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Your Critical Theory of Social Inequality

Although United States law requires all children to attend school, the 10th Amendment allows states to govern education. This means that each of the 50 states has different standards and policies. This lack of regulation is the perfect breeding ground for inequalities and inequities in our education system. One such inequity concerns sexual health education. There is no country-wide mandate for sex education, despite its relevance in our lives. Only "38 states and the District of Columbia require the provision of sex education, HIV education, or both" (Guttmacher Institute, 2025). This means that there are 12 states where sex education is not required. For those that do, many provide cis-heteronormative abstinence-only sex education that is not evidence-based, culturally appropriate, or medically accurate. The content in programs like this reinforces race, gender, class, and sexuality inequalities. This is an example of both the educational system and the medical system supporting the "Imperialist White Supremacist Heteropatriarchy," a term coined by bell hooks.

I am from New York, where only HIV/STI education is mandated, but I had the privilege to receive comprehensive sexual health education. However, I have been living in Worcester, Massachusetts, since I began my undergraduate education at Clark University in 2021. Despite its progressiveness, Massachusetts is a state that does not require schools to offer sex education. Therefore, it is not a surprise that Worcester did not offer any kind of sex education until recently. The ongoing debate in the Worcester Public Schools resulted in the implementation of the *Advocates for Youth* Rights, Respect, Responsibility curriculum in May 2021. I reference Worcester because it is the second-largest city in Massachusetts with a diverse population of

207,621 as of 2023 (United States Census Bureau, 2023). This should put the following statistics into perspective:

- In 2020, the Massachusetts teen birth rate dropped. “The teen birth rate was 20.1 births per 1,000 females age 15-19 in 2008, while in 2020 the rate was 5.9 births per 1,000 females age 15-19” (The Commonwealth of Massachusetts, 2023).
- “Between 2019 and 2020, the percentage of births to birthing people age less than 20 decreased for Hispanic and White Non-Hispanic but increased for Asian/Pacific Islander Non-Hispanic and Black Non-Hispanic. Despite this decrease, the percentage of Hispanic teen births remained over five times higher than the percentage of White Non-Hispanic teen births (Table 2, Figure 2)” (The Commonwealth of Massachusetts, 2023).
- “In 2022, in Massachusetts, 56% of chlamydia cases and 35% of gonorrhea cases were reported among adolescents and young adults aged 15-24 years” (Massachusetts Department of Public Health, 2024).
- “Adolescent and young adults aged 15–24 years newly diagnosed with HIV infection in Massachusetts during 2020 to 2022 were predominantly Hispanic/Latinx (46%) or black (non-Hispanic) (27%), assigned male at birth (85%), and US-born (65%), with an exposure mode of male-to-male sex (69%)” (Massachusetts Department of Public Health, 2024).

The lack of sexual health education for youth is extremely detrimental, especially for BIPOC communities. As seen in the statistics above, adolescent and young adult health outcomes result in racial disparities. BIPOC youth experience disproportionate rates of teen pregnancy, STIs, HIV transmission, etc. This specific phenomenon reflects the larger context of racial inequities in social institutions. Systemic racism is embedded within institutional policies.

Queer communities are also negatively affected by limited access to sex education. They similarly face high levels of health disparities due to the discrimination and harassment they face in the medical system. Homophobia and transphobia run rampant and unchecked. This results in queer people being “disproportionately likely to experience negative outcomes like STIS, sexual violence, and physical dating violence” (GLSEN, 2019). Even when queer students are taught sex-ed in schools, 81% of LGBTQ youth in Massachusetts report that LGBTQ topics are not present.

When you consider these two aspects of identity together, it becomes clear that people who are both BIPOC and queer individuals face the highest level of health disparities. This illustrates the need for intersectionality (a term coined by Kimberlé Crenshaw in 1989) when trying to understand social inequality. Intersectionality represents the way social identities overlap and result in unique combinations of privilege and oppression.

Using an intersectional lens, this form of social inequality highlights the importance of having sexual health resources in college. Based on the state of sex education in America, it can be assumed that Clark students who are from the U.S. have varying degrees of sexual health knowledge. There is also an international student population that makes up 7% of Clark’s student body, whose related knowledge is not accounted for in these statistics (Clark University, 2025/). At Clark University, I am involved in the organization Choices. Originating in 1969, Choices is a “queer-inclusive peer sexual health organization that provides on-campus access to sexual health information, resources, and supplies” (Choices, n.d.). It was the first student-run sexuality and contraceptive clinic on a college campus in the U.S.

However, I feel that Choices has not adequately served the needs of the Clark community. With a population of 3,839 students, only 26% are BIPOC (Clark University, 2025).

Clark University is a predominantly white, wealthy university, and many spaces like Choices reflect that demographic. As Choices exists within a university system that supports us, the privilege we have as a club should be translated into providing what the Clark community needs, to avoid perpetuating sexual health education inequities.

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