The consequences of sexual risk behavior can be prevented by your decisions, actions and choice of sexual behavior. Make a good choice today, act now, protect your health, and stay healthy.
Introduction

Sexual risk behaviors are sexual behaviors that can harm participants physically and emotionally. These behaviors predispose participants to teen pregnancy, sexually transmitted diseases (STD) which includes human immunodeficiency virus (HIV) and depression in females exposed to early sexual activity. Sexual risk behaviors (SRB) include having unprotected sex, having sex under the influence of alcohol or drugs, having multiple sexual partners and having sex before the legal age of consent (Centers for Disease Control and Prevention (CDC), 2010 & iKeepSafe, 2011 – 2013).

The Threat of Sexual Risk Behavior (SRB) to Youths

Young people are largely influenced by their peers and the media. They may not be able to appreciate that present day decisions are not only essential but, affect ones future. Hourly, 2 young Americans contract HIV, ninety- six get pregnant, and nearly 350 more contract a sexually transmitted disease. One-quarter of all new HIV infections in the United States are estimated to occur in young people under the age of 21 (National Association of Social Workers (NASW), 2001). Youths are pressured to initiate sexual relationships at earlier ages and use alcohol, cigarettes and drugs. This puts them at high risk for unintended pregnancies and sexually transmitted diseases. At their ages many of them experience a wide range of adjustment and mental health problems. They also establish behavior patterns at these ages though they aren’t fully capable of understanding the relationship between behavior and consequences, or the degree of control they have or can have over making health decision related to sexual behavior increasing their vulnerability to sexual exploitation and high risk sexual behavior (WHO, 2013a).
Epidemiology and Biostatistics of Sexual Risk Behaviors

One-third of sexually active high school students reported not using a condom in their most recent sexual intercourse in 2009 (iKeepSafe, 2011 – 2013). Approximately half of the 19 million sexually transmitted infections diagnosed annually are in youths aged 15- 24 years (CDC, 2013a & iKeepSafe, 2011 - 2013).

In 2011, among high school students that were surveyed in the United States; 47.4% were sexually active; 6% had their first sexual exposure before the age of 13; 33.7% had had intercourse in the previous 3 months of which, 39.8% did not use a condom at their last sexual exposure, 76.7% did not use hormonal contraceptives to prevent pregnancy at their last sexual exposure; and 15.3% had had 4 or more sexual partners during their life time (CDC, 2013a). In 2009, the Centers for disease control and prevention (CDC) was notified of approximately 8,300 young people aged 13–24 years infected with HIV in 40 states. In 2009, more than 400,000 teen girls aged 15–19 years gave birth (CDC, 2013a).

Impact of Sexual Risk Behavior on Public Health

According to the World Health Organization (WHO, 2009); SRB is second of the top ten risk factors in the global burden of all diseases. Twelve million Americans are infected with a STD annually. Forty-three million have viral STDs which, is incurable. “STDs costs the society more than $3.5 billion annually” (WHO, 2009). HIV/AIDS is the sixth cause of death globally. In 2004, 2 million deaths were attributable to HIV/AIDS globally. Approximately 99% of HIV infection in Africa is attributable to SRB. 22 million (67%) of the 33 million people living with HIV live in Africa. With HIV/AIDS, life expectancy at birth is 49 years in Africa. A continent
where more women than men are living with HIV or acquired immunodeficiency syndrome (AIDS) (WHO, 2009). As a result, the reproductive health of African women living with HIV/AIDS and their babies’ health can be compromised in the face of scarce resources competing with health care in Africa.

Cervical cancer is one of the major physical health risks for women engaging in SRB. Cervical cancer is attributed to sexual transmission of the human papilloma virus (HPV). Cervical cancer is responsible for 11% of deaths globally and it is the leading cause of cancer deaths in Africa (WHO, 2009). 6.2 million Americans get a new HPV infection annually (CDC fact sheet, n. d).

Another consequence of SRB is unplanned pregnancy. Lack of use and use of ineffective contraception increases the risk of unplanned pregnancy and its consequences, like unsafe abortions (WHO, 2009). In 2006, 49% of pregnancies in the United States were unintended. More than 4 of 5 pregnancies amongst women aged 19 years and younger were unintended (CDC, 2013b). Nearly half of all abortions globally are unsafe and nearly all unsafe abortions occur in developing countries (Guttmacher institute, 2012). 13% of maternal deaths are caused by unsafe abortions (WHO, 2013b). An estimated 7.4 million new cases of Trichomoniasis occurs annually. Annually, an estimated 2.8 million Americans are infected with Chlamydia. 700,000 Americans get new infections of gonorrhea annually. 45 million Americans have genital herpes. Sexually active men and women still present with syphilis infection (CDC fact sheet, n. d). The consequences of sexual risk behavior results in both physical and emotional trauma. The consequences of sexual risk behavior can be prevented by your decisions, actions and choice of sexual behavior. Make a good choice today, act now, protect your health, and stay healthy – PROJECT MAPS.
The Health Belief Model and its Application to Behavior Change

According to Diclemente, Salazar & Crosby (2013); “the health belief model (HBM) is a value expectancy model. Its primary construct predicts that behavior change will occur only when sufficient benefits remain after subtracting the costs incurred by performing the behavior”. The HBM suggests that 2 main constructs (perceived threat and expected net gain) independently influence health behavior. The construct of perceived threat is formed by 2 constructs (perceived scary stimulus/ severity and perceived vulnerability/ susceptibility) (Diclemente, Salazar & Crosby, 2013). The HBM argues that an individual will act if the individual believes that; he/she is susceptible to the disease condition (perceived susceptibility); the disease condition has serious consequences (perceived severity); acting will reduce their susceptibility to the condition or the condition’s severity (perceived benefits) and the costs of acting (perceived barriers) outweigh the benefits (NCI, 2005).

The HBM also suggests that the construct of modifying factors which includes; age, race, income, education, socioeconomic status and knowledge pertaining to the disease being questioned can exert influence on the construct of perceived threat. The construct of modifying factors may be essential in determining the perceptions held relative to the expected gain. The constructs of perceived threat and expected net gain act on the construct likelihood of action. Likelihood of action measures the degree of motivation one might have to engage in a particular health-protective behavior. The construct cues to action might be events, symptoms and reminders which prompt a desire to change one’s health. It influences the construct of perceived threat. The final construct self efficacy is confidence in one’s ability to change a particular health behavior (Diclemente et al., 2013). An individual will also act if exposed to factors that prompt action like a television advert (cues to action) and is confident in their ability to act successfully.
(self efficacy) (NCI, 2005). The HBM postulates that these 6 main constructs influence people’s decisions about acting to prevent, screen for, and control illness (NCI, 2005).

The author chose to use the HBM to educate and empower youths to prevent sexual risk behavior because it is theorized that people’s beliefs about their susceptible to a disease; and their perceptions of the benefits of preventing the disease influences their readiness to prevent it (NCI, 2005). Also according to the national cancer institute, (2005); “the HBM is a good fit for addressing problem behaviors that evoke health concerns because the 6 constructs provide a useful framework for designing behavior change”. The HBM will communicate the perceived threats sexual risk behavior poses to an individual and the society at large, the benefits of preventing sexual risk behavior and factors that might influence an individual’s decision to act. It also suggests essential constructs that might influence an individual’s decision to prevent or not to prevent sexual risk behaviors (University of California, 2012).

Review of Previous Health Promotion Programs Targeted at Changing Sexual Risk Behaviors.

The Focus Program

FOCUS is an initiative of Alabama department of public health’s (ADPH) HIV/AIDS division, Alabama department of education and Alabama campaign to prevent teen pregnancy. Its aim is to encourage youths to actively participate in preventing sexual risk behaviors. FOCUS achieves its aim by partnering with schools and the community and increasing youth participation in planning the prevention activities to prevent HIV/AIDS by reducing sexual risk behaviors in youths in the state of Alabama (The focus program, n.d). FOCUS uses the Information- Motivation- Behavior skills model to implement its program. It empowers youths with knowledge from trustworthy and reliable sources, leadership skills, and an awareness of
their values in the prevention of sexual risk behaviors. FOCUS motivates and empowers youths through; “group training; peer helping, mediation and tutoring; violence prevention; positive decision making skills; planning monthly health observances; a yearly school health fair and service learning; involving youths in WORLD AIDS day, red ribbon week, great American smoke out and others” (The focus program, n.d). The FOCUS program promotes abstinence in youths and empowers them to quit sexual risk behaviors.

The strength and success of the FOCUS program lies in its access to trustworthy and reliable information which includes ADPH’s extensive resources. The supported it receives from the FOCUS director, ADPH’s HIV/AIDS prevention coordinators to enhance HIV/AIDS prevention and meet the Alabama department of education’s minimum requirement (The focus program, n. d). Fortunately, the FOCUS program has no weakness.

Avahan AIDS Initiative

Avahan AIDS initiative (AAI) is a Bill & Melinda Gates Foundation initiative. Its objective is to prevent HIV transmission in 6 Indian states with high incidence of HIV through a comprehensive HIV prevention program. AAI offers risk reduction education programs and promotes the use of condom amongst members of the population who engage in sexual risk behaviors – female sex workers, intravenous drug users and men who have sex with men. It is also involved in condom distribution, needle/syringe exchange, social marketing and measures that build community resilience and reduce the stigma attached to HIV. AAI was implemented in 2003 and in ten years its health promotion intervention has prevented more than half of the HIV infections that would have occurred in the absence of AAI (Wong, 2013; Galavotti, Wheeler, Kuhlmann, Saggurti, Narayanan, Kiran, & Dallabetta, 2012). AAI led peer outreach and
education, treated sexually transmitted infections, referred suspected cases of HIV and tuberculosis for testing and care (Galavotti et al., 2012).

AAI used the health belief model to implement its program.

AAI’s success lies in its approach of targeting high risk groups with behavioral interventions, the huge rate of community participation, adequate provision of prevention commodities and support for programs that build community resilience (Wong, 2013).

AAI limitation is due to its partnership with local NGOs in order to implement its program. These NGOs have varying skills, experience, comfort ability and length of engagement with the high risk communities which would have resulted in exploration of different “doses” of the intervention. Other limitations to the program would have resulted from the geographic, demographic and other environmental variations across India that could have influenced both the program implemented and its likelihood of success (Galavotti et al., 2012).

All4You

The All4You program was designed to reduce the frequency of sexual risk behavior like unprotected sex amongst students in alternative high schools. The program provided sex education to students using both a classroom curriculum and service-learning activities 2 to 7 times a week (Child trends, 2012). The sex education lessons (a total of 13 and half hours) were interactive sessions which included activities like role plays, demonstration, discussions and games. It addressed HIV/AIDS, STD, and pregnancy prevention; vulnerability to HIV, STDs, and pregnancy; negotiation skills; and condom-use skills. The All4You’s service-learning component (a total of 12 and half hours) includes visits to volunteer sites, schools, senior centers, and service organizations were students participate in a variety of service activity exercises and
reflect on their service (Child trends, 2012). Students who were enrolled in the All4You program were compared to students in a control group. At 6 months follow up, All4You students reported significant prevention of sexual risk behavior by having protected sex with the use of a condom and having less frequent sex in the last 3 months (Child trends, 2012). The All4You program used the IMB skills model. Its success lies in its ability to successfully motivate students to prevent sexual risk behavior. Sadly, the limitations in the All4You program are huge. The impact of the program on students was no longer significant at 12-month or 18-month follow-up. It also did not have an impact on the number of sexual partners, pregnancies or use of effective contraception at last intercourse (Child trends, 2012). Apparently, this is because the sex education was not conducted for more than twenty-six hours.

PROJECT MAPS

Applying the Health Belief Model to Prevent Sexual Risk Behaviors among Sexually Active Youths with a Focus on Condom Use.

Project MAPS aims at using the HBM to educate, encourage and empower youth to act now and make a good choice today so as to protect their health and stay healthy.

In most societies youths are commonly found in schools. Project MAPS will partner with the state’s department of education to enable it access and implement the intervention to youths in all schools in the state. Health/ sex education classes targeted at preventing SRB will be taught to youths by project MAPS at all schools in the state. These classes will be extended to religious youth gatherings. Youths congregate at religious youth gatherings hence, quite a large number of them will be accessed there (United States Department of Health and Human Services, 2012). Youths At these classes, emphasis will be laid with statistics as evidence that youths stand a risk
of SRB and the consequences of SRB will be clearly spelt out. Youths who have being involved in SRB in the past and are living with the consequences of their actions will be invited to mentors other youths and encourage them to quit SRB and use a condom in the event that they will be involved in sexual intercourse. The target audience will be taught the correct way of using a condom. Youths will learn that they are susceptible to SRB and that its effect on their health and well being is severe. They will realize that to stay health it is essential for them to prevent SRB. They will also learn that the use of condoms is beneficial to their health and well being as it protects them against unplanned pregnancy, HIV/AIDS and other STDs. Peer mentoring, role plays and discussions will be encouraged. The construct of modifying factors like age, income, knowledge and education will be considered. Hence, condoms will be distributed to youths at these educative sessions, at clubs and parties. At every project MAPS office, youths will have access to free condoms and will be taught how to use them. Project MAPS will organize a quarterly or annual MAPS fair to reinforce the SRB prevention behaviors adopted by youths.

All these efforts summed up will increase the constructs of perceived threat, expected net gain and the construct of likelihood of action while, reducing the construct of perceived barriers in youths. The construct of cues to action will be increased by holding jingles and sessions counseling against SRB and promoting the use of condoms on radio and television stations as well as distributing flyers to youths periodically to encourage them to quit SRB and use a condom. With repeated educative sessions and the construct of cues to action the construct of self efficacy will increase in these youths.
Conclusion

Public health needs to prevent sexual risk behaviors in youths in our society because they are the future of the society. Project MAPS will team up with public health to repeatedly educate, empower and encourage youths to act now, make a good choice today, protect their health, stay healthy and secure the future of our society.
References


The focus program. (n. d.). Promoting schools and community partnerships for prevention of HIV/AIDS and other adolescent risk behaviors. Retrieved from:
http://www.thefocusprogram.com/


University of California. (2012). Theory informs the message.
Retrieved from: http://www.stdhivtraining.org/YSMT_theory.html

World Health Organization (WHO). (2013a). Adolescent behavior
Retrieved from:
http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/

Retrieved from:
http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/