-based studies which are non-existent" (Kurjak et al., 2022), it is well documented that the U.S. has the greatest maternal mortality rate of any developed country (World Population review, 2023; Hoyert, 2023).

In 2021, the MMR for (non-Hispanic) Black women was 69.9 deaths per 100,000 live births, 2.6 times the rate for (non-Hispanic) white women (26.6) (Hoyert, 2023). Black women's rates were much higher than white and (non-Black) Hispanic women's rates, and increases were high for all race and Hispanic-origin groups from 2020 to 2021 (Hoyert, 2023). Black and Indigenous people in the U.S. are two to four times more likely to die due to pregnancy-related complications than their white counterparts, and this has been true for at least sixty years (CRR,

[3] The maternal mortality ratio (MMR) is defined as "the number of maternal deaths during a given time period per 100,000 live births during the same time period" (WHO, 2023).

[4] The WHO defines a maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (WHO, 2009; Hoyert, 2022).

2011; MHTF, 2018). Currently, Louisiana's MMR of 58.1 deaths per 100,000 births is the highest in the country, followed by Georgia (48.4), Indiana (43.6), New Jersey (38.1), Arkansas (37.5), Alabama (36.4), Missouri (34.6), Texas (34.5), South Carolina (27.9), and Arizona (27.3) (World Population Review, 2023).

Moreover, the common overmedicalization of pregnancy and childbirth is another leading culprit of high MMR. Cesarean deliveries, or c-sections, are the most common operations performed and the number one surgery undergone by women in the U.S. Like any other high-risk surgery, c-sections entail serious health hazards, including infection, hemorrhage, and death (Yarrow, 2019). The procedure is believed to be overperformed by medical and non-medical professionals alike. Thirty-two percent of live births in the U.S. are by c-sections, more than double the WHO's recommended range of 10 to 15 percent (Yarrow, 2019). Racial and ethnic differences in c-section deliveries have severe implications for health disparities in obstetric care, which suggests that people of color have disproportionately higher-risk cesarean rates than whites, even after controlling for socioeconomic status (Edmonds et al., 2015). Studies also show that African American, Latin American, Native American, and low-income women are less likely to have needed c-sections, but more likely to undergo unnecessary emergency c-section deliveries than non-Hispanic whites and Asians (Edmonds et al., 2015; Roth and Henley, 2012). Disparities in cesarean rates underline serious social and bioethical problems since c-sections are closely related to higher maternal deaths (Edmonds et al., 2015), and high rates of unnecessary c-sections are an indicator of low-quality SRH care (Roth and Henley 2012). However, these alarming rates can be mitigated through the careful combination of scientific evidence and transparent communication that has the potential to produce more vaginal births (Yarrow, 2019). In addition to COVID-19, the U.S. is facing a maternal mortality epidemic

because of poor SRH education, policy, and practice. To achieve national and international maternal and children's health goals, midwifery is essential. Scientific literature reports that midwifery interventions can significantly reduce maternal and newborn deaths and stillbirths by 30 to 80 percent depending on the midwives' scope of practice (Nove, et al., 2021; Hoope-Bender, et al., 2014). Hence, it is urgent to develop comprehensive and accessible midwifery training programs in the country, especially at Historically Black Colleges and Universities (HBCUs) and Hispanic Serving Institutions (HSIs) to improve the health quality of the general population.

The U.S. spends at least twice as much per capita on healthcare than every other industrialized country in the world, yet it has some of the largest disparities in SRH, including STIs, HIV/AIDS, maternal mortality and poor birth outcomes (e.g., congenital syphilis and low-birth rates) (Kim and Saada, 2013). Although the 2010 Affordable Care Act made health insurance more available to some, "millions of families still cannot afford the care they need" and deserve (Editorial Board, 2016). Lawmakers continue to attack human rights via SRH with anti-abortion legislations like TX SB8 and transphobic health bans like TX SB14. Repeatedly, politicians "[shortchange] reproductive health programs" due to personal ideas about sex and reproduction, including contraception and hormone therapy (Editorial Board 2016). As a result, health programs and clinics are closed and defunded, and the public, consequently, loses already limited access to services while SRH concerns, including childbirth, are increasingly more deadly here than in other developed countries (Kristof, 2017). Eighty years ago, the U.S. and the United Kingdom had similar MMRs (Kaplan, 2019), but a person today is five times more likely to die during pregnancy or childbirth here than in the U.K. (Kristof, 2017). While European countries like Sweden and France have made successful efforts to reduce the risk of maternal

mortality in recent decades, death rates in the U.S. have more than doubled in the last two decades (Kaplan, 2019). In fact, Texas—home to the largest medical complex on the planet—has one of the highest MMR among developed nations, with Black people dying at higher rates than any other birthing group during and after childbirth (Kristof, 2017).

In Texas, "more than a third of women don't have a single prenatal visit in the first trimester" (Kristof, 2017). The situation is particularly dire for people of color, specifically, African American, Latin American, Native American, and Southeast Asian American women, whose rates of pregnancy-related complications surpass that of other racial and ethnic groups (Smedley et al., 2008; CDC, 2018). Pregnancy-related complications include hemorrhage, pre-eclampsia, and difficulties related to various chronic diseases like asthma and obesity (CDC 2018; Roader, 2019). These populations are less likely to have access to essential SRH services like family planning, abortion, and screenings for STIs and cervical cancer compared to non-Hispanic white women (CDC, 2018). African American and Latin American women, and other vulnerable gender minorities, are less likely than other racial and ethnic groups to receive basic health services, period (Greil et al., 2011). They also account for approximately "80 percent of reported female HIV/AIDS diagnoses" (CRR, 2011) and represent about "29 percent of the nation's female population" (CRR, 2011). To make matters worse, with an MMR of 40 per 100,000, non-Hispanic Black women encounter similar rates of death to women delivering in developing countries (Kaplan 2019). The steady increase of MMR among people of color suggests that not all racial and ethnic groups benefit equally or equitably from public health advances as they should. Yet, it is possible to end this epidemic with social, cultural, and political changes that protect and keep all communities alive *and* healthy.

Conclusions

Health is at times believed to follow a general socioeconomic class ladder—meaning that the greater one's wealth, the better one's health—but racial and ethnic health differences persist even after socioeconomic factors are controlled (MacDorman and Matthews ,2011). Not even education eliminates the infant mortality rate (IMR) racial and ethnic gaps in the U.S. (Smedley et al. 2008). Blacks with college degrees, for instance, have a higher IMR than whites with less than a high school diploma (Smedley et al. 2008). Additionally, all racial minority groups contract STIs at much higher rates than whites (CRR, 2011). These differences speak to the unjust allocation of SRH services, and unacceptable health outcomes that reveal poor health policy. Hence, discrimination (e.g., homophobia, transphobia, racism, colorism, etc.) and stereotyping in public health remain legitimate research questions in need of further and accurate analysis. Although the U.S. is the most fertile publisher of high-quality scientific research and one of the most educated countries in the world, the nation's rampant racial and ethnic health disparities have remained, and grown, for far too long that immediate social, cultural and political action is needed to protect current and future generations. This country's ample amount of trained health professionals, abundant resources, and educational opportunities have always been capable of helping reverse these trends, yet more care and effort from stakeholders is needed. The following are evidence-based recommendations to improve sexual, reproductive, and overall health, especially in marginalized and medically underserved communities.

(1) Always strive to listen without judgement and improve knowledge. When engaging with others, it is important to identify and understand personal biases, strengths and weaknesses to communicate and collaborate respectfully and harmoniously. There are various types of structural biases (e.g., cognitive, unconscious or implicit, contextual,

prejudice, etc.). Addressing structural biases is essential to achieve health equity at organizational, community, and systemic levels. *Listen to Black people. Listen to Indigenous people. Listen to LGBTQ+ people. Trust them, respect them and their choices--they know their bodies better than anyone else-- and respond to their human rights and health needs without inflicting harm.*

(2) Be an agent of positive social change and know your positionality. Demonstrate reflexibility and humility regarding power, privilege, culture, and professional paradigms with genuine commitment to health equity. Take time to learn more about positionality and its impact on public health theories, methods and practices. Understanding white privilege is the first step to implement anti-racist programming and eliminate disparities. Learn why this step is key to dismantling structural racism from Dr. Diane J. Goodman, Ed.D. from the National Civil Rights Museum here.

(3) Develop a non-discriminatory, and high-quality healthcare system that: (a) supports universal Reproductive Justice, "the human right to personal bodily autonomy, have children or not have children, and parent the children we *do* have in safe and sustainable communities" (SisterSong, Inc., 1994); (b) provides *everyone* with equitable healthcare insurance that does not expire until death and includes paid parental leave for *everyone*; (c) genuinely cares about population health and is willing to serve *everyone*; (d) always practices principles of biomedical ethics, and always including autonomy, justice, beneficence, and non-maleficence. (Gain skills in applied philosophy to better understand alternative ethical arguments and different epidemiological techniques.); (e) includes research-based sexual *and* reproductive health education in all school curriculums and community learning resources; (f) guarantees access to diverse sex health educators, full

spectrum doulas, midwives, gynecologists, nutrition and lactation consultations for everyone.

(4) Learn from every child and adult who has died due to SRH inequities. Let us not forget them, take responsibility for their preventable deaths, and encourage diversity in public health to improve provider-patient relationships and healthcare delivery.

(5) Accept that: (a) there is no single person or single factor that contributes to health disparities; (b) structural racism is complex and has always existed in healthcare, medicine, and scientific research; (c) "race" is not encrypted in human DNA; "race" is a social construct with eugenic origins; and the social, cultural, and political fabrication and institutionalization of race as a "biological fact" is contextual; *racism* reproduces medical biases and high levels of morbidity and mortality for people of color; describing race as a "natural or biological" phenomenon distracts attention from addressing social determinants of health (e.g., lack of access to medical care, food deserts in poor and segregated neighborhoods, environmental racism, physically demanding low-wage jobs, and chronic illness and stress as a result of discrimination and poverty, among many others).

(6) Be willing to examine past and current problems in SRH, implement positive changes, and continue making improvements that center the needs and voices of Black, Indigenous and other racial minorities, support their lives, and help prevent their premature death. Include and work in collaboration with health activists and grassroots organizations at every stage of program planning and implementation. Develop products for patients, families, and staff to have a clear and easy way to report inequitable care, miscommunication, and disrespect.

Lastly, this dissertation is meant to prompt proactive, sustainable, and effective social and pollical reform as it pertains to SRH equity. This call-to-action contests structural racism in public health with the goal to raise global consciousness on the connections between history, human rights, and health education. Ideally, this project will help public health professionals and other stakeholders build *and* maintain healthy and trustworthy relationships with the people they serve daily. I trust my research contributions and deliverable will serve useful for SRH promotion and a more just and peaceful world for all.

References

1. Aguilar Rangel, Jazmin. 2022. “Infographic: Afrodescendants in Mexico.” https://www.wilsoncenter.org/article/infographic-afrodescendants-mexico
2. CDC. 2018. “Pregnancy Complications.” Centers for Disease Control and Prevention.
3. CDC. 2020. “Life stages populations: Adolescents and Young Adults.” Centers for Disease Control and Prevention.
4. City of Houston. 2023. “City Hall History.” https://www.houstontx.gov/abouthouston/cityhallhistory.html
5. Collins TW, Grineski SE, Morales DX. Sexual Orientation, Gender, and Environmental Injustice: Unequal Carcinogenic Air Pollution Risks in Greater Houston. Ann Am Assoc Geogr. 2017;107(1):72-92. doi: 10.1080/24694452.2016.1218270. Epub 2016 Sep 30. PMID: 29098204; PMCID: PMC5662114.
6. CRR. 2011. “Addressing Disparities in Reproductive and Sexual Health Care in the U.S.” Center for Reproductive Rights.
7. David B. Gracy, “Austin, Moses,” Handbook of Texas Online, accessed April 20, 2023, https://www.tshaonline.org/handbook/entries/austin-moses. Published by the Texas State Historical Association.
8. DOI: https://dx.doi.org/10.15620/cdc:113967
9. Dorado Romo. 2005. “Ringside Seat to a Revolution, An Underground Cultural History of El Paso and Juarez: 1893-1923.” Cinco Puntos Press.
10. Editorial Board. 2016. “America’s Shocking Maternal Deaths.” The New York Times.
11. Edmonds, J. K., Hawkins, S. S., & Cohen, B. B. 2014. “The influence of detailed maternal ethnicity on cesarean delivery: findings from the US birth certificate in the State of Massachusetts.” Birth, 41(3): 290-298.
12. Greater Houston Partnership. 2023. “Timeline.” https://www.houston.org/timeline#1830s

13. Greil, A. L., McQuillan, J., Shreffler, K. M., Johnson, K. M., & Slauson-Blevins, K. S. 2011. "Race, ethnicity and medical services for infertility: Stratified reproduction in a population-based sample of US women." Journal of Health and Social Behavior, 52(4):493-509.
14. Hamilton, B. E. (2020). State teen birth rates by race and Hispanic origin: United States, 2017–2018.
15. Hoyert DL, Miniño AM. Maternal mortality in the United States: Changes in coding, publication, and data release, 2018. National Vital Statistics Reports; vol 69 no 2. Hyattsville, MD: National Center for Health Statistics. 2020.
16. Hoyert DL. Maternal mortality rates in the United States, 2020. NCHS Health E-Stats. 2022.
17. Hubach, R. D., Zipfel, R., Muñoz, F. A., Brongiel, I., Narvarte, A., & Servin, A. E. (2022). Barriers to sexual and reproductive care among cisgender, heterosexual and LGBTQIA + adolescents in the border region: provider and adolescent perspectives. Reproductive health, 19(1), 93. https://doi.org/10.1186/s12978-022-01394-x
18. Kaplan, E. M. 2019. "Reducing Maternal Mortality." The New York Times.
19. Kim, D., & Saada, A. 2013. "The social determinants of infant mortality and birth outcomes in Western developed nations: a cross-country systematic review." International Journal of Environmental Research and Public Health, 10(6): 2296-2335.
20. Kristof, N. 2017. "If Americans Love Moms, Why Do We Let Them Die?" The New York
21. Kurjak, A., Stanojević, M. & Dudenhausen, J. (2023). Why maternal mortality in the world remains tragedy in low-income countries and shame for high-income ones: will sustainable development goals (SDG) help?. Journal of Perinatal Medicine, 51(2), 170-181. https://doi.org/10.1515/jpm-2022-0061
22. Lopez, B. 2022. "Texas has banned more books than any other state, new report shows." The Texas Tribute. https://www.texastribune.org/2022/09/19/texas-book-bans/
23. Wall L. L. (2006). The medical ethics of Dr J Marion Sims: a fresh look at the historical

record. Journal of medical ethics, 32(6), 346–350. https://doi.org/10.1136/jme.2005.012559

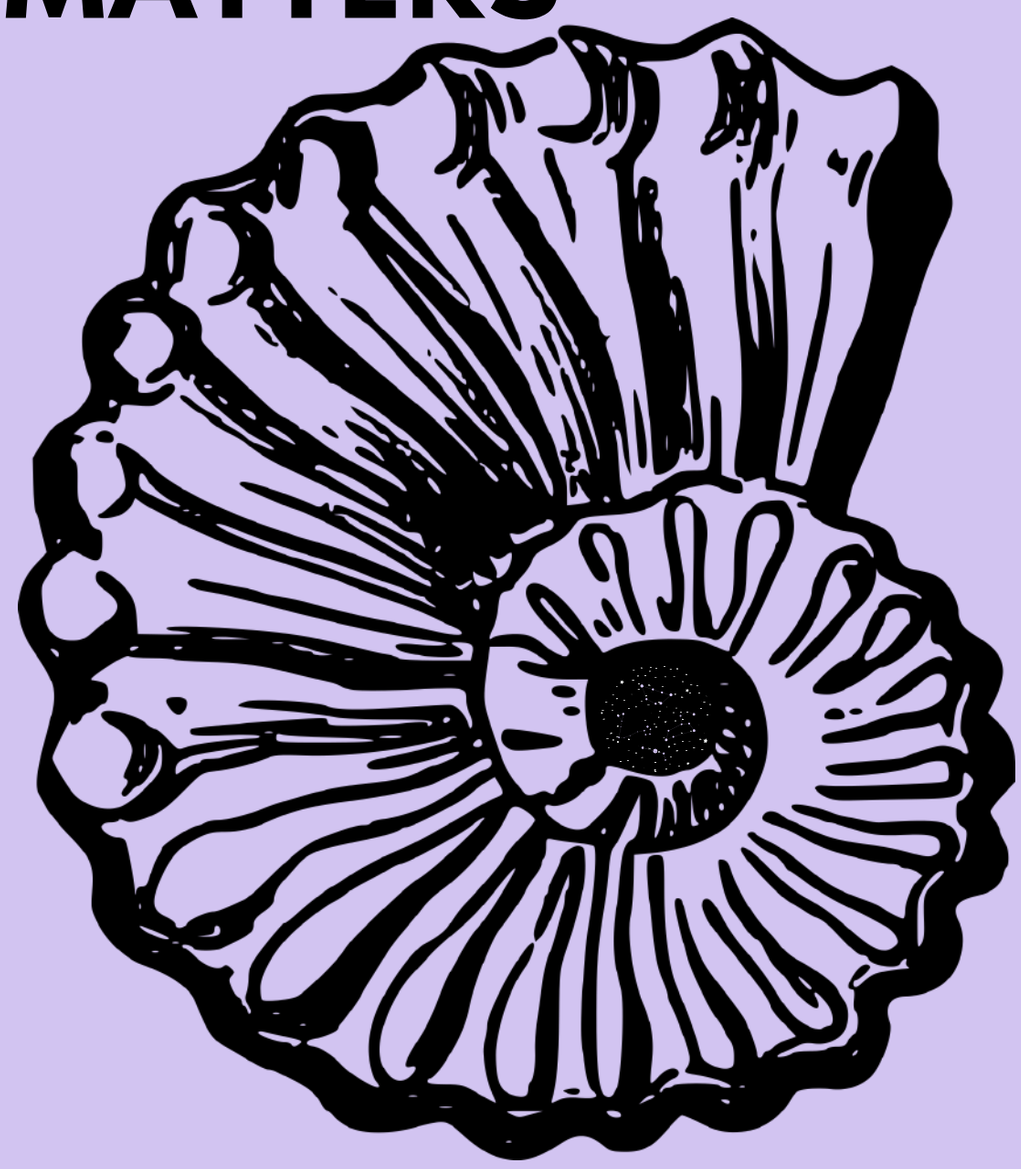
24. MacDorman, M. F., and Mathews, T. J. 2011. "Understanding racial and ethnic disparities in US infant mortality rates." CDC Stacks, MMWR 60 (Suppl):1-116.
25. Mađerek, P. (2017). War: Glory or Doom of Humankind (Doctoral dissertation, Josip Juraj Strossmayer University of Osijek. Faculty of Humanities and Social Sciences. Department of English Language and Literature).
26. McCann, A. 2023. "2023's Most & Least Ethnically Diverse Cities in the U.S." WalletHub. https://wallethub.com/edu/cities-with-the-most-and-least-ethno-racial-and-linguistic-diversity/10264
27. Roader, A. 2019. "America is failing its Black mothers." Magazine of the Harvard T.H. Chan
28. Rodriguez Mitchell. N.J. and Perez Rojas, L.M. 2015. "Festival Oaxaca Negra." Universidad Nacional Autóma de México, Coordinación de humanidades, Programa Universitario de Estudios de la Diversidad Cultural y la Interculturalidad.
29. Roth, L. M., and Henley, M. M. 2012. "Unequal motherhood: racial-ethnic and socioeconomic disparities in cesarean sections in the United States." Social Problems, 59(2): 207-227.
30. Sanborn et al. 2023. "Growing Up In Houston: Assessing the Quality of Life of Our Children." Children At Risk. https://childrenatrisk.org/guih2023/
31. School of Public Health.
32. Secretaría de la Defensa Nacional. 2019. "2 de marzo de 1836, Texas declara su independencia." https://www.gob.mx/sedena/documentos/2-de-marzo-de-1836-texas-declara-su-independencia
33. SIECUS. 2021. Texas State Profile. https://siecus.org/state_profile/texas-fy21-state-profile/#:~:text=Texas%20that%20declared%20state%20laws,%E2%80%9Copt%2Din%E2%80%9D%20policy.
34. Smedley, B., Jeffries, M., Adelman, L., & Cheng, J. 2008. "Race, racial inequality and health inequities: Separating myth from fact." Unnatural Causes.
35. Statistical Atlas. 2023. "Map of Race and Ethnicity by Neighborhood in Houston."

https://statisticalatlas.com/place/Texas/Houston/Race-and-Ethnicity

36. The Colonial Williamsburg Foundation. 2023. “Slavery and Remembrance: Middle Passage.” https://slaveryandremembrance.org/articles/article/index.cfm?id=A0032
37. Times.
38. Varney, S. 2023. “Girls in Texas could get birth control at federal clinics — until a dad sued.” NPR.
39. Vaughn, B. 2023. “Afro-Mexico: An Informational Website of Afro-Meicans of the Costa Chica by Bobby Vaughn: Historical Sketch.” https://afromexico.com/historical-sketch/
40. Wall L. L. (2006). The medical ethics of Dr J Marion Sims: a fresh look at the historical record. Journal of medical ethics, 32(6), 346–350. https://doi.org/10.1136/jme.2005.01255
41. Wien, S., Miller, A. L., & Kramer, M. R. (2023). Structural racism theory, measurement, and methods: A scoping review. Frontiers in Public Health, 11.
42. World Health Organization. International statistical classification of diseases and related health problems, 10th revision. 2008 ed. 2009
43. World Population Review. 2023.”Texas Population 2023.” https://www.google.com/search?q=word+how+to+alphatize+a+list&oq=word+how+to+alphatize+a+list&aqs=chrome..69i57.8243j0j7&sourceid=chrome&ie=UTF-8
44. Yarrow, A. 2019. “One Hospital’s Plan to Reduce C-sections: Communicate.” The New York Time

Appendix

BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS
BLACK MEXICAN MATTERS



HISTORY, HUMAN RIGHTS & HEALTH EDUCATION FOR ADOLESCENTS IN HOUSTON, TEXAS: A SPECIAL STUDIES PROJECT

EDITION I · LIBRO M ORADO

BLACK MEXICAN MATTERS

INTRODUCTION

POSITIONALITY STATEMENT:

THIS IS NOT A DISCLAIMER. IN THE SPIRIT OF SELF-AWARENESS AND REFLEXIBILITY, I SHARE THE FOLLOWING INFORMATION ABOUT ME TO IDENTIFY MY POSITIONALITY, PRIVILEGE AND INTERSECTIONALITY. I WAS BORN IN HOUSTON, TEXAS TO A BLACK MOTHER AND WHITE FATHER FROM MEXICO. I AM A YOUNG LIGHT-SKINNED PERSON WITH LIVED EXPERIENCES IN UNITED STATES, MEXICO, BELIZE, AND SOUTH AFRICA. MY PHYSICAL APPEARANCE AND SOCIAL IDENTITIES INFLUENCE HOW INDIVIDUALS, COMMUNITIES, SYSTEMS AND INSTITUTIONS APPROACH ME, INTERPRET THE MEANING AND VALUE OF MY CONTRIBUTIONS, AND ULTIMATELY, GRANT OR DENY ME HUMAN RIGHTS AND RESOURCES. CONSEQUENTLY, THESE EXPERIENCES INFLUENCE HOW I APPROACH GLOBAL HEALTH AND RESEARCH SCIENCE.

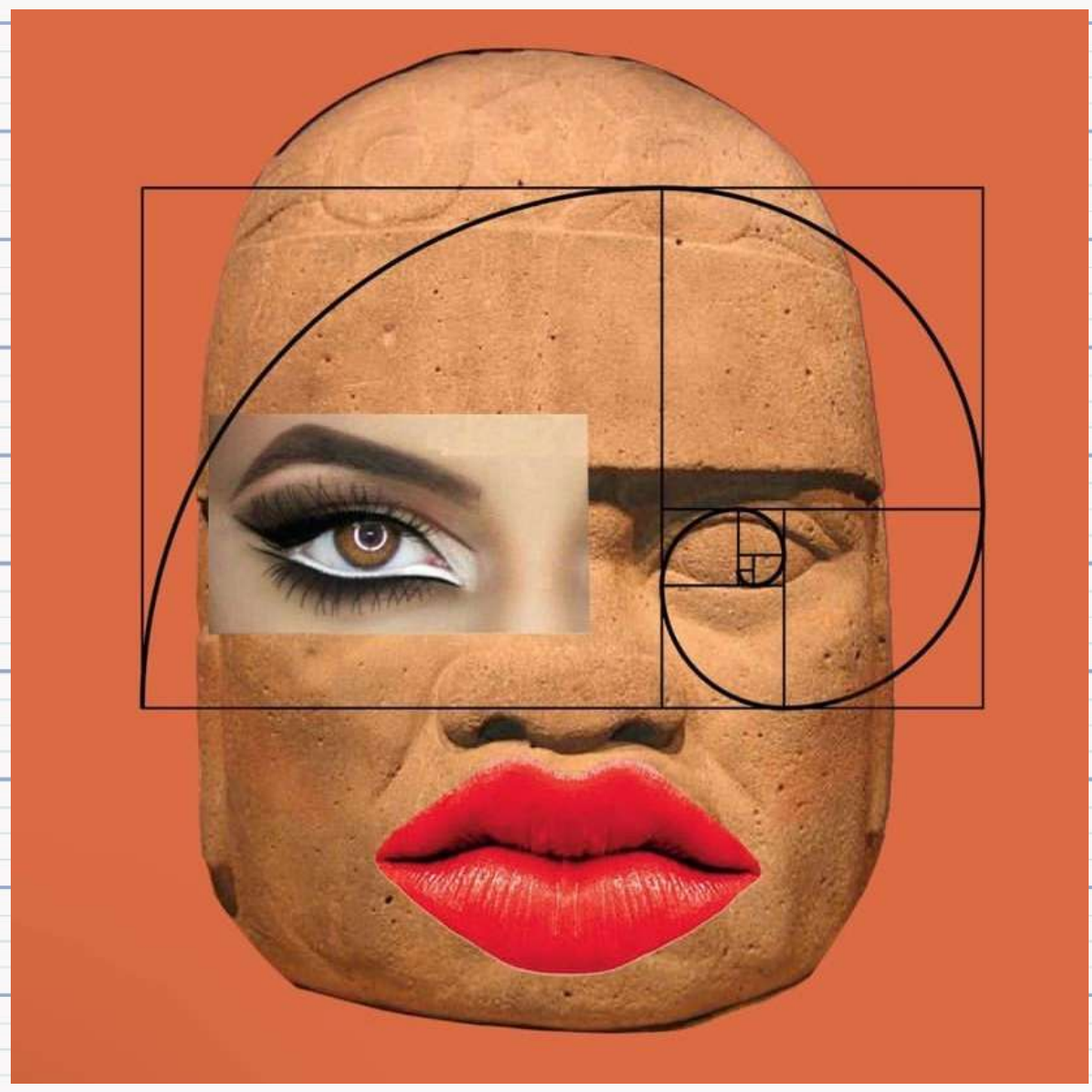
HISTORY, HUMAN RIGHTS & HEALTH EDUCATION FOR ADOLESCENTS IN HOUSTON, TEXAS:
A SPECIAL STUDIES PROJECT

1

April 20th, 2023

STATEMENT OF PURPOSE:

For sexual reproductive health (SRH) equity, collective global collaboration and reproductive justice is needed for all. This eBook is meant to deliver comprehensive, medically accurate, and culturally congruent SRH education with a human rights perspective. In it, you'll find key information about autonomy, anatomy, sexuality, and safer sex. You'll also notice key historical information about Black Mexican matters. My goal is to promote informed decision-making, SRH services use, the eradication of all forms of violence, including structural racism, and ultimately, the empowerment of underrepresented and underserved populations in and outside the African diaspora.



"Soy prieta. Soy hermosa." By: Maribela Figueroa
@diosa.prieta.mua

CONSENT IS *YOUR* PERMISSION FOR SOMETHING TO HAPPEN OR *YOUR* AGREEMENT TO DO SOMETHING. CONSENT IS A HUMAN RIGHT.

Consent is sexy.

CONSENT IS IMPORTANT FOR ALL ACTIVITIES, NOT JUST SEX. TO BE CONSENSUAL, EVERY PERSON MUST BE FREE TO ACT, FULLY CONSCIOUS, AWAKE, AWARE, AND ABLE TO CLEARLY COMMUNICATE THEIR WILLINGNESS AND PERMISSION. CONSENT IS ABOUT RESPECT.

"NEVERMIND."

"SHOULD I STOP?"

"I LIKE THAT."

"JUST CHECKING IN."

"DO I HAVE YOUR CONSENT TO...?"

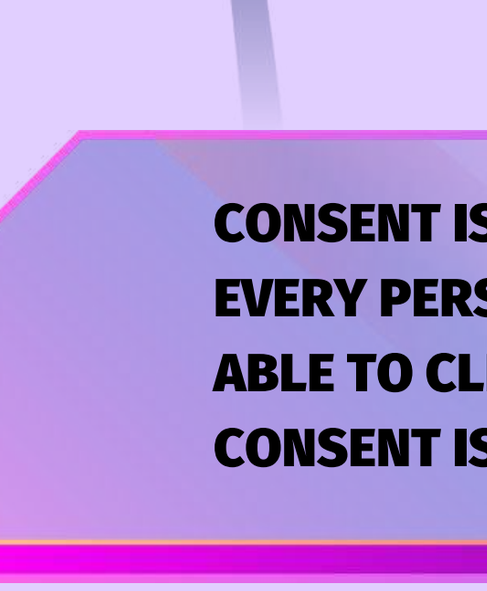
"I DON'T LIKE THAT."

"I CHANGED MY MIND."

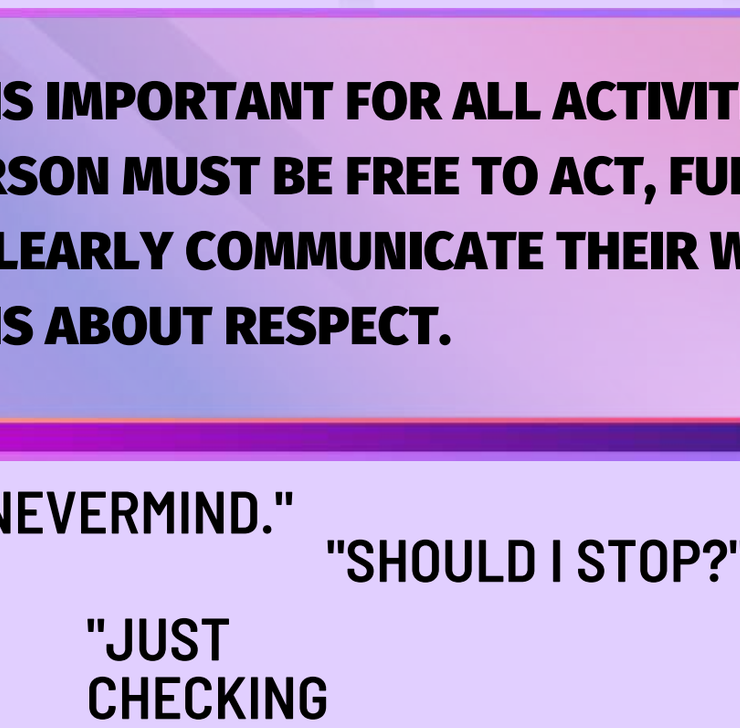
"IS IT OKAY IF I ...?"

"STOP."

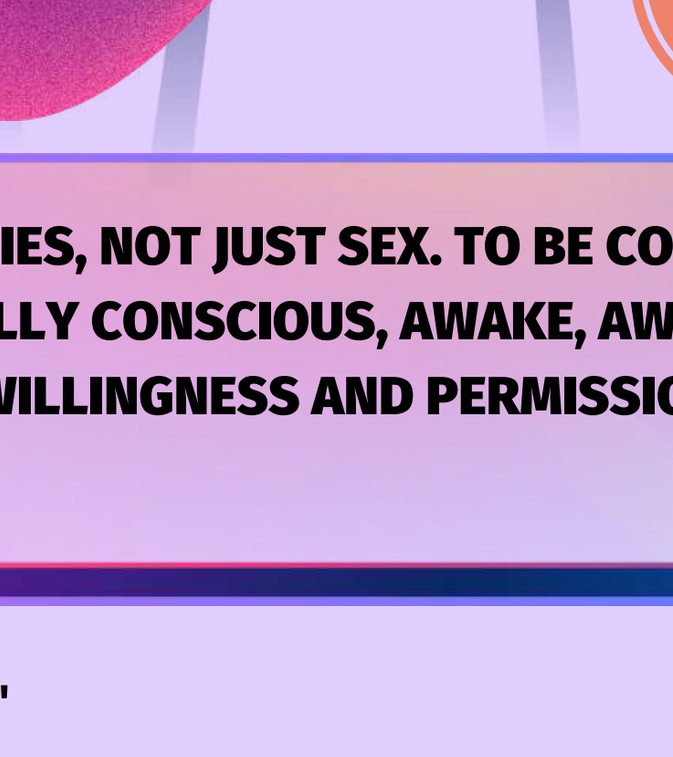
"NO."



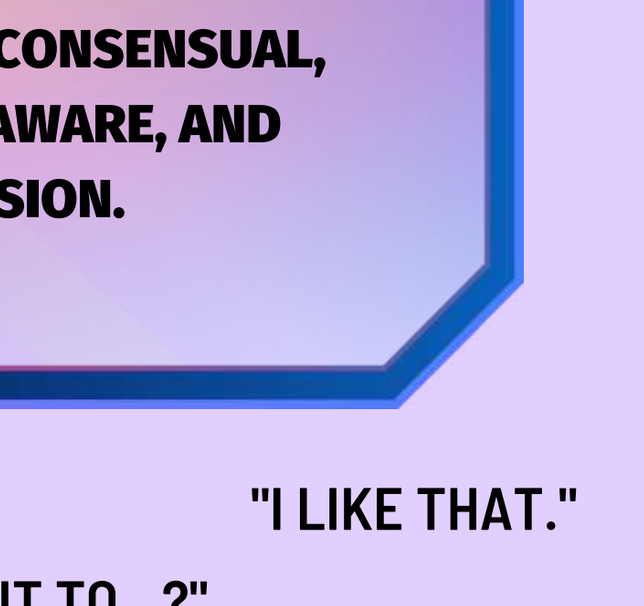
"DOES THAT FEEL GOOD?"



"IS THIS STILL OKAY?"



"YES."



"TELL ME WHAT FEELS GOOD TO YOU."

au·ton·o·my

noun

a person's right to act on their own free will

ON SEPTEMBER 16TH, 1829, PRESIDENT VICENTE RAMÓN GUERRERO (1782-1831) ABOLISHED SLAVERY IN MÉJICO. *HOWEVER*, SLAVERY CONTINUED STATES LIKE TEXAS AND OAXACA . MEXICAN TEXANS ARGUED THEIR ECONOMY WOULD CRASH WITHOUT SLAVERY AND RECEIVED AN EXEMPTION FROM THE MEXICAN GOVERNMENT. ON JANUARY 1ST, 1863, PRESIDENT ABRAHAM LINCOLN (1809-1865) ABOLISHED SLAVERY IN THE U.S., BUT AUTONOMY WAS NOT GRANTED TO SLAVES IN TEXAS UNTIL JUNE 19TH, 1865 . THIS HOLIDAY IS KNOWN AS JUNETEENTH.

3

Wikipedia Commons.

Vicente Ramón Guerrero, first Black Mexican president.

Territorial evolution of Mexico from 4 October 1824 to 8 October 1974
By User: Golbez - Own work, CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=1797539

REPRODUCTIVE JUSTICE IS THE HUMAN RIGHT TO MAINTAIN PERSONAL BODILY AUTONOMY, HAVE CHILDREN, NOT HAVE CHILDREN, AND PARENT THE CHILDREN WE HAVE IN SAFE AND SUSTAINABLE COMMUNITIES.

SisterSong, Inc. 1994.

HEALTHY AND CONSENSUAL DECISION MAKING IS IMPORTANT FOR GENERAL WELLBEING. AUTONOMY IS IMPORTANT FOR SAFER SEX. EVERY PERSON HAS THE RIGHT TO CHOOSE WHAT TO DO WITH THEIR BODY. WHEN A PERSON DECIDES FOR THEMSELVES WHAT TO DO AND WHO TO DO IT WITH, THEY ARE EXERCISING THEIR AUTONOMY.

Gender is fluid. Gender is an interaction between gender expression, gender attribution, and gender identity. As these elements of gender flow and evolve, gender changes too. (www.queersexedcc.com)

Anatomy

Handout: "Rethinking Gender" and "The Gender Unicorn"

4

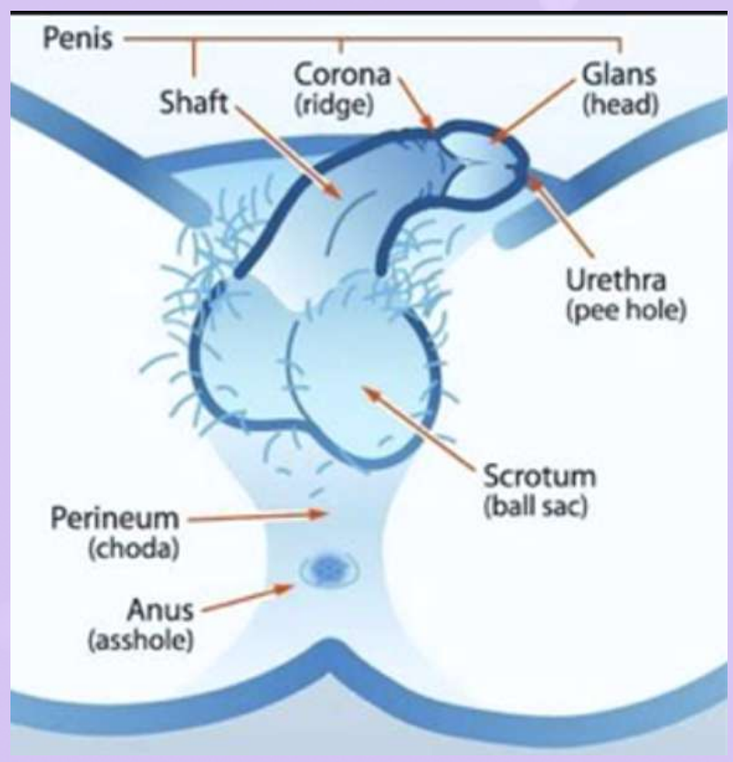
REMEMBER, EVERY BODY DIFFERENT, AND DIFFERENT IS NORMAL. SEX AND GENDER ARE SOCIAL CONSTRUCTS UNDERSTOOD AS SPECTRUMS. "MALE," "FEMALE," OR BOTH TO REFER TO SEX ASSIGNED AT BIRTH. WHEN A PERSON HAS "MALE" *AND* "FEMALE" ANATOMY, THEY ARE INTERSEX. INTERSEX TRAITS OCCUR NATURALLY, ARE NOT A DISEASE, AND DO NOT NEED TO BE "CORRECTED". AROUND 1.7% OF THE GLOBAL POPULATION IS BORN WITH INTERSEX TRAITS (AMNESTY.ORG). "IT'S STILL ALL THE SAME PARTS, JUST ORGANIZED IN A DIFFERENT WAY," (FROM EMILY NAGOSKI'S BOOK COME AS YOU ARE, P.32).

"Typical External Anatomy of People with Penises."

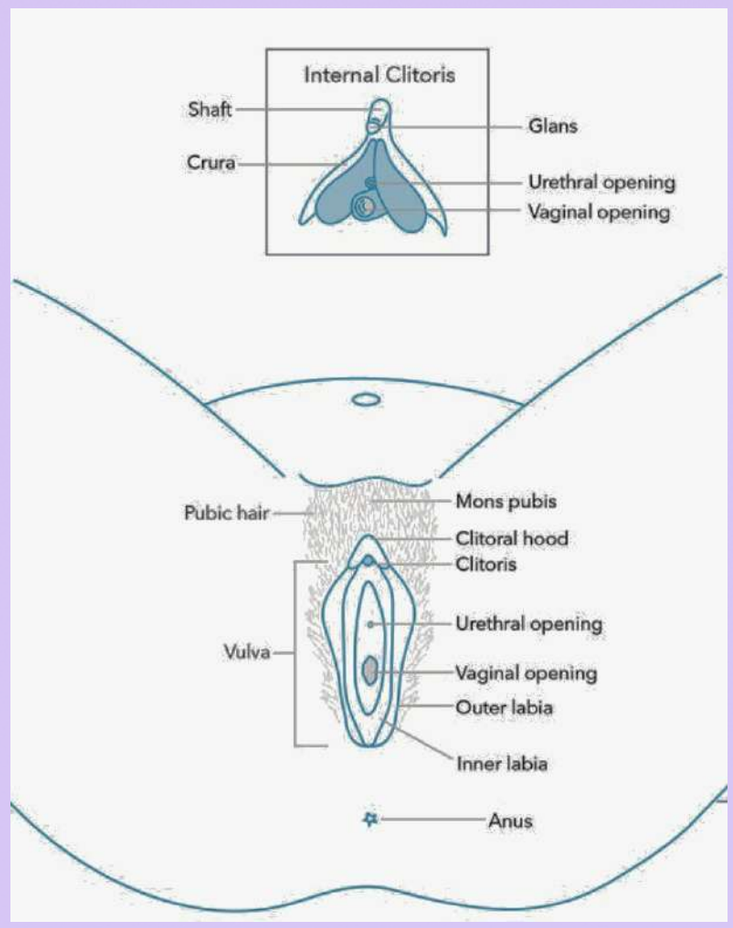
- The head of the penis: a.k.a. glans penis, the sensitive bulbous tip of the penis. In non-circumcised penises, the foreskin covers most of the head.
- The shaft of the penis: extends from the head of the penis to where it connects to the pubic area (lower belly) The urethra, where pee comes from, is inside the shaft.
- The scrotum: a.k.a. balls or ball sac, the sack that contains the testicles. Testicles make sperm and hormones.
- The perineum: the sensitive area between the anus and scrotum.
- The anus: a.k.a. asshole

"Typical External Anatomy of People with Vulvas."

- The vulva: a.k.a. mons pubis, the pubic area (blower belly) with all of the sexual organs outside of the body. Not to be confused with the vagina, which is an internal sexual organ. The vagina is discussed in Module 3.
- The clitoris: a.k.a. clit, glans, bundle of joy, the sensitive bulbous tip that sits where the tops of the labia meet. This is the only organ in the human body that is exclusively for sexual pleasure. The clitoral head and hood are outside of the body, and the rest of it extends internally. The entire clitoris is about the same size as a penis.
- The vaginal opening: the hole to the vaginal canal.
- The labia majora: literally means "large lips", the major flaps of skin that protects the vulva. Some labia majora cover the labia minora.
- The labia minora: "small lips" located inside the labia majora that potects the vagina opening.
- The hymen: a piece of tissue covering or surrounding part of the vaginal opening. Some people are born with them, others without them. Many hymens look like a donut. They stretch, but they don't break.
- The perineum: the sensitive area between the vulva and the anus.
- The anus: a.k.a. asshole



Wikipedia Commons.



Wikipedia Commons.

CHANGE THE NARRATIVE.

LOVE YOURSELF, ALL OF YOURSELF.

think outside the BOX

5

SEXUALITY IS HOW YOU SEE AND EXPRESS YOURSELF SEXUALLY. WHO YOU HAVE A CRUSH ON? WHO YOU WANNNA DATE? WHO DO YOU WANT TO HAVE SEXUAL ENCOUNTERS WITH? SEXUALITY IS ALSO A SPECTRUM. PEOPLE CHARACTERIZE THEIR SEXUAL ORIENTATION IN A VARIETY OF WAYS LIKE GAY, QUEER, FLUID, STRAIGHT, ASEXUAL, ETC. ALL SEXUALITIES ARE VALID.

"WHAT'S PLEASURE?"

"WHAT'S MASTURBATION?"

PLEASURE IS ABOUT WHAT FEELS GOOD TO YOU. MASTURBATION IS A FORM OF SELF-SEX AND PLEASURE. MASTURBATION IS TOUCHING YOUR BODY, INCLUDING SEX ORGANS. MASTURBATION IS COMMON, SAFE AND HEALTHY. IT'S A GOOD WAY TO GET TO KNOW YOUR ANATOMY AND LEARN WHAT YOU ENJOY AND DO NOT ENJOY DURING SEX.

"VIRGINITY" IS A SOCIAL CONSTRUCT. YOU DECIDE IF MASTURBATION CHANGES YOUR VIRGINITY STATUS.

MYTHS ABOUT MASTURBATION:
"MASTURBATION IS BAD."
"MASTURBATION IS ADDICTIVE."
"MASTURBATION CAUSES HARM."
"IF YOU'RE NOT SINGLE, YOU SHOULD NOT MASTURBATE."
"IF YOU MASTURBATE, YOU'RE NOT A VIRGIN."

SEXUALITY

HANDOUT: "SEXAPALOOZA"

SAY: " I AM COMMITTED TO UNDERSTANDING MY DESIRES. I AM COMMITTED TO MY WELLBEING."

OTHER BENEFITS OF SELF-PLAY:
1. INCREASE COMFORT WITH YOUR BODY
2. RELEASE TENSION AND STRESS
3. RELIEVE CRAMPS

"WHAT'S AN ORGASM?"

AN ORGASM IS YOUR BODY'S NORMAL RESPONSE TO SEXUAL AROUSAL AND STIMULATION. YOUR MUSCLES TENSE UP, AND BLOOD RUSHES TO YOUR SEX ORGANS, LIKE WHEN YOU BLUSH. THE MUSCLES IN YOUR GENITAL AREA CONTRACT TO RELEASE THE TENSION AND THE RELEASE FEELS PLEASURABLE. SEX AND ORGASMIC EXPERIENCES VARY. ORGASMS CAN BE QUIET OR LOUD, OR BOTH. IT IS IMPORTANT TO HAVE FUN AND LISTEN TO YOUR BODY DURING SEX. THE GOAL OF SEX IS NOT ALWAYS TO HAVE AN ORGASM.

"AND, HOW DO I GET ONE?"

SOME PEOPLE WITH VULVAS NEED DIRECT CLITORAL STIMULATION TO HAVE AN ORGASM, OTHERS DO NOT.

MOST PEOPLE WITH PENISES EJACULATE DURING ORGASM, MEANING THEY RELEASE A WHITEISH FLUID, A.K.A. CUM. SOME PEOPLE WITH VULVAS ALSO EJACULATE DURING ORGASM, MEANING THEY RELASE A CLEAR FUILD, A.K.A. SQUIRTING.
REMEMBER TO TAKE ANY PRESSURE OFF YOURSELF WHEN ENGAGING IN SEXUAL ACTIVITIES, ALONE AND WITH OTHERS, RELAX, EXPLORE, AND ENJOY YOUR SEXUALITY.

PREVENTION SAVES LIVES.

Safety

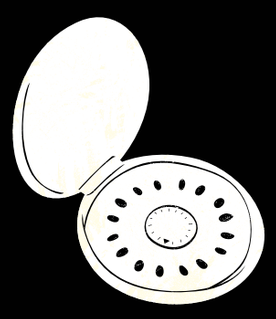
6

Handout: "CDC STI Infographic"

PREVENTION IS

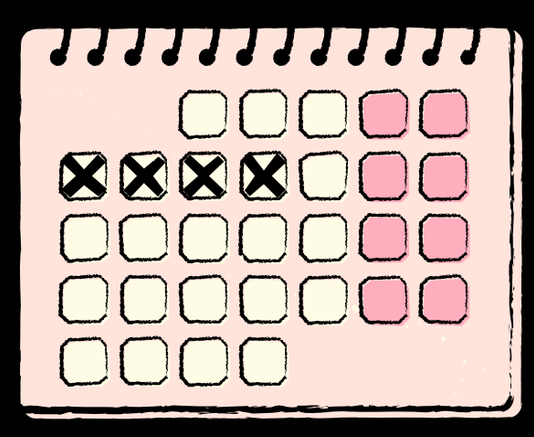
GOOD

COMMUNICATING BOUNDARIES AND LIMITS IS ESSENTIAL FOR SAFER SEX. LIMITS ARE PERSONAL GUIDELINES OR RULES ABOUT THE THINGS YOU ARE WILLING AND NOT WILLING TO DO SEXUALLY.



Examples include, but are not limited to:

1. "No sex without a barrier methods like external and internal condoms."
2. "No sex without getting tested for sexually transmitted infections (STIs) like chlamydia and syphilis, two of the most common STIs in the globe."
3. "No sex without dual protections, meaning one barrier method and one birth control method (like an external condom + the pill)."
4. "I'm not having sex with you unless we're dating each other."
5. "No sex with anyone more than "X" years older or younger than me."



PRACTICE USING "I" STATEMENTS TO EXPRESS YOURSELF.

FOR EXAMPLE, "I WANT TO HAVE SEX WITH YOU." INSTEAD OF, "DO YOU WANT TO HAVE SEX?" SINCE THIS QUESTION MAY BE MISINTERPRETED. JUST SAY WHAT YOU MEAN, AND WHAT YOU WANT.

THE SPARK METHOD

SPARK STANDS FOR:

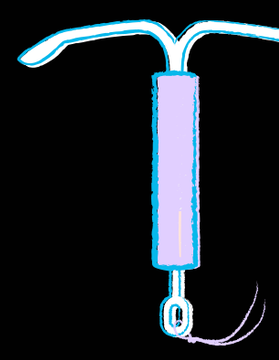
1.STAY POSITIVE

2. PRACTICE

3. APPLY A VARIETY OF STRATEGIES (VERBAL, NONVERBAL, COMICAL, SEXY)

4.RELAX AND REASSURE

5. KEEP IT IN THE MOOD



Rethinking Gender: Review of Key Terms

These terms are used by the Emory Office of Lesbian/Gay/Bisexual/Transgender Life. The language may not be inclusive of everyone, so if you have questions or feedback, please let your facilitator know. It is better to ask sincere and courteous questions about how a person identifies and what pronouns a person prefers than to make assumptions and use words that a person might be uncomfortable with.

SEX

- **Sex** - This term refers to the sex that a person is **assigned** at birth, and/or the sex that is recorded on a person's documentation such as their birth certificate or passport. A person's sex is typically assigned based on the appearance of genitalia at birth. However, a person's sex might also be determined by other characteristics such as chromosomes, hormones, and internal anatomy. Some people call the sex we're assigned at birth "biological sex." But this term doesn't fully capture the complex biological, anatomical, and chromosomal variations that can occur.
    - Here are several words to describe **assigned** sex: Intersex, Female, Male
- **Intersex**: *Intersexuality* is the term adopted by medicine during the 20th century applied to human beings whose biological sex cannot be classified as either male or female. The system of sex classification is binary and relies on hormones, chromosomes, anatomy, etc. and cannot be relied on to absolutely assign someone as male or female.
- **Assigned Female at Birth:** Sometimes abbreviated AFAB, the term "assigned female at birth" is preferred to "biological female" or "female-bodied" to describe someone who's assigned sex was female when they were born.
- **Assigned Male at Birth:** Sometimes abbreviated AMAB, the term "assigned male at birth" is preferred to "biological male" or "male-bodied" to describe someone who's assigned sex was male when they were born.

GENDER IDENTITY

- **Gender Identity** - This term refers to how a person sees and/or feels about their gender. It may or may not be congruent with their assigned sex.
    - Here are several words to describe Gender Identity: man, woman, non-binary, gender non-conforming

Additional Gender Identity Definitions:

- **Agender:** An umbrella term encompassing many different genders of people who do not have a gender and/or have a gender that they describe as neutral.
- **Transgender**: A gender identity defined by a person's assigned sex not aligning with the person's gender.
- **Trans woman**: A person assigned male at birth who identifies as a woman. Label recognizes her identity as a trans person. She may not always identify as a transwoman and may instead identify simply as a woman. Sometimes trans women identify as male-to-female (also MTF, M2F, or trans feminine). Always use the terms that someone self-identifies with.

- **Trans man**: A person assigned female at birth who identifies as a man. Label recognizes his identity as a trans person. He may not always identify as a transman and may instead identify simply as a man. Some trans men identify as female-to-male (also FTM, F2M, or trans masculine). Always use the terms that someone self-identifies with.
- **Passing**: Being perceived by others as a particular identity/gender or cisgender regardless how the individual in question identifies, e.g. passing as straight, passing as a cis woman, passing as a youth. This term has become controversial as "passing" can imply that one is not genuinely what they are passing as.
- **Gender fluid**: A changing or "fluid" gender identity.
- **Genderqueer**: A gender identity outside the societal binary of masculine/feminine or man/woman.
- **Cisgender**: A gender identity defined by a match between a person's assigned sex and assigned gender. "Cis" is a Latin term meaning "On the same side of" while "trans" means "across" or "opposite of." Cisgender is therefore used to contrast "transgender" on the gender spectrum.
- **Gender non-conforming:** A descriptive term for a person whose gender identity and/or expression does not conform to the traditional expectations of the gender binary, expectations of masculinity and femininity, or how they should identify their gender.
- **Non-binary:** Preferred umbrella term for all genders other than female/male or woman/man, used as an adjective (e.g. Jesse is a nonbinary person). Not all nonbinary people identify as trans and not all trans people identify as nonbinary. Sometimes (and increasingly), nonbinary can be used to describe the aesthetic/presentation/expression of a cisgender or transgender person.

GENDER EXPRESSION

- **Gender Expression** - This term refers to how a person presents their gender through the use of gender cues. For example, a person's gender expression might be connected to how that person chooses to dress or look, how they behave, or their speech and mannerisms.
    - Here are several words to describe Gender Expression: Masculine, Feminine, Androgynous

SEXUAL IDENTITY

- **Sexual Identity -** This term might also be used interchangeably with sexual orientation or sexuality. It refers to the emotional, romantic and/or sexual desires that one person might have for another person or other people, or who someone has an affinity for. It also might refer to a person's choice of whether or not to engage in sexual relationships and practices.
- Many cultures and societies around the world and particularly in the West, have certain expectations about what a person's sex, gender identity, gender expression and sexual identity should be. For example, a person assigned female at birth who identifies as a woman, wears feminine clothes, and is attracted to men is often considered "normal" because that person's sex, gender identity, gender expression, and sexual identity all "line up" according to that society's ideas about sex and gender.

- Being an **ally** means recognizing, accepting and supporting the idea that often a person's sex, gender identity, gender expression and sexual identity can be any combination of terms, and that these terms might shift over the course of a person's life.

Some words we use to describe Sexual Identity include:

- **Gay**: A sexual identity that typically refers to men individuals who have an affinity for other men. This term is sometimes used as an umbrella term to include all non-heterosexuals, but this is problematic given the historical and cultural context of the word. The term gay is grounded in White, male, middle-upper class society and therefore can be seen as a very exclusionary term if used to represent diverse sexual identities.
- **Asexual**: A sexual identity describing individuals who do not experience sexual attraction or do not have interest in or desire for sex. This is not the same as celibacy, which refers to a deliberate abstention from sexual activity.
- **Aromantic:** An identity describing individuals who do not experience romantic attraction or desires.
- **Pansexual**: A sexual identity characterized by the potential for aesthetic attraction, romantic love, or sexual desire for people, regardless of their gender identity, gender expression, or assigned sex. Some pansexuals suggest that gender and assigned sex are insignificant or irrelevant in determining whether they will be sexually attracted to others. For others, an individual's assigned sex, gender expression, or gender identity can be a key factor of attraction, despite the pansexual individual's wide range of attractions. The Greek prefix pan means "all" or "of everything." Omni is an English prefix meaning, "all," some people may use the words omnisexual and pansexual interchangeably.
- **Bisexual**: A sexual identity characterized by attraction to both the same gender and one or more other gender(s). Unlike pansexuality, it does not *always* specifically include people who fall outside the gender binary. While some people who identify as bisexual define the term as attraction to men and women, others might use the terms bisexual and pansexual interchangeably or to mean the same thing.
- **Lesbian**: A sexual identity that typically refers to women who have an affinity for other women.
- **Heterosexual:** A sexual identity that refers to individuals who only experience sexual and/or emotional attraction to individuals of the opposite sex.
- **Same-Gender-Loving**: A term coined for African American use by activist Cleo Manago, is a description for homosexuals, particularly in the African American community. It emerged in the early 1990s and is often used by those who prefer to distance themselves from terms that they see as associated with "white-dominated" lesbian, gay, and bisexual communities.

UMBRELLA TERMS

- **Queer**: Can describe sexual orientation and/or gender identity or gender expression that does not conform to heteronormative society. Often used as an umbrella term to encompass all of the identities we have just discussed.
- **Two-spirit:** Identity of Native Americans who fulfill one of many mixed gender roles found traditionally among many Native Americans and Canadian First Nations

indigenous groups. Traditionally the roles included wearing the clothing and performing the work of both male and female genders.

- **Fluid:** A changing or "fluid" gender or sexual identity.

IMPORTANT NOTES

Language is complicated. It is important to note a few things:

- A person's identity can be any combination of terms from each of the categories. For example, a person might be male, transgender, feminine and pansexual.
- The language that people in the LGBTQ community use to describe themselves has changed and is still changing as people become more aware of how language affects them.
- For example, not so long ago, a person's sexual orientation or identity might have been described as their "sexual preference." However, now that term is often considered offensive because it implies that who a person is or is not attracted to is a choice. The term hermaphrodite was once used to describe people who are born with sex characteristics typically associated with both maleness and femaleness. Now that term is considered medically inaccurate, and offensive, and so "intersex" is a more commonly used and appropriate term.
- Sometimes, you might hear a person self-identifying with a word that you'd always thought was an offensive word. For example, someone might self-identify as queer, a dyke, a fairy, a tranny, or a fag. To many people, these words have always been and still are offensive slang words. However, some people might choose to self-identify with one or more of these words because they want to reclaim negative language and turn it into something powerful and positive. Reclaiming negative language is the prerogative of members of marginalized groups; allies should still refrain from using words that might be heard as slurs such as dyke, fag, etc.
- In particular, the word 'queer' has recently gained widespread usage in academia, with colleges offering queer studies courses, and scholars publishing books and articles about queer theory. This has helped break down some of the taboos around the word queer, but it doesn't mean it's acceptable to be used in all circumstances as it does still have negative connotations for a lot of people.
- **A good guide:** Listen to who is using these words, when they are using them, and in what context, and follow their lead. If you're not sure if you should be using a particular word, then err on the side of caution and refrain from using it.

For more information about any of the above terminology:

TSER: https://www.transstudent.org/definitions

Asexual Visibility and Education Network (AVEN) https://asexuality.org/

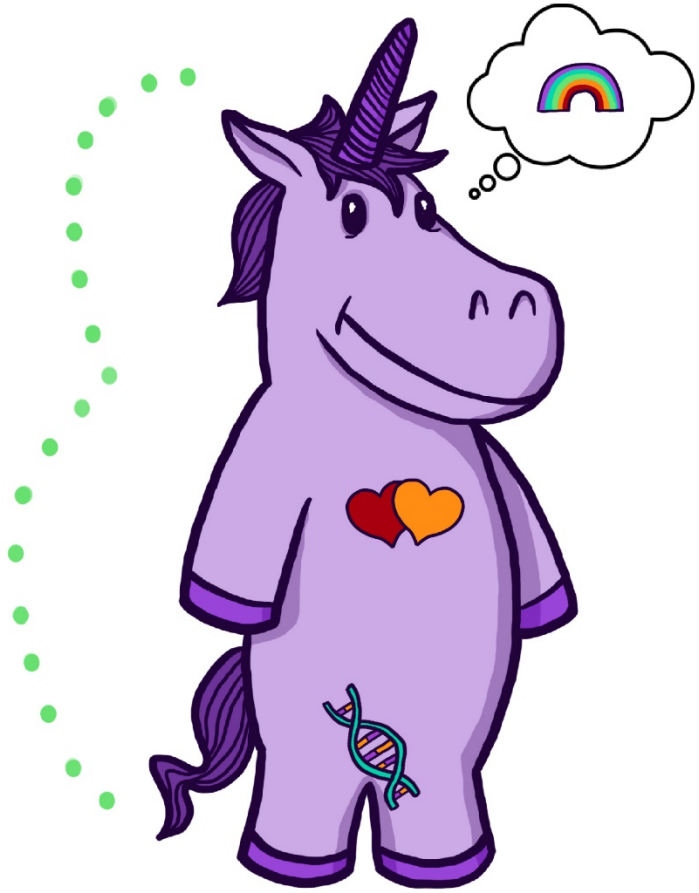
InterACT: https://interactadvocates.org/

The Trevor Project:https://www.thetrevorproject.org/trvr_support_center/glossary/

Planned Parenthood: https://www.plannedparenthood.org/learn/sexual-orientation-gender/gender-gender-identity

The Gender Unicorn

Graphic by:
TSER
Trans Student Educational Resources



Gender Identity

- Female/Woman/Girl
- Male/Man/Boy
- Other Gender(s)

Gender Expression

- Feminine
- Masculine
- Other

Sex Assigned at Birth

Female | Male | Other/Intersex

Physically Attracted to

- Women
- Men
- Other Gender(s)

Emotionally Attracted to

- Women
- Men
- Other Gender(s)

To learn more, go to:
www.transstudent.org/gender

Design by Landyn Pan and Anna Moore

We're gonna kind of make this like the hanky code. Check the circle on the left for giving / topping and the right for receiving / bottoming. If it's kind of a mutual activity, or one you do by yourself, one circle will be provided. If you can think of a way for those activities to be topped or bottomed, add a second circle because you're badass smart like that. If something doesn't apply to you and your partner(s), mark it N/A. If there's something you like to fantasize and talk dirty about, but you don't want to do it IRL, mark it FA. Remember, this worksheet is meant to be hella customized. Add shit! Mark it up! Color outside the lines. We're not the sex czars, probably we don't know everything (probably). As helpful as lists are, we can't be reduced to them, so see this for what it is—a tool, a jumping off point for conversation.

WHAT I WANT TO DO

	GIVING / TOPPING	RECEIVING / BOTTOMING
Masturbation	○	
Holding hands	○	
Kissing (please discuss where)	○	
"Necking" (kissing on the neck)	○	○
Activities that leave marks (please discuss where)	○	○
Tickling	○	○
Wrestling or "play-fighting"	○	
Massage (back, shoulders, legs)	○	○
Chest/Breast/Nipple play	○	○
Dry humping/clothed body-to-body rubbing	○	○

	GIVING / TOPPING	RECEIVING / BOTTOMING
Tribadism (scissoring, rubbing naked genitals together w/ a partner)	○	
Chest/Breast/Nipple licking/sucking	○	○
Chest/Breast/Nipple biting	○	○
Masturbating in front of a partner	○	○
Hands or fingers on penis	○	○
Hands or fingers on strap-on	○	○
Hands or fingers on testes	○	○
Hands or fingers on vulva	○	○
Fingers inside vagina	○	○
Vaginal fisting	○	○

	GIVING / TOPPING	RECEIVING / BOTTOMING
Hands or fingers on or around anus	○	○
Fingers inside rectum	○	○
Anal fisting	○	○
Ejaculating on someone's body	○	○
Ejaculating in someone's body	○	○
Using vibrators alone	○	
Using dildos alone	○	
Using masturbation sleeves alone	○	
Using vibrators with a partner	○	○
Using dildos with a partner	○	○

WHAT I WANT TO DO (CONT'D)

- Using masturbation sleeves with a partner
- Tongue or mouth on vulva
- Tongue or mouth on penis
- Tongue or mouth on strap-on
- Tongue or mouth on testes
- Tongue or mouth on anus
- Vaginal intercourse
- Anal intercourse
- Using food items as a part of sex (never inserted)
- Cross-dressing during sex
- Biting (please discuss where)
- Scratching (please discuss where)
- Blindfolding
- Restricting movement (rope bondage, bondage tape, restraints..)
- Slapping or spanking
- Pinching (please discuss where)
- Clamps (please discuss where)
- Paddles, floggers, whips, crops, canes (circle/invent yr own)
- Role playing (please discuss what/how)
- Dirty talk (please discuss what/how)
- Phone sex
- Skype sex
- Sexting (discuss appropriate phone numbers/emails)
- Reading erotica alone
- Reading erotica with/to a partner
- Watching porn alone
- Watching porn with a partner

A FEW THINGS ABOUT TOYS & LUBES

Materials/ingredients I'm sensitive or allergic to:

Materials/ingredients that turn me on:

Materials/ingredients I'm comfortable using:

Materials/ingredients that I wouldn't touch with a ten-foot pole:

Use this space to write/draw/collage/art-ify your way into what turns you on. Maybe it's something you think is "expected" or maybe it's something you think would surprise a partner. **Everything you can think of is worth including.**

WHAT TURNS ME ON

So we just used a lot of "science" terms (i.e., terms that doctors would use to describe our bodies). But we're not doctors (and if we are, we're probably not doctors in the sack. We're probably just, I dunno, giant pleasure centers with reptilian brains).

Let's talk language.

WHAT WE'RE GONNA SAY

Please refer to my gender as:

(#1)

Please refer to my genitals as:

(#2)

It's acceptable to refer to my gender as:

(but it just doesn't make me as hot as #1)

It's acceptable to refer to my genitals as:

(but it just doesn't make me as hot as #2)

Please never refer to my gender as:

Please never refer to my genitals as:

When I want you to stop, I say:

When I want you to keep going (enthusiastically), I say:

When I want to check in with you, I say:

When you want me to stop, hearing the following makes sense to me:

When you want me to keep going, hearing the following makes sense to me:

When you want to check in with me, hearing the following makes sense to me:

Fantasies are a-okay! And if you're into dirty talk, knowing each other's fantasies can be fabulous! Hell, even if you're not into it, being able to tap into what you know other parties are imagining is pretty fucking cool.

WHAT I'M GONNA THINK

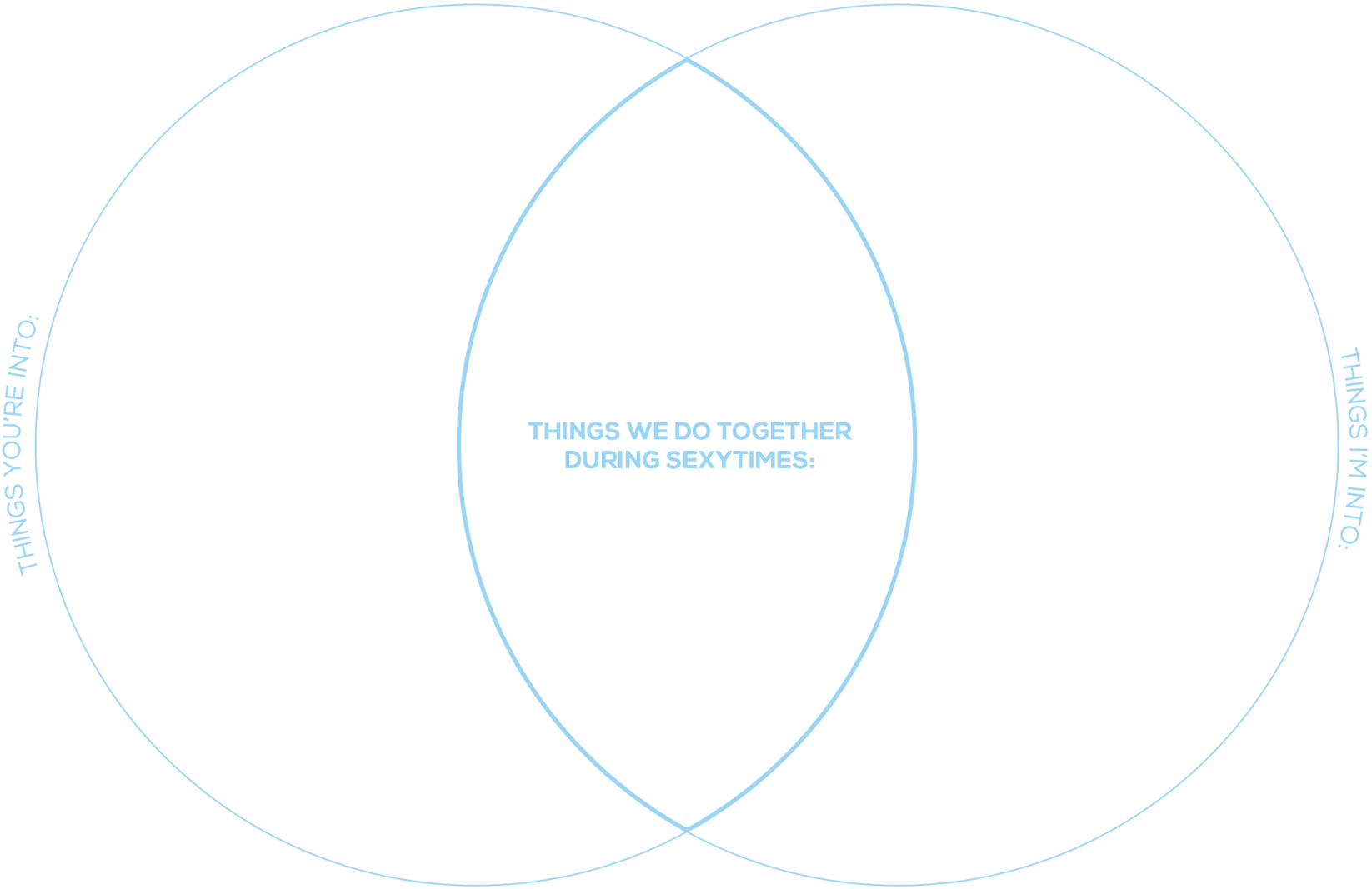
During sex, I like to image I:

During sex, I like to image you:

Using protection during oral sex		"Kiss and Tell" (talking to friends about what happens in the sack)		Orgy
Bottom			Using protection during intercourse	Top
Polyamory	STI/HIV Testing	Penetration		Power Play
	Pain		Monogamy	Fetish
Using latex gloves		"Fuck buddy"	Threesome	

WHERE I DRAW THE LINES

Draw lines through the boxes where your boundaries are and write small explanations. **What kind of lines you draw are totally up to you, as is what you write.** In blank boxes, create your own words that you'd like to draw boundaries around.



WHERE WE INTERSECT

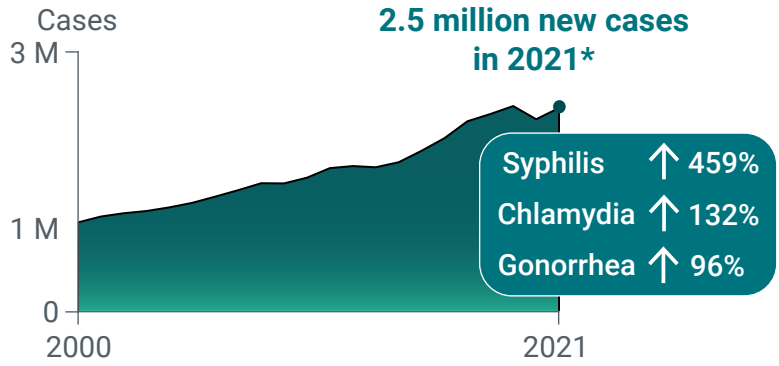
STI FACT SHEET

Reversing the Rise in STIs: Integrating Services to Address the Syndemic of STIs, HIV, Substance Use, and Viral Hepatitis

Reported cases of sexually transmitted infections (STIs) have increased dramatically in recent years. HIV, substance use, and viral hepatitis affect similar populations as STIs and each of these health concerns directly affects the others. A holistic, whole-of-society approach, including addressing social and economic barriers, is required to improve this syndemic and America's health.

STI Overview

Chlamydia, gonorrhea, and syphilis cases have been increasing for years.



People most affected by STIs include:

- Adolescents and people aged 15-24 years
- Gay, bisexual, and other men who have sex with men
- Pregnant people
- People from some racial and ethnic minority groups

STIs & HIV

STIs like chlamydia, gonorrhea, and syphilis increase the chance of getting HIV. STIs also increase the chance of transmitting HIV to others.

6%

of sexually acquired HIV infections are attributed to chlamydia, gonorrhea, and syphilis.

New HIV infections attributed to STIs are costly.

In 2018, the lifetime medical costs for 1,896 new HIV infections attributed to chlamydia, gonorrhea, and syphilis totaled:

$800 MILLION

💰 = $100 Million

www.cdc.gov/std

*Note: 2020 and 2021 data reflect the effect of COVID-19 on STD surveillance trends.

STIs & Substance Use

Use of opioids and other substances has been linked to increasing STIs and outbreaks of infectious diseases.

3x
More Likely

Young adults who used an illicit drug* in the past year were **3 times** more likely to get an STI.

STIs & Viral Hepatitis

4 in 10 **acute hepatitis B cases** in the United States are estimated to result from **sexual transmission**.

Hepatitis B is preventable with a vaccination series that can be started and completed during STI care visits.

Holistic, Coordinated Care Is Critical for Addressing These Overlapping Epidemics

A "no-wrong-door" approach – providing or connecting a person to all the services that meet their needs wherever they seek care – is crucial.

The first step in implementing this approach is **increasing access to quality healthcare settings.** STD clinics are important spaces for people who are uninsured, need flexible appointments, need low- or no-cost services, or are looking for expert and confidential services.

We must reduce the effect of social and economic conditions that can influence health outcomes - called social determinants of health - which have been documented as key contributors to negative health outcomes, including STI transmission. Strategies to reduce these conditions can include:

- **Promoting prevention and care in related systems,** including housing, education, and the justice system.
- **Providing patients with resources,** including housing, food, transportation, and employment.
- **Integrating existing programs,** such as syringe services, substance use disorder treatment programs, and HIV testing and pre-exposure prophylaxis programs in STD clinics.
- **Identifying "outside-the-box" opportunities for collaboration and integration.** New solutions could include developing partnerships with pharmacies and retail health clinics or modernizing and streamlining data systems.

GET THE FACTS ON STIs • www.cdc.gov/std

*Note: Illicit drug includes cocaine, hallucinogens, heroin, inhalers, methamphetamine, and pain relievers, sedatives, stimulants, and tranquilizers not prescribed by a doctor.