

**INVENTORY OF SEXUALITY EDUCATION
AND REPRODUCTIVE HEALTH RESOURCES
IN UPPER DELAWARE**

by

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A thesis submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Bachelor of Sciences in Human Services with Distinction.

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ABSTRACT

According to the Center for Disease Control and Prevention, in 2011 Delaware ranked number one in the U.S. for percentage of sexually experienced youth, number two for percentage of sexually active youth, and number three for percentage of youth with three or more sexual partners. In addition to Delaware ranking at the top of the United States for sexual activity, the U.S. ranks at the top of the industrialized world for sexual activity, teen birth rates, and sexually transmitted infections. In Delaware, sexuality education and reproductive health services are provided to youth from a variety of different sources, the most prominent of these being schools and non-profit organizations.

The present study included a literature review of global, national, and local sexuality education policies and programs, and 14 interviews with sexuality education professionals in public schools, private schools, religious schools, non-profit organizations, and state departments located in New Castle County, Delaware. The purpose of this research study was to explore these sexuality education programs, particularly focusing on the main debate between teaching abstinence-only versus comprehensive education. While comprehensive health education is required across all public schools in Delaware, private schools are not held to any specific standard. The main goals in this study included discovering the key players in sexuality education, the methods and approaches used by these institutions, and the relative effectiveness of these programs in reaching their targeted population.

Results from the literature review found wider support for comprehensive programs, particularly evidence based programs that have provided results such as delay of sexual activity, reduction of sexual partners, reduction in pregnancy and sexually transmitted diseases, and an increase in the use of condoms or other contraceptives. Among interviews with professionals, the majority (11) utilized a comprehensive approach to sexuality education, while three used an abstinence-only approach. Among many statements and suggestions, professionals talked about the importance of sexuality education to youth, the need for more communication between parents and children about sexuality, and the need for better funding and resources.

Conclusions from the literature review and interviews show that comprehensive sexuality education is both effective and more widely implemented in the state of Delaware. Suggestions to professionals include taking advantage of the resources made available to them (found in Appendix A), encouraging open communication about sexuality education between youth and parents, and considering the target population in creating or choosing an effective sexuality education program.

Chapter 1

INTRODUCTION

Although formal sexuality education has been considered controversial in many U.S. schools for decades, the research evidence consistently supports the need to do a better job of protecting our youth by providing accurate information and additional resources for making healthy decisions. The present study explores the sexuality education initiatives and programs that exist in schools and non-profit organizations across New Castle County, Delaware. The purpose was to discern what sexuality education programs are being implemented in schools and youth groups, what strategies were used, and if there have been any measures of success. In order to understand the issue of sexuality education, policies and programs involving sexuality education across Delaware, the broader regions of the United States and the rest of the world, particularly European countries were explored.

There is no doubt that Delaware youth are relatively high in sexual activity in comparison to other states. According to the Youth Risk Behavior Survey that was distributed among public high schools across the United States in 2011, Delaware ranked number one for percentage of sexually experienced youth in the nation (59%), number two for percentage of currently sexually active youth in the nation (43%), number three for percentage of youth with multiple partners (21.7%), and number four for youth who have had sex before age thirteen (8.8%) (US Department of Health and Human Services, 2012). Sexuality education has been a controversial topic in the United States. According to a study reported by Realini, Suzi, Smith & Martinez

(2010), “U.S. teen pregnancy rates decreased 38% between 1990 and 2004, and teen birth rates declined by 34% between 1991 and 2005” (p. 314). However, teen birth rates have since increased by “5% between 2005 and 2007” and the approximate number of newly diagnosed cases of HIV and AIDS has “increased 15% from 2004 to 2007” (p. 314). It is evident that the risk of sexually transmitted infections, teen birth rates, and abortions is a vital issue facing Americans today, and an apparent perennial issue as time goes on.

History of Sexuality Education Policy in the United States

There are two main types of sexuality education taught throughout the United States: abstinence-only sexuality education and comprehensive sexuality education. Abstinence-only education teaches, “sexual abstinence before marriages is the only 100% safe way to prevent sexually transmitted diseases (STD’s) and teen pregnancy, without providing information on safe-sex practices” (Gresie-Favier, 2010). In traditional abstinence-only education settings, if contraception is addressed at all, its risks and inadequacy are emphasized (i.e. its failure rates rather than effectiveness rates). Comprehensive sexuality education, also referred to as abstinence plus sexuality education, “promote[s] abstinence as the preferred option for adolescents; this policy allows contraception to be discussed as effective in protecting against unintended pregnancy and STD or HIV” (Weaver, Smith, & Kippax, 2005 p. 177). Another defining distinction of comprehensive sexuality education is, “that the best way to educate adolescents about their sexuality is by preparing them for the healthy expression of their sexuality instead of focusing only on the prevention of negative consequences” (Che, 2005). Professionals seem to agree that in comprehensive and

abstinence plus education, both abstinence and contraception are addressed, and open communication regarding sexuality is encouraged.

Although sexuality education has been addressed through various policies over the past several decades, there are still no “federal laws in the United States that require sexual health education in schools” (Weaver, Smith, & Kippax, 2005 p. 176). The policies discussed in the upcoming paragraphs are mainly guidelines that institutions need to follow in order to get funding for sexuality education. The first of these policies is the Adolescent Family Life Act (AFLA), passed in 1981. This federal initiative promoted sexual abstinence and became “a central organizing tool for subsidizing the developing abstinence- only based curricula in schools” (Weaver, Smith, & Kippax 2005 p. 177). According to the US Department of Health and Human Services (2012) the Office of Adolescent Pregnancy Program now administers AFLA and its funds support “research, care, and prevention demonstration projects.”

The next federal initiative involving sexuality education was not passed until 1996, with the development of Title V, Section 510 of the Social Security Act. Under this act, also known as the Welfare Reform Law, states can receive funding for abstinence-only sexuality education programs as long as they meet eight specific criteria, often referred to as the A-H criteria. These criteria include that abstinence-only sexuality education:

- A. Has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- B. Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
- C. Teaches that abstinence from sexual activity is the only certain way to avoid out of wedlock pregnancy, sexually transmitted diseases, and other associated health problems,

- D. Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;
- E. Teaches that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects,
- F. Teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parent, and society;
- G. Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- H. Teaches the importance of attaining self sufficiency before engaging in sexual activity (Gresle-Favier, 2010 p. 415).

Abstinence-only education became the standard for schools across the United States, and was also supported in both “presidential and public discourses” (Gresle-Favier, 2010 p. 415). Even though many schools were receiving funding for abstinence-only education through Title V, the actual curriculum and programs implemented by individual school districts varied considerably. According to Weaver et al. (2005), a survey taken at the end of the 1990s found that “69% of school districts had a policy to provide sex education, and the other 31 % left sex education policies to individual schools within the district or to individual teachers” (p. 177). In addition, of the schools surveyed, 51% taught abstinence plus curriculum (promotes abstinence but allows contraception to be discussed), and 35% were strictly abstinence-only. Another study, reported by Jeffries, Dodge, Bandiera & Reece (2010) found that even in abstinence-only funded schools, teachers provided “instruction on contraception and condoms, or vice versa” (p. 173). Jeffries et al. (2010) also found that the “vast majority of teachers believed that youth should receive accurate information about birth control and safer sex, and that the dissemination of accurate information does not encourage youth to become sexually active” (p. 180). It is

important to note that the state of Delaware has never accepted abstinence only federal funding through Title V or AFLA, mainly because of the limitations these curricula had set.

During the 2000s, scientific and medical opposition to abstinence-only education became more prevalent in the United States. With organizations such as SIECUS and Advocates for Youth providing a strong stance that comprehensive sexuality education was the most effective form of sexuality education, support for comprehensive or “abstinence plus” education grew tremendously. SIECUS was founded in 1964, as a non-profit organization whose mission states, “SIECUS affirms that sexuality is a fundamental part of being human, one that is worthy of dignity and respect. We advocate for the right of all people to accurate information, comprehensive education about sexuality, and sexual health services. SIECUS works to create a world that ensures social justice and sexual rights” (SIECUS, 2012). Advocates for Youth (2008b) was founded in 1980 and encourages the “three R’s: rights, respect and responsibility” in the field of sexuality and sexuality education. Advocates for Youth (2008a) also were the authors of a comparative research study that searched academic journals to find sexuality education programs in the United States that “worked” or were deemed successful based on a set of criteria including preventing teen pregnancy and reducing the transmission of HIV and other STDs. Professionals such as Douglas Kirby (Kirby, 2002a; Kirby, 2002b; Kirby, 2008) also began to conduct research on the effectiveness of abstinence-only versus comprehensive sexuality education at this time.

While public support for comprehensive education is more widespread in recent years, it is apparent that issues regarding sexuality have been discussed and

debated by professionals long before the turn of the century. For example, the Groves Conference on Marriage and the Family, an annual meeting of professionals in the human development and family studies field, has been debating sexuality issues since at least 1938. According to Rubin, “as early as 1938, accessibility and legality of contraception and abortion was discussed and debated” (Rubin, 2012, p. 223). Other sexuality topics addressed at the Groves Conference in later years include “a special showing of films on sexuality education” in 1947, “Influence of going steady and not going steady upon sexual behavior of boys and girls” in 1952, and “The implications of the Kinsey Research for Marriage Counselors” in 1954. (Rubin, 2012, p. 223-224). The Groves Conference exemplifies that open discussions regarding sexuality and the need for comprehensive education were debated among professionals long before its surge in popularity in recent years.

As the Title V Abstinence-only until marriage program was set to expire in 2009, the government formulated new sexuality education initiatives in which states could apply for funding. The result was three different government initiatives. The first, entitled the “President’s Teen Pregnancy Prevention Initiative,” beginning in 2010, provides “grants to public and private entities to fund medically accurate and age-appropriate programs that reduce teen pregnancy” (SIECUS, 2011). Federally funded programs included those that covered teen pregnancy, HIV and AIDS, and contraception information. This program was again funded in 2011, and the President is continuing to request funds on a yearly basis. The next program, known as the “Personal Responsibility Education Program (PREP)” will receive mandatory funding between 2010-2014 (SIECUS, 2011). PREP also supports comprehensive sexual education, requiring “information on both abstinence and contraception for the

prevention of unintended pregnancy and STIs, including HIV” (SIECUS, 2011). In its first year of funding, PREP received applications from 43 states, including Delaware. Finally, even though Title V expired in 2009, it was renewed for the time period of 2010-2014 as well. According to SIECUS (2011), these abstinence programs may be a little more flexible, but still require adherence to the eight restrictive criteria, or the “A-H definition for ‘abstinence education’” (p. 2).

Overview of Policies and Sexuality Education in Delaware

The state of Delaware does have a policy that mandates comprehensive health education, including sexuality education for youth grades K-12. This policy, entitled Title 14 Education of the Delaware Administration Code specifies how many hours each teacher needs to spend on comprehensive health education for each grade. It also states the topics these grades are supposed to cover. For example, in grades 7 and 8, “a minimum of 60 hours of comprehensive health education and family life education of which 15 hours in each grade must address drug and alcohol education” are required (State of Delaware, 2010). There is only one section in the entire policy that mentions sexuality education, stating the need for “inclusion of a comprehensive sexuality education and HIV prevention program that stresses the benefits of abstinence from high risk behaviors” (State of Delaware, 2010). As mentioned in other scholarly sites such as the Advocates for Youth website, this policy is vague and “does not specifically require that students receive information about condoms and contraception” (Advocates for Youth, 2008). The ambiguous terms in this policy seem to leave the sexuality education program development up to the discretion of individual school districts or even individual schools and teachers. However, it is apparent that Delaware does not seem to advocate for an “abstinence-only approach”

since in 2009 and 2010, the state did not apply for Title V funding, while in 2010 Delaware did apply for the Personal Responsibility Education Program (SIECUS, 2010).

Why is sexuality education important in Delaware? In addition to the alarming youth risk behavior survey results, according to Advocates for Youth (2008), the teen pregnancy rate in Delaware is 83 out of 1000 women, while the national average is 70 out of 1000. In 2005, Delaware also ranked 7th in the United States in teen pregnancy rate and 5th in teen abortion rates with a rate of 27 abortions per 1000 young women, ages 15-19” (SIECUS, 2011, p. 3). In addition, the annual rate of AIDS diagnoses, and the STI rate is also higher than the national average. According to the Youth Risk Behavior Survey done by the Center for Disease Control in 2011, 43% of Delaware youth grades 9-12 were sexually active, and among this group, 41.3% of these students did NOT use a condom when last having sex (Center for Disease Control and Prevention, 2012). Based on this data, it is apparent that teen pregnancy and sexually transmitted infections remain a major concern in Delaware, which should be addressed through an improvement in sexuality education.

Learning from Global Society: Successful Sexuality Education Programs in Europe

Sexuality education and the sexual health of adolescents is not just an issue faced by the United States. Worldwide, sexuality education has increasingly been addressed through policies and mandates, particularly in other industrialized countries. A study by Weaver, Smith & Kippax (2005) compared sexuality education between the Netherlands, France, Australia, and the United States and found that both the Netherlands and France required sexuality education, while Australia has national

policy guidelines for implementing sexuality education. The Netherlands supports a comprehensive approach to sexuality education including education about contraception, but leaves “Dutch schools free to determine the materials, methods approach and time spent on each objective” (Weaver, Smith, & Kippax, 2005 p. 174). Topics that schools are mandated to cover include “pregnancy, STI’s, sexual orientation, homophobia, value clarification, respect for differences in attitudes, and skills for healthy sexuality” (Weaver, Smith, & Kippax, 2005 p. 174).

France also follows a comprehensive sexual education approach, but its “primary focus continued to be upon biological sexual maturation, sexual reproduction, HIV and STD prevention and methods of contraception” (Weaver, Smith & Kippax, 2005 p. 175). Likewise, Australia supports a comprehensive approach and emphasizes sexual diversity among its five key components. While all three of these countries have more comprehensive sexuality education policies than the United States, they also have lower teen pregnancy rates and teen abortion rates than the United States; the lowest pregnancy rate being Netherlands with a rate of 2.2 per 1000 vs. 30.4 per 1000 in the United States (p. 179).

One study looked into a successful sexuality education program in Austria entitled, “Love Talks” (Wilgen & Kapella, 2007). “Love Talks” is a unique program that involves parents, teachers, and students in the planning and presentation of sexuality education, where each group is seen as “experts” and participate in “working group meetings led by a ‘moderator’” (Wilgen & Kapella, 2007 p. 20). This program takes both a comprehensive and interactive approach to sexuality education with its three-stage model of encouraging students and parents to participate in working groups (students must be 15 years of age to participate but younger students can

submit questions). Then the working groups meet to discuss which topics in sexuality education are most pertinent to them, and finally they implement the projects decided by the working group in schools. Some examples of topics that have been formulated by these working groups are, “‘Love and Partnership’, ‘Pregnancy and Birth,’ Birth Control,’ Male and Female Sexuality,’ Setting Limits,’ and Taking on Another Role’” (Wilgen & Kapella, 2007 p. 23). Although there is not a longitudinal study or control group to evaluate the success of the program, “the feedback from students is overwhelming,” and evaluation studies have shown that “Love Talks really does get involved at three levels of prevention” (Wilgen & Kapella, 2007, p. 24). In addition, the success of “Love Talks” and other comprehensive sexuality education programs in Austria can be correlated with the low birth rates among 15-19 year olds of 13.2 per 1000 women (Parker, Wellings, & Lazarus, 2009 p. 231). “Love Talks” has also been implemented in other European countries including “Germany, northern Italy, and the Czech Republic” (Wilgen & Kapella, 2007 p. 25).

Another interesting approach to sexuality education comes from Finland, where teachers actually rated teaching abstinence as the “least popular objective in sex education in Finland” (Kontula, 2010 p. 384). In Finland, the “Ministry of Social Affairs and Health began publishing an annual sexuality magazine in 1987,” which is sent to all 15 year olds and includes a condom and a letter to parents about adolescent sexuality. (Kontula, 2010 p. 375). While this may seem quite controversial in the United States, it has received positive feedback from both parents and youth in Finland. In addition, according to Parker, Wellings, & Lazarus (2009), Finland has a teen birth rate of 18.4 out of 1000 among 15-19 year olds in the population while Weaver, Smith & Kippax (2005) report the United States teen birth rate of 30.4 per

1000 women aged 15-17, and 82 per 1000 women aged 17-19. Finland also has half the rate of legal abortions among 15 to 19 year olds compared to the United States (14.8 per 1000 women vs. 30.2 per 1000 women respectively). Evidently, the evidence-based and comprehensive nature of sexuality education in Finland does not cause an increase in birth rates or abortions in Finland, as many argue would happen in the United States. While this correlation is very promising, it is important to note that the United States and Finland may differ on other variables such as political climate, cultural values, and socioeconomic status which could also contribute to the outcome of sexuality education.

Empirical Studies and Evaluations on Current United States Programs

In addition to providing funding for sexuality education, there has been increased funding for research studies to evaluate abstinence-only in comparison to comprehensive education for their effectiveness in reaching youth. In 2008, Advocates for Youth published a report in which they summarized 26 different research studies of “successful” sexuality education programs across the United States. In order to be included in this report, these programs had to have an “experimental or quasi experimental design, published in a peer reviewed journal, and include at least 100 young people in treatment and control/ comparison groups” (Advocates for Youth, 2008). Success was measured by “postponement or delay of sexual initiation, reduction in the frequency of sexual intercourse, reduction in the number of sexual partners/increase in monogamy, increase in the use, of contraception and/or condoms, the reduction in the incidence of unprotected sex, and/or the effectiveness of reducing rates of pregnancy, STIs, or HIV in intervention youth” (Advocates for Youth, 2008). Out of the 26 programs studied, 23 of them involved both abstinence and

contraception information, and the other three did not include sexual health education at all. The three types of programs included in this report were school-based programs, community-based programs, and clinic-based programs. Out of the 26 programs analyzed, “14 helped sexually active youth to increase use of condoms, 13 showed reductions in the number of sex partners and/or increased monogamy among participants, and 10 programs helped sexually active youth to reduce the incidence of unprotected sex” (Advocates for Youth, 2008, p. vi).

One of the programs mentioned in the report is entitled “Safer Choices,” a high school intervention program including “school organization, an intensive curriculum with staff development, peer resources and school environment, parent education, and school-community linkages” (Kirby et al., 2004, p. 442). The intervention was tested in twenty different schools with almost 4000 ninth grade students participating, who were divided into four categories: gender, race/ethnicity, prior sexual experience, and prior sexual risk taking. Results indicated that the program was effective in increasing condom use and delaying sexual activity. The program was most effective in increasing condom use in males rather than females, had a greater effect on delaying sexual activity with Hispanics than other races, and, “its greatest overall effect was an increase in condom use among students who had engaged in unprotected sex before the intervention” (Kirby et al, 2004, p. 442). This study demonstrates the importance of creating and testing a program among varying populations in order to see which type of interventions work for different populations.

Another program, “Reach for Health” was specifically developed for seventh and eighth graders who were disadvantaged and lived in an urban environment. This program provides classroom instruction (74 lessons total over seventh and eighth

grades) regarding health topics and emphasizing the risks of unprotected sex, violence, and substance use. Similar to the Austrian “Love Talks” model, students, parents and teachers were all involved in the development of the curriculum as well as feedback about the implementation of the program. In addition to classroom learning, some students also participated in three hours of community service a week. Students were then encouraged to actively reflect on their experiences participating in community service and classroom discussions. The researchers found that those students who received the community service as well as the classroom instruction were less likely than the students who only received classroom instruction to “report sexual initiation, as well as recent sex” two years later (O’Donnell et al., 2002, p. 93). This finding supports the idea that, in order to reach youth, interventions need to be pervasive, existing not just in a youth’s school environment but also in their home and community as well.

After reading about the curriculum and methods of these programs, it is evident that successful programs have used a wide variety of approaches to education. For example, some programs involve intensive lessons taught on consecutive days, while others are taught over time from a few weeks to a couple years. The people appointed to teach these sexuality education programs also vary greatly, including peer educators, teachers who have gone through sexuality education training, outside health professionals, school nurses, and parents. The age at which sexuality education is introduced in these successful programs also ranged from kindergarten through 12th grade. Even though these programs differed on many aspects, there were also some commonalities among them.

First, most of the programs reviewed provided information about both abstinence and contraception, and none utilized an abstinence-only approach. Second, many of these successful programs involved activities and lessons that encouraged youth to become involved in the community and worked on building healthy relationships, activities that are not necessarily directly related to sexuality. A third commonality among many of the programs (16 out of 26) is the use of role-playing and group discussions during or after lessons. Other notable components include involving parents with sexuality education and providing full or partial health care in addition to education. Providing full or partial health care through these school or community programs is beneficial not just for convenience and confidentiality, but because many low income students have limited access to care. For these students, the health care provided through these programs might be the only care they have access to.

Additional studies not listed in the Advocates for Youth report have measured the effectiveness of both comprehensive and abstinence-only education. One notable study of comprehensive sexual education took place in Texas, where “94% of school districts report offering abstinence-only education” (Realini et al. 2010). This study tested the effectiveness of the Big Decisions curriculum, which still emphasizes abstinence as the best choice for teens but also includes information about contraception, hoping to ultimately prevent teen pregnancy, HIV, and other STDs. The results of this study found that participation in “Big Decisions” resulted in “positive changes in students attitudes about abstinence, STD, condoms, contraception and sexual pressure, behavioral intentions with regard to abstinence, STD’s, and pregnancy, and self-efficacy regarding condom use and refusal of sex” (Realini et al.,

2010 p. 322). This study, along with many other comprehensive sexuality education research (Jemmott, Jemmott, & McCaffree, 2012; Kirby, Korpi, Barth, & Cagampang, 1997; O'Donnell et al., 2002; Rotheram-Borus, Koopman, Haigmere, & Davies, 1991; St. Lawrence, 2005; Villarruel, Jemmott, & Jemmott, 2009) points out that the comprehensive or “abstinence plus” approach does NOT increase sexual activity in young teens, contrary to the beliefs of many abstinence-only proponents.

While many studies support the effectiveness of comprehensive sexuality education, there are also some research studies and articles that argue that abstinence-only education is the best approach for sexuality education in the United States. Many of these articles argue that most scholars conclude that abstinence programs are ineffective, but in reality “there are simply few studies that have examined the impact of abstinence education on student sexual behavior” (Denny & Young, 2006). Two such studies that sought to do just that were completed by Denny & Young (2006) and Jemmott, Jemmott, & Fong (2010). Denny and Young (2006) evaluated an abstinence-only program entitled, “Sex Can Wait” in schools in grades 5 and above. The results of this study found “significant differences at 18 months between the treatment and comparison groups in regard to several variables, including sexual behavior in both the upper elementary and middle school curricula, and for knowledge and ‘abstinence intent’ at the high school level” (Denny & Young, 2006 p. 420). When interpreting the results, the authors suggest that an abstinence-only approach may be more effective for younger adolescents than older adolescents in regards to abstaining from sex in the period of 18 months after the program was implemented.

Jemmott, Jemmott & Fong (2010) also found an effective abstinence-only program for younger youth in grades 6-7 (averages age: 12.2). This study compared an

abstinence-only intervention to a safer sex only intervention and a comprehensive intervention and found that “the abstinence-only intervention compared with the health- promotion control intervention reduced by about 33% the percentage of students who ever reported having sexual intercourse by the time of the 24 month follow up” (Jemmott, Jemmot & Fong, 2010 p. 157). The results of both of these studies suggest that some abstinence-only programs have reduced self-reported sexual activity in younger youth before age 14, but do not provide data for sexual activity for these youth later in the lifespan.

Overall, the literature reviewed shows increasing support and evidence for the effectiveness of comprehensive sexuality education programs. Additionally, the literature shows that effective comprehensive education programs can include a wide variety of interventions that still result in positive outcomes including reduced frequency of sexual activity, delayed initiation of sex, increased condom use, increased contraception, increased monogamy, and decrease in sexually transmitted diseases. The abstinence-only programs that were found successful were implemented among middle school students and found that sexual initiation was delayed two years later, but do not provide data for the risk behaviors of these students later on in the lifespan.

Chapter 2

METHODS

Materials

The present study aimed to address the sexuality education approaches and practices used in the densely populated, but relatively small geographic area of New Castle County, Delaware. After a literature review of programs and policies globally, nationally, and locally, the researcher formulated a set of general questions to ask professionals (appendix C). The questionnaire was used as a guideline for interviews, so that not every participant was necessarily asked every question, but the majority of questions were discussed in each interview. Both the questionnaire and informed consent form received Institutional Review Board approval. The consent form consisted of information about the research study, how the results were going to be used, potential risks involved with participating, and options to remain anonymous by name, anonymous by organization or school, and/or anonymous by type of school or organization (see appendix B). Interviewees also had the option of choosing whether or not they wanted the interview to be audio recorded, and none refused. Of the 14 organizations interviewed, none requested to keep the type of institution private, but six requested to keep the name of the institution private, and six requested to keep their names private.

Procedure

In order to recruit participants, the researcher sent emails to health teachers and guidance counselors from public school districts in New Castle County; to principals, health teachers, and guidance counselors from private schools and private religious institutions; and to non-profit organizations involved with sexuality education. In total, 51 professionals were emailed, and 14 agreed to participate. Of those choosing not to participate, 31 never responded, and one said that they were not interested. Five professionals agreed to participate but did not follow up to schedule an interview. Follow-up phone calls were also used to contact some of the agencies and school districts. After initial contacts were made, a “snowball sampling” method was implemented in which the researcher would ask the interviewee for potential contacts to subsequently interview. The interviews lasted anywhere from 25 minutes to an hour and 25 minutes, and took place from June 2012-December 2012. Each interview was recorded and then transcribed word-for-word onto a separate document in order to obtain direct quotes and accurate information.

In addition to interviews, the researcher observed two different adult workshops; the first focused on preventing child sexual abuse, the second provided suggestions to parents about how to talk to their children about sexuality. The child abuse prevention workshop’s target audience was any adult who has contact with children either personally or professionally such as parents, teachers, and religious leaders, while the target audience of the sexuality workshop was parents who have children of any age.

Upon completion of interviews, the researcher reviewed transcriptions and found common topics and themes among the answers provided by participants. Most of the common topics were related to the questions asked among participants

including types of sexuality education provided, components of education programs, parent involvement in programs, sexual orientation and diversity, evaluation of programs, the use of the internet, resources needed, and most important aspects of sexuality education. After reviewing the interviews, additional topics were prevalent through inductive analysis including parent education, evidence based programs, and the use of wellness centers. Based on the answers provided on these topics, themes were then identified including the importance of meeting the needs of the population, consistency in sexuality education, and providing all of the information to students and parents.

Participants

In total, 14 interviews were completed. Of the 14 institutional representatives interviewed, six were from non-profit agencies, four were from public schools, two were from private secular schools, and one represented a private parochial school. The last of the 14 institutions represented was the Delaware Department of Education. The professionals interviewed varied depending on the type of school or agency. Health teachers were interviewed from public and private schools, and the guidance counselor was interviewed from the religious school, as there was no health teacher. The education director was interviewed at the non-profit agencies of Children and Families First (Adolescent Resource Center), Alliance for Adolescent Pregnancy Prevention (Christiana Care), A Door of Hope and AIDS Delaware, while the vice president of education and training was interviewed at Planned Parenthood. One of the professionals interviewed represented three different non-profit organizations, but was the head of Delaware Nurses for Life. The director of health and physical education was interviewed from the Department of Education. Out of the four types of

institutions interviewed (non profit organizations, public schools, private schools, religious schools) it was most difficult to set up and complete interviews with private and religious schools.

In order to complete interviews with participants, the research study was approved by the IRB (Institutional Review Board) of the University of Delaware. An informed consent, the initial contact email, and information regarding the privacy of participants and data storage were submitted to the IRB and approved. In accordance with the IRB protocol, all informed consents and transcriptions will be kept in a locked filing cabinet. The audio recordings will be destroyed in June 2013, and the transcriptions of the audio recordings will be destroyed in June 2016.

Chapter 3

RESULTS

Participants shared information about the nature of their programs and philosophies for sexuality education, resources they have used and resources that are needed, and various components included in their programs and curricula. Addressed in this section are the types of sexuality education in both the non-profit organizations and schools, information about the Wellness Centers being implemented in public schools, the extent to which programs addressed sexual orientation and sexual diversity, the use of evidence based programs, parental involvement and parental education, the use of the Internet among students and professionals, resources needed among professionals, educator's views on the most important aspects of programs, and how programs are evaluated.

Types of Sexuality Education

In total, ten of the professionals interviewed taught a form of comprehensive or abstinence plus education, while three of the professionals taught strictly abstinence-only. Out of the six non-profit organizations interviewed, four agencies (Planned Parenthood, AIDS Delaware, Children and Family First ARC of DE, and Alliance for Adolescent Pregnancy Prevention) taught comprehensive education, and two (A Door of Hope and Delaware Nurses for Life) used an abstinence-only approach. To divide these programs into the different approaches, all of the public and private schools interviewed employed a comprehensive approach, while the religious school taught

abstinence-only. Two of the middle school educators classified their programs as “abstinence based,” but later stated that they did mention contraception as an option that sexually active people used. Both of these educators mentioned that the message they wanted to send to the students at this age was that abstinence is the best and healthy choice, and that students at their age should not be sexually active. At the public high school level, contraception was talked about in greater detail than at the middle school level, but condom use was never demonstrated, nor were condoms distributed by any of the teachers. In all of the programs at the public, private, and religious schools, all students in the specified grade level where the class or program was offered participated in the class. The only students who did not participate were the few whose parents opted for their children not to participate.

The Use of Non Profits in Schools and Communities

Out of all of the non-profit organizations interviewed, five (A Door of Hope, ARC of DE, Planned Parenthood, AIDS Delaware, Alliance for Adolescent Pregnancy Prevention) out of six provide sexuality education programs in a school setting. A Door of Hope, and ARC of Delaware were the two most frequently cited organizations used among the public, private, and religious schools interviewed. Out of all of the schools interviewed, four schools said that they have used A Door of Hope, four schools said that they have used ARC of Delaware, two schools said that they have brought in AIDS Delaware, and one school had brought in Planned Parenthood. While Planned Parenthood did not do presentations in schools as frequently as other non-profits, they provided teacher education for educators in both the private and public schools. As the sole recipient of the federal Personal Responsibility Education Program (PREP) grant, Planned Parenthood provides sexuality educator training for

two different evidence based programs. Both of these programs are considered comprehensive sexuality education programs, but are aimed at different age groups, although they can be adapted for both middle school and high school students. SIECUS, the national organization dedicated to promoting comprehensive education, also provides teacher workshops and professional development. There was a Delaware conference for sexuality education professionals in Dover in July 2012. The conference was not open for outside observers in order to protect confidentiality and privacy of the professionals who participated.

Although many teachers may go through these evidence-based educator-training programs, only a portion of the teachers decides to implement the program in fidelity (implementing the program in a way it was designed to be taught). One of the public high school teachers interviewed implemented the Making Proud Choices program. She said that she mostly follows the eight lesson plans, with the exception of taking out one of their activities and using one of her own. She also teaches physiology and anatomy, two topics that are not included in the Making Proud Choices curriculum.

The education taught by non-profits in schools consisted mainly of 1-3 one-hour assemblies where an educator representing the non-profit will speak to a classroom or an entire assembly of students about sexuality education. Even though the non-profits categorized themselves as either abstinence or comprehensive based, the approaches used by educators in these organizations varied. Both Planned Parenthood and ARC of Delaware emphasize that abstinence is the most reliable method for preventing pregnancy, STDs and STIs, but also talk about and explain how to use condoms and other contraception. Planned Parenthood and ARC of Delaware

will also do condom demonstrations, but only if the school in which they are presenting is comfortable with that. For example, the representative from ARC of Delaware said that there are more conservative public schools in southern Delaware “where they don’t want us to distribute those youth pamphlets [about contraception], where we can’t talk about birth control, we can’t talk about condoms.” This limitation shows that even though non-profits may have a comprehensive based philosophy, they often adjust their education to the setting in which they are teaching, as opposed to not entering the school at all.

The representative for AIDS Delaware reported that he framed comprehensive education a little bit differently than all other non-profits and schools interviewed.

When asked if he emphasized that abstinence is the best choice, he responded,

“No not the best way but a viable choice, that you can make even if you have had sex, that you can always go back to being abstinent. Most schools and most educators that I have worked with don’t promote it in that way. They always promote it as the **best** way if you don’t want to get infected, it’s abstinence, abstinence, abstinence, and what that says to a young person in my time with working with them, what that says to them is well shoot if I’m not being abstinent then I might as well keep having sex. Where as we have to let them know that okay you have had sex now you can always say no.”

By using this approach, he believes that he will be able to reach youth who have already chosen to be sexuality active and empower them with the idea that they have the choice to become abstinent again. The AIDS Delaware representative did not say that he provided condom demonstrations, but did distribute condoms in the community settings where he taught. Delaware policies state that condoms are not allowed to be distributed by teachers or outside professionals in public schools, so even if a non-profit provided them during a demonstration, students would only be allowed to access them through the school’s wellness center.

A Door of Hope is the sole abstinence-only based non-profit that seemed to have a large presence in the private, public, and religious schools. A Door of Hope is a faith-based pregnancy-planning center that provides options counseling to women of any age who are facing an unplanned or unexpected pregnancy. I met with their education director, who is the person that implements their RAP (relationships, abstinence education and personal integrity) education program in schools across the state. While they are a faith-based organization, the content of their presentations vary, based on the needs and requests of the school they are presenting in. They never deviate from their abstinence-only message, but will not talk about religion in public schools, or private schools upon request. The message the education director wanted to emphasize through her program is not just to tell kids to “say no” to sex, but to consider their personal goals and values in all aspects of decision making in their lives. A Door of Hope provides a variety of self developed programs, implemented at both the middle and high school level. These programs include *Taking Aim*, which is recommended for 6th graders and focuses on personal values and responding to peer pressure, *Treasure Your Gift*, a program recommended for 7th-8th graders and focuses on understanding their personal worth, and *Reality Check*, a program that talks about the consequences of decisions used with high school students (A Door of Hope Pregnancy Center, 2012).

The Alliance for Adolescent Pregnancy Prevention, which is run by Christiana Care, provides three different sexuality education programs to youth ages 11 to 18 in the New Castle County area. The first program is entitled Wise Guys, and is a comprehensive sexuality education program focusing on male responsibility and sexual health, and is targeted at males ages 13 to 18. The other two programs are

entitled, Be Proud Be Responsible, and Making Proud Choices. The Be Proud Be Responsible Program (Jemmott Jemmott, & McCaffree, 2012a) is targeted at youth, ages 13 to 18, and Making Proud Choices (Jemmott, Jemmott, & McCaffree 2012b) is targeted at youth, ages 11 to 13. These are both evidence-based programs in which Planned Parenthood offers educator training through the PREP grant. All students who participate in and complete any three of these programs receive a \$50 incentive at each program's culmination.

Delaware Nurses for Life is the only non-profit organization that currently does not visit schools to provide educational sessions regarding sexuality. The representative of Delaware Nurses for Life also was involved in two other non-profit organizations that had the same philosophies of both a pro-life approach to abortion, and abstinence-only based approach to education. The organization used to have a family that spoke to students in some schools in the area, but after they retired, no other representatives have been available. Delaware Nurses for Life and its two partner organizations mainly provide their education through fairs, exhibit, and conventions such as the Delaware State Fair, and the women's conference at the University of Delaware. The representative emphasized that the information they provide to the public is all evidence based on scientific studies. She believes that there is a lack of publications and media attention to scientific findings that support a pro-life approach because journals only publish articles that represent a pro-choice point of view. The representative expressed that her organization offers information that students are unable to find in other databases. She remarked, "We're able to offer this other side, peer reviewed, articles and journals and links that they [students] can't find, you go into a public library for example and look up pro life and you'll get mostly

cross referencing to the abortion side." Delaware Nurses for Life has a library of resources in their main office, and handed out pamphlets about STDs, sexual exposure and oral sex in which the majority of sources cited were statistics and trends from the U.S. Centers for Disease Control and Prevention.

Wellness Centers in Public Schools

There are 14 wellness centers in New Castle County public high schools. These wellness centers are funded by the Delaware Department of Public Health and provide health related services to all students who have a signed parental consent form. Wellness centers are usually located in the nurse's office, and provide mental health, nutrition, and reproductive health services. In terms of reproductive health services, two of the fourteen wellness centers in New Castle County have been approved to distribute both condoms and female oral contraceptives. All fourteen of the wellness centers, however provide screenings for sexually transmitted infections. The representative from the Christiana Care's Alliance for Adolescent Pregnancy Prevention Program, who is in charge of overseeing the wellness centers, mentioned that the provision of HIV testing in wellness centers "is on the horizon."

While youth, ages 12 and up, are legally allowed to access reproductive health services in the state of Delaware without parental consent, this rule does not apply to wellness centers in public high schools. At the beginning of the school year, parents receive a consent form and place a check beside whether or not their student is allowed to access a list of services (i.e. mental health, nutrition services, reproductive health) provided by the wellness center. If the parent checks "no," a student seeking those services will be turned down. However, the students are still allowed (and are directed to) reproductive health services outside of the school setting, such as Planned

Parenthood and ARC of Delaware. If a parent checks “yes” to reproductive health services, their student will be allowed to access the services, and the parents will not be notified whether or not the student has done so. Therefore, even though the student is not technically allowed to access reproductive health services without parental consent, if their parent consents, the student’s use of the services will remain confidential. Unless students have a conversation with their parents about the types of services their parents have consented to, the students will not find out which services are accessible to them until they attempt to access them at the wellness center.

Components of Schools’ Education Programs

The content of the sexuality education programs varies widely across and within public, private, and religious schools. The public and private middle schools were all relatively similar in the content of their sexuality education programs, but varied by age group and length of time used to cover various content. Both of the private school institutions were kindergarten through 8th grade, so teachers were able to address health and sexuality education over a longer period of time. One of the two middle schools interviewed started their sexuality education in third grade, while the other started in fourth. In the time period between the start of the program through eighth grade, both sexuality curricula progressively addressed puberty and physical, emotional and social changes in their own sex, puberty changes in the opposite sex, family dynamics, and decision making. Sexual behavior and contraception as a way to reduce risk were addressed in both programs, but were not the main focus. The public middle school addressed similar topics of puberty, decision-making, sexual behavior and contraception, but also addressed HIV and its myths and facts, as well as sexual

harassment. Sexuality education in this public middle school is taught for about three weeks in both the 6th and the 8th grades.

The religious middle school did not have a formal sexuality education program, but included information about healthy relationships in the family life education classes that were taught beginning in 1st grade and lasting through 8th grade. The professional interviewed admitted that their family life education programs are “very, very watered down” in that in the early years they mostly teach that “Jesus loves us, love yourself, care about each other.” Although they used to have a program that addressed anatomy, their current program does not address anatomy nor physiology. The only time sexual relationships are addressed is when A Door of Hope comes in to talk to the 8th grade students, telling them to follow their values, respect themselves, and to abstain from sexual relationships until marriage. Child Abuse Delaware also comes into the school, and teaches fourth grade students about emotional and physical abuse, and eight grade students about sexual abuse and sexual assault prevention. In addressing sexuality, all Catholic schools in the area must adhere to the doctrines of the Roman Catholic Church, enforced in many of these schools by the Diocese of Wilmington. The Catholic Church believes that sexual intercourse should only be used for procreation, and union purposes within a heterosexual marriage. This means that oral sex, masturbation, and all forms of contraception are not supported or allowed in the Catholic Church (Vatican, 2013).

Among the public high schools in this study, the sexuality education component of the health curriculum lasts for about 3 weeks. The health curriculum lasts for two full marking periods which adds up to about 18 weeks total. Two of the public high school representatives interviewed taught sexuality education at the 9th

grade level, while the third public high school taught it at the 10th grade level. This is representative of all public schools across the state, as the Delaware Department of Education encourages sexuality education to be taught earlier rather than later. In previous years, sexuality education was taught in the 11th grades. One public high school teacher remarked on this change, “that’s really the problem of 9th graders compared to 11th graders, very immature, I would rather do 11th grade but I mean that’s the way it is here in Delaware.”

Others view the change to 9th grade positively. Another public high school educator stated, “Well the maturity level is a lot better in the 11th grade, but I think they definitely need it, like I pushed for it in 9th grade because I think they definitely need to be reached sooner.” Among the public school teachers interviewed, all of them addressed contraception, abortion, sexually transmitted diseases and HIV, safer sex and risk behaviors, and relationships. Three of the programs addressed anatomy, gender identity, and sexual orientation. Two of the teachers mentioned pregnancy as a topic they addressed. Other topics mentioned among the public school interviews were planning for the future, sexual harassment and myths regarding sexuality and sexually transmitted diseases.

At the private high school interviewed, the students had to take one trimester of health before they graduated, but this trimester could be taken anywhere from 9th to 12th grade. This means that one health class could have an incoming freshman as well as a graduating senior. The sexuality education component of the health class includes information on relationships, contraception, STDs, and pregnancy. In addition to the trimester of health, students also are required to take an anatomy class in 12th grade.

This class was described as using a “scientific point of view,” and talks about fetal development, anatomy, physiology, and touches again on contraception.

Sexual Orientation

One of the questions asked of each interviewee regarded sexual orientation, and whether or not it was addressed in the curriculum, as well as how it was treated. When I met with the health and physical education director from the Delaware Department of Education, he shared that their department encourages teachers to use gender-neutral language when referring to relationships in their classes. When referring to respecting diversity in sexuality education classes, he shared, “I don’t think that we want the issue of being gay or lesbian to be just part of a sexual health class, we want gay or lesbian to be part of an equity issue in a school. So, it’s not about who you are, it’s about what you do that puts you at risk for a variety of health risk behaviors, so ideally we want students to be treated with fairness across the board. And so, to that end, aside from what happens in a sexual health class we want schools to consider establishing GSAs which are gay straight alliances so that students feel supported where they are.”

Out of the seven teachers interviewed, one private school and one public school mentioned that they have Gay-Straight Alliance clubs for their students. It is important to note that while the researcher inquired about diversity, no specific questions about Gay-Straight Alliance clubs was asked, so some of the schools interviewed may have one but did not mention it in their interviews. In addition to the Delaware Department of Education, five of the interviewees stated that they try to respect diversity by using the term “partner” when referring to relationships, rather than “girlfriend” or “boyfriend.” Some of the professionals addressed same sex

relationships when talking about potential risks. One professional from a public high school shared with his students that, while there is not a risk of pregnancy in a same sex relationship, partners are still putting themselves at risk for STDs. Three of the interviewees said that they do not specifically address sexual diversity, but if it is addressed, they “encourage the students to talk to their parents about their feelings and beliefs.”

While sexual orientation was not addressed in the family life education curriculum in the religious school, the professional said that as a guidance counselor, she has spoken with a number of students who are questioning their sexuality. Although she is not allowed to *condone* same sex relationships because of the guidelines of the Catholic Church, she has responded to these students with empathy, “I just sort of say, ‘Well this is what you’re thinking, have you talked to your parents about it, would you like to talk to somebody else about it, maybe your pediatrician, would you like me to call your folks and tell them that you are confused about it,’ but I could never tell a child they are wrong.” This response does not break any of the rules of the Catholic Church, but also encourages the student to find someone close to them whom they can talk to about sexuality and sexual orientation.

Evidence Based Programs

Professionals were asked about the content of their programs, and the curriculum they use, particularly if any evidence based programs were used. Out of all six of the non-profits interviewed, three professionals said they used evidence-based programs in fidelity and the other three used combined elements of research-based programs. A representative from ARC remarked on why they do not always implement programs in fidelity.

“We don’t do evidence based programs in fidelity in the schools because we don’t have the ability to do that. You know, programs in fidelity are normally you know 8 weeks once a week or 10 weeks once a week. We don’t have the ability to do that because teachers do their sexuality education unit in a two week block, and they don’t want somebody coming in when they are talking about exercise to talk about condom use, but we take components of evidence based programs, we take lesson plans that we get online, or from books... and then we also create our own.”

This comment is characteristic of other non-profit organizations, as well as many of the school professionals interviewed. Many of the professionals have been teaching sexuality education for over 10 years, and have developed and made small changes to their programs over time, taking ideas and activities from a variety of sources, but only one has implemented an evidence based program in fidelity. Teachers stated that they used research and evidence based material from various textbooks, curricula from non-profits such as ARC and Planned Parenthood, information from government and health websites (i.e. BrainPop, 2012 & Nemours, 2013), and lessons that follow both the state and national standards for sexuality education.

Planned Parenthood has the biggest involvement with evidence-based programs. The two programs that Planned Parenthood implements in fidelity in a variety of community and school settings are entitled “Making Proud Choices” (Jemmott, Jemmott & McCaffree, 2012a), and “Be Proud Be Responsible” (Jemmott, Jemmott, & McCaffree, 2012b). “Making Proud Choices” is an eight-module program that is intended for middle school students, but can also be implemented among high school students. “Be Proud Be Responsible” is very similar to Making Proud Choices, but is made for high school students and implemented in six-modules. The modules for both of these programs can be combined in a variety of ways: four sessions of two

modules (for Be Proud Be Responsible), two sessions of three modules (for Making Proud Choices), one module a week, or any other combination of modules that can be spread out over a period of time. “Be Proud Be Responsible” and “Making Proud Choices” are both characterized as comprehensive programs because they emphasize that abstinence is the best choice, but also teach about birth control and contraception. Other elements of both of these programs include discussing relationships, goals, and values, learning about STD and HIV transmission and infection, how to effectively use a condom, negotiation skills and enhancing refusal skills.

In addition to “Be Proud Be Responsible and “Making Proud Choices,” Planned Parenthood has also purchased and has access to a variety of other evidence based programs. Included in their library are “A Focus on Youth: an HIV prevention program for African American youth” (University of Maryland Department of Pediatrics, Wayne State University Department of Pediatrics, Children's Hospital of Michigan & West Virginia University Department of Pediatrics, 2009), “Cuidate” (Villarruel, Jemmott & Jemmott, 2009), a culturally based program to reduce HIV sexual risk behavior among Latino youth, “Reducing the Risk: Building Skills to Prevent Pregnancy STD and HIV” (Barth, 2004), “BART: Becoming A Responsible Teen” (St. Lawrence, 2005), an HIV risk reduction program for adolescents, “Draw the Line, Respect the Line: setting limits to prevent HIV, STD, and Pregnancy” (Marin, Coyle, Gomez, Jinich & Kirby, 2003), “PARE Parent Adolescent Relationship Education” (Lederman, Williams, Chan & Roberts, 2003), a program that promotes family communication about preventing teen pregnancy and STD,” and “All 4 You” (Coyle, Douglas, Gardner, Sterner, Walker & Williams, 2011), for students in

alternative education settings. In order to see more information on any of these programs, view Appendix A.

The representative from Delaware Nurses for Life put particular emphasis on her belief that all of the information she presents is research based and has gone through peer-reviewed meta-analysis. While the website provided by the representative (Delaware Right to Life, 2013), only cites Center for Disease Control, the organization provides the majority of their information through pamphlets. These pamphlets include, “Your Sexual Exposure” (Heritage House, 2009b), “Oral Sex: Get the facts” (Heritage House, 2009a), and “STD’s: the Facts” (The Medical Institute, 1999). The representative from Delaware Nurses for Life believes that her organization is unique from other abstinence-only pro-life organizations because they provide information through a scientific perspective rather than a moral or religious one.

Parental involvement in Schools

Parental involvement and influence was one of the topics addressed in the interviews, and varied among the professionals. Parental influence and involvement was minimal at most of the public schools. Although parents in most public schools do not exclude their children from sexuality education, some schools have more parental censorship than others. For example, one public high school teacher shared that one of the districts in the state has two middle schools: one that teaches abstinence-only education, and one that teaches comprehensive education. She remarked, “the one that teaches abstinence the parents were very upset from, from past hearing about this they’re very upset when somebody from ARC comes in and talks about it [comprehensive education], they have come to the school board and the school board

lets this middle school, this one middle school just have abstinence, and the other one can teach the whole...”

Other public school teachers remarked that they worry about parental pressures if they share too much in their sexuality education classes. One teacher shared that she used to bring in Planned Parenthood but doesn't anymore because of parental influence; “parents aren't as receptive to Planned Parenthood, they have a tendency of being more hands off there especially, you kind of have to think about the political aspects of what's going on in the world.”

Private school educators reported a similar self-censorship. Because parents pay the school for their child's education, educators are very wary of not offending parents, or teaching anything that might make them uneasy. Parental involvement was higher in private schools, however feedback regarding sexuality education was mixed. One private school educator stated, “We've got some parents that come up and say they really appreciate the fact that we don't get into that [sex, contraception] as much in the younger grades because they feel like that's the parental job, the parental involvement, but then on the flip side, we have other parents that say when are my kids getting the talk?”

Parental feedback from religious schools was similar to private schools. According to one religious school guidance counselor, many of the parents “have their children here because they want them sheltered.” On the other hand, when the middle school brings in a representative from an outside religious non-profit organization, such as A Door of Hope, who talks about empowering youth to make smart decisions, some parents express gratitude, and even remorse when their children miss out for illness. Even though this counselor admits that the family life program is very

“watered down,” she thinks that the little information they do provide is helpful to parents who do not feel comfortable doing it themselves. Like public and private schools, very few children’s parents have them opt out of the family life education and A Door of Hope presentations at religious schools.

The amount of parental involvement varies across middle and high school, public, private, and religious. In every school, administrators and teachers are aware of parental opinion, and many teachers are wary of what might not be “socially accepted” when planning their lessons. Even though public schools are under “state regulations,” as mentioned in the health education policy, the mandated “comprehensive education” is very vague. This allows each public school teacher to develop his or her own curriculum, based on his or her own philosophies, advice and regulations from administrators, and most likely also parental censorship. Private school teachers are also at similar liberties, but are very aware of their own school’s philosophies in creating their programs. Many Catholic schools are under the supervision of the Catholic Dioceses of Wilmington, and are therefore mandated to follow the Catholic guidelines in teaching about sexuality. This allows for little variation among teachers in teaching about sexuality.

Parental notification and consent also varied among agencies and schools. Out of the six non-profit organizations interviewed, three organizations have parental consent forms available if requested by the school in which they are presenting. Two of the organizations did not have any form of parental notification or consent, and one of the organizations required a signed permission form from parents in order to participate in the program. Most of the school educators interviewed did not require parental consent for participation in health class, but did send a syllabus home to

parents notifying them about the curriculum being implemented. In total, four school educators sent a syllabus home informing parents about the upcoming curriculum, one school educator required a signed permission form, and one school educator did not send a syllabus home nor require a signed consent. In one private middle and high school, parents were invited to attend a parent coffee in which the health educators introduced the parents to the health curriculum and allowed them to ask any questions or provide feedback.

Parent Education and Child Abuse Prevention

In addition to interviewing sexuality education professionals, two different workshops regarding adults' involvement with sexuality education were also attended. The first workshop was part of a child sexual abuse prevention program that is being implemented across the state of Delaware. The program is developed by an organization known as "Darkness to Light" and teaches adults seven steps to protect their own children, and other children they may come in contact with from sexual abuse. The steps involve learning the statistics about child sexual abuse, teaching children what type of touching and relationships are appropriate and not appropriate, recognizing signs and symptoms in a child who may have been or is being abused, as well as ways to prevent one's own children from getting into situations in which abuse might occur. Although one might not characterize a child abuse prevention program as sexuality education, teaching children about "good touch" and "bad touch" is a very important aspect of sexuality education. While this research paper focuses on sexuality education at both the middle school and high school levels, it is important to remember that teaching children about protecting themselves can and should occur at young ages. According to the Steward of Children (2007) pamphlet, "30-40% of

children who are sexually abused are abused by family members, 60% are abused by people that the family trusts, and more than 90% of children who are sexually abused know their abusers.” These alarming statistics show that unfortunately children may be put into situations in which there is potential for abuse, so teaching children at a young age about their bodies, “good touch and bad touch,” and how to trust their instincts and say no to their abusers is both necessary and important.

The other workshop attended was presented by Yvonne Nass (2010), who is a certified parent educator from the state of Delaware. Her workshop for parents entitled, Talking to Your Kids about Sexuality, provided instruction about the emotional, physical, and social changes that children encounter throughout their childhood, as well as how to speak to them about these changes, protecting themselves, and making smart decisions. In addition to sexuality education, Nass provides other workshops that include instruction for parents in other realms such as academics, parenting styles, and relationships within the school and community. Nass presents these workshops in both school and community venues. While these other workshops may not directly address sexuality education, they can teach skills to parents that can help them create better relationships and more open communication with their children.

Use of the Internet in Sexuality Education

With the increase in access to the Internet and constant exposure to media in today’s society, educators were questioned about their awareness of the impact the media and Internet has had on distributing false vs. sound information about sexuality. Most educators responded that every year students come in with questions or myths they read about on the Internet, and many times saw on a television show or movie.

This reflection from a public middle school teacher shows how teachers have to adjust and adapt to the increasing influence of the Internet on students:

“And I’ve taught health, 21 of those years, yeah we have made a lot of changes over the years, I mean where society is now compared to 20 years ago and what we could say and what we couldn’t say, and what we needed to say. The maturity level, the 6th graders were so much more innocent, but now with YouTube and the internet and all of the stuff they have and 900 channels coming into their house, it’s very different than 20 years ago when a kid wasn’t exposed to much at all. I mean it was very rare for kids to be exposed, 6th graders didn’t really think about sex or know about sex, it is very different now. Every year I look at my curriculum and make adjustments.”

This expansion in accessibility to the Internet provides an increase in information flow to students, both correct and incorrect. Some examples of false information mentioned in the interviews were that students thought that drinking “Mountain Dew” can prevent pregnancy, saran wrap can be used as a condom, males can get pregnant, and that sleeping with a bra on causes cancer. In total, ten of the professionals interviewed reported receiving questions from students about false information they have heard from outside media sources.

Many professionals also have used the expansion of the Internet to their advantage. Delaware Nurses for Life and Planned Parenthood both encouraged the use of their own websites for students and teens to find more information. In total, eleven of the professionals interviewed responded that they encouraged the use of safe websites for their students to utilize in finding medically accurate information. The following websites were utilized by one or more of the professionals: Kidshealth.org (Nemours, 2013), BrainPOP (2012), and WebMD (2013). Three of the professionals had their students complete a project in which they used reliable websites to find information about a health topic. The representative from the religious middle school

said that their school utilizes a program entitled “Isafe” (2013) which teaches 8th grade students about using the Internet safely to find correct information.

Resources Needed and Advice for Other Professionals

Interviewees were asked about what resources they believed were needed in order to improve sexuality education in their program, their school, and across the entire state of Delaware, as well as advice they would give to other professionals to improve their programs. Most responses, especially those of the non-profits, mentioned money as one of the main obstacles in creating better programs. Schoolteachers mentioned the steep price of textbooks, and how easily they can become outdated as new health facts and discoveries are made each year. When asked about resources needed, the representative from ARC of Delaware said, “we need money.” She explained that since President Obama has been in office the non-profit organization has been able to apply for more funds, because there are funds available for both abstinence-only and comprehensive programs, instead of just the abstinence-only programs that were funded by the Bush administration. She said that with more money, ARC could expand their services to be more frequent and reach a broader population: “But we could always use more money, you know I’d like to have more educators to do more in schools, and go into more schools, we’d like to go into Sussex County, particularly western Sussex County because the pregnancy rate and STD rate is really high in western Sussex County for adolescents so there’s so much more we could do.”

Interviewees from schools also shared that more money was needed for improvement in effectiveness of programs. One public high school teacher remarked, “Truthfully, it really is just supplies. You know, the money that I put out supplies, you

know the paper, for the kids to do group work, you know just for the basis, you know I think, the book I have is decent I can go by, but you know I would love a new birth control kit, with all updated supplies, all the stuff in there is dated, you know 1995.” Other professionals shared that they have textbooks that are out of date because purchasing new text books are very costly, and require money that the teachers and school board simply do not have.

While organizations such as ARC, Planned Parenthood, and AIDS Delaware receive government funding (in addition to other donations, grants, funding sources) for their education projects, A Door of Hope and Delaware Nurses for life receive all of their funding from private donations. Public school teachers receive very little funding to cover expenses such as outside speakers and textbooks. One public high school teacher mentioned that some outside speakers, such as Planned Parenthood, charge for their presentations, and that is just not something the school can afford. Another public school mentioned that they too do not use Planned Parenthood anymore for financial reasons.

The advice given to other professionals from the interviewees provided very useful insight into the philosophies and approaches of both the people being interviewed and the organization they represented. Planned Parenthood receives the most government funding because of their status as the sole recipient of the PREP program. When asked about what advice she would give to others who want to have more effective programs, the Planned Parenthood representative replied, “Don’t invent them. They’re already out there. There is a wonderful host of evidence based, age appropriate, curriculum programs out there, they’re just, they’re already invented and they’ve already been tested so why reinvent them?” The representative went on to

explain that there are databases of evidence-based programs that are aimed at addressing specific populations and needs, such as Latinas, boys, middle school students, people living with HIV, etc.

Because AIDS Delaware focuses specifically on HIV prevention, the education director's advice was that students, teachers, and adults need to be "open to the information." He explained, "HIV is not a socially acceptable disease and because of the stigma and discrimination that continues to exist with HIV, schools don't see it as that much of an issue, because they have other issues to deal with." Additionally HIV has a long incubation period, and often goes unnoticed for many years, especially among members of younger populations. He then discussed how schools put so much energy into testing scores in order to receive funding such as "Race to the Top" money that health class and health issues seem to be put to the side.

A public high school teacher also believed that sexuality education and health education is not given the attention that it deserves. She believes, "Health and phys-ed [physical education] are the most important subjects in the school but nobody wants to realize that because we don't do state testing on that, because the more physically fit and healthy people are, it doesn't matter, students or adults, they will do better academically, but nobody wants to pay attention to that, so health and phys-ed is pushed to the side."

Other professionals agreed that our sexuality education programs are not providing our students with all of the information they should hear. The representative from Delaware Nurses for Life shared, "They've got to go back and look at the science, take all of the political stuff out of it." The director at A Door of Hope talked about how buzzwords are interfering with people making informed decisions. If a

person hears that another is either “pro life” or “pro choice” they may not listen to what they have to say just because of that defining characteristic. The director at A Door of Hope also said that she did not feel students were receiving enough information to understand the whole picture, in order to make a rounded and informed choice about becoming sexually active, using birth control, and having abortions.

“What I’d like to see personally is a more balanced approach to education, you know they are asking it’s the women’s choice and her body, but lets talk about the emotional ramifications, lets talk about some of the statistics about the percentage, and you know I can’t quote this at the top of my head but the percentage of the women that have breast cancer because they’ve had multiple abortions, let’s talk about the psychological impact to men when [they] know their partner has an abortion, I would like to see you know a more even scale, I feel like we’ve kind of swung from one side in fear of women’s rights, well her right is to know the whole truth, and I don’t feel like she’s getting the whole truth.”

While the representative shares that multiple abortions are linked with breast cancer, according to the American Cancer Society (2011), “scientific research studies have not found a cause-and-effect relationship between abortion and breast cancer.” Those who support a causal linkage between breast cancer and abortions believe the relationship is due to the interruption in the normal cycle of hormone levels after an abortion (American Cancer Society, 2011).

One of the public high school teachers shared a similar complaint about students not receiving all of the information they should. He responded, “I get offended at educators that only show one side, because how is a kid going to make an informed decisions if they only get one side of the argument?” In his curriculum, he discusses both abstinence and contraception, but also makes sure to bring in professionals from both abstinence-only and comprehensive organizations. For

example, in the past few years he brought in representatives from both ARC and A Door of Hope to present to his students.

The AIDS Delaware professional also discussed the importance of sharing information with youth, saying that the youth in his program “always appreciate the realness of the conversation that we’ve had about sex.” He said that it is important as a young person to “understand what it means to be a sexual being, understand as a young person to begin the discovery exploration of your body and you know, a lot of them don’t understand that part because it was never presented to them.” He felt that professionals should be more open in talking to youth about sexuality because youth will both respect them more, and can often tell if professionals and adults are not giving them the whole truth.

The health teacher from the private middle school shared that he wished there were more quality resources for younger students. “Instead of giving them a sheet of paper from 1975 you know, having the resource of more websites that would have games and think like if they are kind of having fun doing it but they are learning about it you know.” As the use of the Internet is becoming a commonality for youth of all ages, some of the professionals interviewed said that they encouraged “safe” websites. For example, at the beginning of the semester, one public high school teacher does a reliable website class. She encourages websites such as “CDC, Med Plus, Mayo Clinic, [and] diabetes.org...I tell them do not go to Wikipedia, you know, do not go to anything that says dot com.”

Professionals were also concerned about how much false information a child can come across not just through the Internet, but also through movies and television shows. Many of the public school teachers found that because of the web restrictions

given to their computers at work, they often couldn't use some of the websites or videos they would have hoped to with their students. One public middle school teacher shared her frustrations with using the Internet at school, "But it can be frustrating too because even the sites that you know are good sites but because it has that, you know SEX word in it, it's automatically blocked." Private school educators did not have the same restrictions, and were able to use the Internet more freely.

It is apparent that professionals are both concerned and knowledgeable about resources they need to improve their programs, as well as advice they wish other professionals would include. Common concerns included needing more money, updated textbooks, accessible Internet websites, interactive games and activities, and ensuring that youth are hearing all of the information in order to make a healthy and informed decision.

Educator's Views on the Most Important Parts of Programs

Educators were asked about the most important topics that should be included in any sexuality education program. The researcher provided a list of topics that included relationships, biological knowledge, technology and medical information, gender equity, fertility and reproductive choice, communication, decision making and risky behavior, impaired judgment, birth control and access to birth control. Three of the professionals responded that they thought all of the topics on the list were important, but specifically emphasized diversity, biological knowledge, decision-making, communication, and relationships. Among the rest of the responses, the most frequently cited topics that professionals thought should be included in any sexuality education program were risky behavior and decision making (7 professionals), relationships (5), communication (5), and biological knowledge (5). Other topics that

were mentioned multiple times were STDs, sexual orientation and diversity, and skills to achieve safer sex and healthy sexuality. When discussing risky behavior and decision making, most of the professionals mentioned that their lessons included speaking to their youth about the effects of drugs and alcohol on the decision making process. Many of the professionals agreed that a lot of these topics overlap, and an effective program would have many of these elements.

Evaluation of Programs

Although some of the non-profit organizations and schools interviewed for this research study have implemented evidence-based programs, no research has been found for empirical evaluations of programs implemented in the state of Delaware. However, many of the non-profit and school educators used pretest and posttests to measure changes in knowledge, changes in attitude and intent of behavior among the participating youth. A Door of Hope, AIDS Delaware, Planned Parenthood, ARC of Delaware, and AAPP all used some combination of these questionnaires.

Out of all schools and non-profit organizations interviewed, Planned Parenthood had by far the most extensive ongoing evaluation plan. Because they provide workshops that educate teachers about how to implement specific evidence based programs, they provide “on going technical assistance” to these teachers to ensure that they are implementing the program in fidelity, as well as help them with any questions or problems. The Planned Parenthood education staff also recently implemented observations of community service providers and teachers of their evidence based program, to again ensure fidelity. In this sense, implementing a program in fidelity means that the person who is teaching the curriculum is doing so in the manner it was designed to be taught. This is important because “evidence based”

programs are described as such because they were validated as being implemented or taught in a specific way. If professionals who are adapting or using the programs make big changes or eliminate some of the activities, there is a risk that the program will not have the intended impact.

If program providers want to adapt the program in any way, the Planned Parenthood staff reviews the proposed adaptations in order to make sure they do not interfere with the overall message and intent of the program. Small adaptations, such as changing the time spent on a certain activity, or changing the names in a role-play are reviewed and usually accepted by the Planned Parenthood staff. Larger adaptations, such as cutting out a condom demonstration, however, are actually submitted to the authors of the sexuality education curriculum. If the authors do not approve the changes, the program would no longer be considered as “implemented in fidelity” and could potentially lose their funding. Extra “boosters sessions” are also provided to educators if needed, and pre and posttests are given to all students who participate in the programs. The pre and posttests measure knowledge and behavioral intent, as well as survey the students about what they liked and did not like about the program.

The Alliance for Adolescent Pregnancy Prevention (AAPP) is one of the organizations that implement the evidence-based program by Planned Parenthood and therefore takes part in the pre and posttests, as well as the educator evaluations. ARC of Delaware also uses pretests and posttests in their educational programs. Additionally, because ARC provides medical services, they monitor both “the return rate for adolescents who test positive for STDs, and the adherence rate to hormonal birth control.” AIDS Delaware provides a pre test survey to see the types of self-

reported behaviors that youth are engaging in before they receive the training program. However, a posttest survey is not provided, and the representative admitted that while he looks over the responses from the pretest survey, he does not have enough resources to analyze the responses, or view changes in trends over the thirteen-year period that he has been implementing his sexuality education program.

Because health education and family life education in schools are part of classes in which students receive grades, each school interviewed tested students' knowledge on information learned throughout the course. Additionally, three of the schools interviewed (one private, two public) also used a pretest to see the amount of knowledge students had about sexuality before taking the course. All of the teachers who implemented a pre and post test said that they used the tests not just for their own teaching purposes, but also to show the students how many myths are out there and that they don't know everything there is to know about sexuality. These pre and posttests are also given through the non-profit organizations that enter the schools, so students are often evaluated on their knowledge, present behaviors, and behavioral intent on multiple occasions. While pre and posttests offer some insight onto effectiveness of educational programs, they have limited value in predicting long-term behaviors in youth.

While no formal long-term evaluations of behavioral changes were made by any of the professionals interviewed, many teachers shared informal anecdotes regarding the effectiveness of their programs on reaching their students. One public high school teacher had her students keep their own journals throughout their sexuality education class in which they wrote down important information, as well as reflected on their own thoughts and values. In receiving feedback about her program, she

remembers, “They will keep those things [the journals] they will come up to me next year or the year after say in their neighborhood they were talking and they were disagreeing on something, usually it has to do with drugs or sex or something like that, they say, I ran into my house and I got my health book and I showed them, if you guys had [my teacher] for health you would have known.” Other teachers (4) who handed out questionnaires asking about attitude and behavioral changes reported that many students gave positive feedback about how they have decided to abstain from sex, use condoms, etc. as a result of their program. While we do not know the actual outcomes of these intended behaviors, teachers seemed to be very effective in making the students think about sexual risk behaviors and how that could impact their lives in the future.

The best statistical way to look at broad behavioral changes in the state of Delaware is to use the Youth Risk Behavior Survey statistics described previously. The Youth Risk Behavior Survey is a national survey but is distributed and analyzed in Delaware by the Center for Drug and Alcohol Studies of the University of Delaware. These surveys show the percentage of sexually active teens, sexually experienced teens, teens that have had sex before age 13, teens that have had four or more sexual partners, teens that have given or received oral sex, teens that have been physically forced to have sex, percentage of sexually active teens who used a condom the last time they had sex, percentage of sexually active students who use birth control, percentage of sexually active students diagnosed with an STD, percentage of sexually active students who have been pregnant or gotten someone pregnant, and students reasons for having sex. While one can look at the types of programs implemented in the state and compare them to the change in statistics from year to

year, there are so many other variables that may influence the statistics that it would be difficult to establish any type of direct correlation in one specific year. However, it may be reasonable to look at broad changes over time in the type of sexuality education taught in schools versus the statistics of sexual activity, pregnancies, and STD transmissions. Kids Count Data Center, organized by the Annie E. Casey Foundation (2013) collects annual data for Delaware including low birth weight babies, births to single teen mothers, and births to single mothers. These statistics can be utilized in addition to the Youth Risk Behavior Survey in examining broad trends in both Delaware and the United States over time.

Teacher evaluations are also used by the Delaware Department of Education, and given to all students in public schools to see if they know all of the information the state expects them to know for that particular grade. While this can be another tool to indirectly test the knowledge of the youth in our state, it might not be an adequate way to test the effectiveness of each teacher. Because the standards for sexuality education are somewhat ambiguous, and teachers are free to develop and implement a curriculum of their choosing, it may be hard to develop one test that will fairly test the knowledge changes in ALL students, especially if it relies on inferences from teacher knowledge. One teacher remarked on these frustrations with state mandated health testing:

“I think it’s inconsistent because, again the state is going to put their money into test scores, and I just got copies of the test that I am supposed to use to evaluate whether I’m a good teacher or not in health and they don’t really align to my curriculum very well.”

While completing evaluations of both students’ knowledge and teachers’ knowledge and/or effectiveness may have some benefits, enforcing a standardized test does not

seem to be in line with the freedom teachers have been given for teaching sexuality education curriculum.

In considering the results from the fourteen interviews, it is evident that while professionals implement programs that vary in approach and content, there are many overlapping beliefs regarding what youth need to be taught in sexuality education, the most important aspects or elements of sexuality education, and changes that need to be made in sexuality education in Delaware and the United States. Differing beliefs were highly correlated with the professionals' educational approach: the abstinence-only oriented professionals and comprehensive-oriented professionals had more consistent beliefs within their respective groups than between these two groups. All professionals interviewed, however, would agree that sexuality education for youth is important, and that the statistics provided by the Youth Risk Behavior Survey about sexual activity in Delaware teens are an issue that needs to be addressed through more effective education and intervention programs.

Chapter 4

DISCUSSION

After reviewing the research, literature and interview data on sexuality education in Delaware, a number of conclusions can be drawn about the nature of these programs, and how they may be improved or adjusted. While it is impossible to say that one specific program will work across all situations, there are a number of key elements that have been shown to be effective, including: 1. Acknowledgement of the statistics on high sexual activity among Delaware youth, 2. The assessment of how programs can meet the specific needs of a given population, 3. Providing consistent, medically accurate information to youth, 4. Building on existing strengths of Delaware programs, and 5. Encouraging parent involvement in sexuality education.

Meeting the Needs of the Population

Many interviewees expressed the need to consider the population one is working with when deciding how to approach the topic of sexuality education. This idea is represented in the literature as well, as many of the 26 “programs that worked” were created to address a specific population (Advocates for Youth, 2008). Some examples of these programs are, “Postponing Sexual Involvement” (Kirby, Korpi, Barth, & Cagampang, 1997), a program aimed at eighth grade sexually inexperienced youth at high risk; “Self Center” (Zabin, Hirsch, Smith, Streett, & Hardy, 1986), aimed at urban, black, and economically disadvantaged female youth; “Adolescents Living Safely: AIDS Awareness, Attitudes and Actions” (Rotheram-Borus, Koopman,

Haignere, & Davies, 1991), for runaway black and Hispanic youth living in shelters; “Becoming A Responsible Teen” (St. Lawrence, 2005), for African American youth ages 14 to 18; “California’s Adolescent Sibling Pregnancy Prevention Program” (East, Kiernan, & Chavez, 2003), for siblings of pregnant and parenting teens; “Cuidate” (Villarruel, Jemmott, & Jemmott, 2009), for Latino youth, especially those whose first language is Spanish; and “SiHLE- STI & HIV Prevention for African American Teenage Women” (DiClemente et al., 2004), for sexually active African American teenage females. The representative from Alliance for Adolescent Pregnancy Prevention mentioned a program aimed specifically at male youth ages 13 to 18, entitled “Wise Guys” (Advocates for Youth, 2006 p. 77).

While both the literature and the programs in Delaware suggest that adjusting or creating programs to address specific populations can be helpful, it is important to keep in mind that while educators may be using different approaches to speak to various populations, the message still needs to be the same: while promoting abstinence as the safest choice, more focus should be on providing youth with the knowledge to make smart decisions when they do become sexually active. These programs show that while adults will most likely not speak to an 11th grader the same way they speak to a 6th grader, or a sexually experienced youth versus a sexually inexperienced youth, the overall message should remain consistent. Additionally, educators and parents need to be open and truthful with youth about sexuality as a normal part of development over the lifespan. Providing open and honest communication early in a child’s life creates opportunities for ongoing discussions about sex because youth will be more inclined to use that adult as a resource person in the future.

Consistency

The programs implemented in both the non-profit organizations and schools varied widely. While this variation may be helpful to meet the needs of differing populations, a lack of consistency for students as they progress from elementary to middle to high school may cause confusion. For example, a student may go to a middle school that uses a comprehensive approach, and then go on to a high school that teaches abstinence-only. This may be particularly likely to happen when students attend a public middle school, and then enroll in a faith-based high school. Students within the same school may also hear different messages depending on the health teacher they have. This may create confusion among the students about what the “right” choices are for them, and what the facts really are, since the curriculum is not always medically accurate and consistent. An example of a country that provides consistent, comprehensive, medically accurate, and evidence-based information to youth about sexuality is Sweden. The government, schools, parents, and organizations in Sweden support the ideals of “honesty, equality, and the inclusion of diverse sexualities, ethnicities, and socioeconomic classes into mainstream society” (Wilgen, 2011 p. 3). When students receive the same factual information from all aspects of their life (i.e. school, parents, media, peers), they will be better able to make an informed and healthy decision about sexual activity.

While it is understandable that the Delaware Department of Education wants to give teachers freedom to implement the curriculum that they are comfortable with and find most effective, the ambiguity of the guidelines for health education may increase rather than decrease inconsistency among schools. The Department of Education provides both resources and guidelines for teachers regarding lesson plans and overall messages, but the information regarding what is “mandatory” is vague. The only line

about the sexuality education requirement on the DOE website states, “Inclusion of a comprehensive sexuality and an HIV prevention program that stresses the benefits of abstinence from high risk behaviors” (State of Delaware, 2010). This requirement does not provide an explanation nor definition for comprehensive health education, leaving the standard up for interpretation. The overall Delaware health education standards (not requirements) can be found in Appendix D. One suggestion to reduce inconsistencies is an increase in internal communications between the health and family science teachers in Delaware, as well as more detailed descriptions of the health standards for sexuality education in schools. It is important to note, however, that included in the suggested resources for educators is the “Making Proud Choices” curriculum that encourages the goal of educating sexually active youth about condom use. If the standards and expectations specifically for sexuality education were better defined in addition to providing multiple online resources, educators will hopefully have the courage and freedom to use the activities and assignment that work best for them, but still ensure that the students are receiving consistent messages across the state.

When deciding which school to send their student to and preparing them for the transitions from elementary school, to middle school, to high school, parents should also be aware of the different approaches to sexuality education in these schools. When disparities are observed between the former school and the new school, parents could be educated themselves to fill the gap in knowledge when an abstinence only curriculum replaces a comprehensive approach. Because it is impossible to regulate sexuality education across all schools in Delaware, parent involvement in “filling the gap” between the information provided by various schools could be helpful

to maintain some consistency. In addition to open communication with teachers, parents can work to “fill the gap” by taking parent education classes through Planned Parenthood, or use the SIECUS (2012) or Advocates for Youth (2008) websites to learn about how to talk to their children about sexuality with medically accurate, evidence-based information.

All of the Information

It was evident in the interview process that both professionals who advocated for abstinence-only education as well as comprehensive education emphasized that youth need to hear ALL of the information. The abstinence-only advocates discussed how youth are not hearing all of the potential “negative consequences” of using birth control such as condoms and oral contraception, as well as the “negative emotional problems” that may result from the initiation of sex. The comprehensive education advocates also believe that the abstinence-only approach does not provide youth with adequate information. They argue that only telling students “not to have sex” fails to provide them with the tools and knowledge to have safer sex if they do indeed become sexually active, or are already sexually active.

What is the solution? Is it possible to provide youth with ALL of the information from both sides, while still ensuring they are receiving scientific facts, without completely confusing them? While these questions may not have a clear answer, there are possibilities to explore that address the concerns of both sides. For those schools implementing an “abstinence-only approach,” emphasizing the emotional and physical risk factors of having sex, encouraging youth to wait for marriage or a monogamous relationship as adults, it may be possible to include information about contraception for youth while still adhering to their own

philosophies and morals that they want to teach. For example, abstinence-only educators can emphasize that students should save sexual activity until marriage, but provide them information about contraception for students when the time comes. Sexuality education classes for adults are few and far between, so teaching contraception to youth when they are still in school might be the only time they will learn about it from a professional in a class setting. In this way, educators are still encouraging “abstinence-only” but also providing contraceptive information for students to use in the future. This addresses the short-term needs of the educators in emphasizing abstinence-only, and the long term needs of the students who will most likely engage in sexual activity at some point before marriage. This solution is very similar to the philosophy behind abstinence plus programs, but the message may be framed in a particular way that puts the abstinence-only advocates more at ease. It is important to note that some of the religious programs, which state that all contraception methods are abortifacient (cause abortions), and that sex should only be used for reproduction, will not use this solution.

The comprehensive education advocates could also adjust their approach to include more of the risk factors mentioned by the abstinence-only professionals. While addressing that contraception is an effective way to reduce risk when engaging in sexual activity, they may share that using contraception can put a person at risk for STD’s. It is important, however, for professionals to frame this information in such a way that they are not discouraging the use of contraception, but simply providing students with all of the information in order to make a healthy decision. Placing a higher emphasis on the important of healthy relationships (based on honesty, equality and responsibility), personal values, and personal ownership (i.e. every person has the

right to their own body and no one has the right to take their choices away from them) in making decisions about sexual behavior could also strengthen comprehensive education programs. While many comprehensive programs already include this information, some of the abstinence-only programs seem to place a stronger emphasis on these topics.

Strengths of Delaware Programs

The components of the various sexuality education programs offered through the Delaware non-profit organizations and public, private, and religious schools, are similar to many components of the evidence-based programs that have been deemed successful in other states around the country. According to the Advocates for Youth (2008) report, some of the components of the 26 programs deemed successful include teaching skills in risk reduction and refusal, experiential activities about abstinence and contraception, condom use, information about STDs and HIV, public service announcements, individual and group counseling, school based clinics, parent workshops and communication with parents and family, community service, daily after school activities, goal setting and social competence training.

The programs described by the professionals interviewed in Delaware have a variety of these components. One particular strength of the public high schools interviewed is that they have “Wellness Centers” that provide STD screenings, counseling services, and some even provide access to contraception. Wellness centers and school based clinics have been shown to contribute to safer sex among youth in other states, so would potentially have a similar impact on the youth in Delaware. The emphasis on healthy decisions, values, goals, and relationships in the abstinence-only programs and some of the comprehensive programs is also characteristic of the

programs deemed successful in the Advocates for Youth report. If programs are able to empower youth to make healthy decisions, they may become more effective in reducing the onset of sexual activity and/or encouraging safer sex among youth.

Why Does Delaware Rank so High in Sexually Active Youth? Is There a Solution?

As mentioned in the introduction of this report, Delaware youth rank in the top of US rates for teen sexual activity, sexual activity with multiple partners, and sexual activity at an early age. After completing an extensive literature review on sexuality education in Delaware, the United States, and European countries, as well as interviewing 14 professionals across New Castle County, there are still no simple answers to this question. However, there are important factors to consider in interpreting these statistics. First, in considering the generalizability of the statistics, one must note that the Youth Risk Behavior Survey is given to students only in public schools across the state of Delaware. This means that students from both private and religious schools were not included in this survey. It is impossible to tell, however, how the statistics would change if private and public school students were included in this data. As multiple professionals mentioned throughout the interviews, it is naïve to think that students in rich, suburban neighborhoods that attend private school are much less likely to have sex than students in urban neighborhoods and public schools. A Youth Risk Behavior Survey provided to public schools, private schools, and religious schools across the country is necessary to answer the question of how private and public students may differ in sexual activity.

The statistics showing that Delaware teens rank high in sexual activity are interpreted quite differently, depending on the approach to education a professional

chooses. Abstinence-only supporters argue that comprehensive education has not been effective in reducing teen sexual activity, so it is necessary to try abstinence-only education instead. While the sequence of their line of reasoning is quite evident (i.e. teens are having sex, so teach them not to have sex), the ineffectiveness of many abstinence-only programs has been documented across many research studies, and according to “a 2007 congressionally mandated study... federally-funded abstinence-only programs have no beneficial impact on young people’s sexual behavior” (Guttmacher Institute, 2012).

The comprehensive education advocates address these statistics in a very different way. They argue that some teens will engage in sexual activity, regardless of what parents or educators say. For these teens, the answer is not to tell them that they cannot have sex, but to encourage the use of condoms and other forms of contraception to reduce the risk of both pregnancy and sexually transmitted diseases if they become sexually active. Contrary to the beliefs of many abstinence-only advocates, research has clearly shown that comprehensive programs do NOT increase sexual activity among teens (Jemmott, Jemmott, & McCaffree, 2012; Kirby, Korpi, Barth, & Cagampang, 1997; O’Donnell et al., 2002; Realini et al., 2010; Rotheram-Borus, Koopman, Haigmere, & Davies, 1991; St. Lawrence, 2005; Villarruel, Jemmott, & Jemmott, 2009). This finding means that providing information about contraception to teens does not encourage them to have sex, but instead provides safer sex tools to teens that have already become sexually active, or will become sexually active in the future.

In addition to ranking at the top of the list for teen sexual activity, Delaware also ranks fifth in the United States for percentage of teens that did not “use any

method to prevent pregnancy during last sexual intercourse,” seventh in teen pregnancy rates, and fifth in teen abortion rates (SIECUS, 2011). This shows that teens that are sexually active are not using proper birth control and especially not condoms to protect themselves from both sexually transmitted diseases and unwanted pregnancies. While the results from the interviews show that, among the programs sampled in New Castle County area, there are more comprehensive programs than abstinence-only programs, it is apparent that there are still many teens who are either not receiving the correct (if any) information about safer sex, or teens who are receiving the information, but choosing not to use it, or do not have access to the appropriate forms of birth control.

Parental Involvement: How Can We Encourage It?

While it seems that comprehensive education in Delaware may be correlated with a lower rate of STDs and teen pregnancies among those that are sexually active, there is still a need to address the issue of high rates of sexual activity among the youth of Delaware. One way to address this is encouraging informed parental involvement in the sexuality education of their children throughout their lifespan. In addition in the need for consistency across various schools that a child attends, there also seems to be a need for consistency in the messages provided in both the school environment and at home. Based on the interviews completed, parent involvement in sexuality education varies from family to family. Some families do not want to address it with their kids at all, and rely on the school to be in charge of teaching sexuality education. Other parents do not want the school to address sexuality education at all, and want to be the sole educators of that topic to their children. This ambivalence from parents can also be represented by parents’ beliefs about what to

emphasize regarding sexuality if and when they do speak to their children about the topic. In a research study by Sinnikka Elliot (2010), parents were interviewed regarding what they teach their children about sexuality. Elliot found that many of the parents wanted their children to be abstinent until marriage, but realized that this wish was very unrealistic. At the same time, parents didn't want to give their teen children "permission" to have sex, because they felt responsible for the consequences. These ambivalent feelings created mixed messages in terms of how parents communicated with their children about sexuality.

Parents can be involved in sexuality education in a variety of ways. In the "Love Talks" program implemented in Austria, parents as well as students and teachers were involved in the joint planning of the topics for the sexuality education programs, and how they would be presented (Wilgen & Kapella, 2008). While parents might not have as much say in the curriculum of health classes in both private and public schools in the United States, parents can still monitor the information they provide their children at home, as well as learn about the sexuality education being taught at the schools their children attend. The results show that many health teachers either send home a syllabus of their curriculum to parents, or require parental permission for participation in sexuality education programs. Additionally, many teachers discussed their willingness to speak with any parents who had questions about their curriculum, but usually received few calls. Parent participation in open houses varied, but almost all teachers said they rarely receive phone calls or individual meeting requests from parents, even though they make that known as an option.

In addition to schools, there are a variety of resources parents can use to learn how to talk to their kids about sexuality. Yvonne Nass, whose website is listed in the

resources section, holds a three part class for parents about how to discuss sexuality with their children, and which topics are appropriate to discuss at different ages throughout the lifespan. ARC and Planned Parenthood both offer parent education classes locally as well, but unfortunately, according to the representative from Planned Parenthood, few parents take them up on that offer. In addition to this local resource, SIECUS, Advocates for Youth, and Planned Parenthood have excellent information about how parents can talk to their children about sexuality education. Advocates for Youth has a “Parent’s sex ed center” which provides information about physical changes, advice from parenting experts, and a wide range of tips in how to discuss sexuality with their children. SIECUS provides a fact sheet with frequently asked questions, and a series of newsletter pamphlets with advice for parents and caregivers written in both Spanish and English. Planned Parenthood has information from parents about parent teen relationships, talking to kids about sexuality, keeping teens healthy by setting boundaries, helping teens to delay having sex, parenting teens who are sexually active, and information about puberty and sexual orientation.

If more parents become aware of the curriculum and involved in the education taught at their children’s schools, they could be better able to create a consistent message for their children about sexuality, and reinforce the lessons the children learn in school. Likewise, more involvement could facilitate broader acceptance of more and better sexuality education in schools. According to Krafchick and Biringen (2003), “children and adolescents who are informed and educated about issues of sexuality are more likely to be sexually responsible and less likely to put themselves in sexually risky situations [and] parents can play a pivotal role in imparting accurate information and values to their children in a developmentally appropriate manner (p.

57). In this article, Krafchick and Biringen (2003) discuss the importance of talking about sexuality to children throughout the lifespan and provide advice to therapists in how to encourage parents to talk to their children about sexuality. Just as in any school subject, if students learn a subject for two weeks and never use it or discuss it again, they are quite unlikely to remember many of the facts, and likewise unlikely to label the topic as highly important. According to research completed by NCHS (National Center for Health Statistics), “parental communication about sex education topics with their teenagers is associated with delayed sexual initiation and increased birth control methods and condom use among sexually experienced teenagers” (Martinez, Abma, & Casey, 2010). Therefore, even if students receive messages in school about the importance of relationships and values in making decisions about sexuality, as well as tools to use safer sex, they will be more likely to remember these ideas and use them if the same message is also reinforced at home.

Chapter 5

CONCLUSION

As Jocelyn Boryczka (2009) suggests, the ongoing debate surrounding sexuality education could be summed up into one simple question, “Whose responsibility is it?” This question could be interpreted in a couple of different ways: is it the family’s or the school’s responsibility to teach the youth of our country about sexuality? Boryczka suggests an alternative question: is remaining abstinent and/or living a healthy sexual life the responsibility of each individual person? Or does our society have a collective responsibility to ensure the sexual health of our youth? Despite what research may say as the “most effective” forms of sexuality education, across the United States there may continue to be a disagreement on the above question. Regardless of the lack of consensus on this issue, it is apparent that most schools across the United States will continue to address sexuality education in some form. As school boards and educators work to decide on the best sexuality education program for the youth in their district, school, or area, it is necessary to look at the research to decide on the most effective program for the type of population they are addressing. As the Advocates for Youth report and numerous other studies suggest, there is not just one “perfect curriculum” for an effective sexuality education program. As educators are deciding on the type of program to enact in their institution, it is important to take into consideration that while the activities and methods an instructor uses to teach sexuality education may differ across situations, the message to the students still needs to be consistent and age appropriate.

While teen sexual activity has been a controversial and pressing issue in the United States for a long time, it is apparent that effective sexuality education is needed now more than ever. With increased access to Internet and exposure to sexually saturated media on a daily basis, teens today have access to overwhelming amounts of information, much of which is based on myths, stereotypes, or inaccuracies. It is vital that both schools and parents take responsibility for teaching our youth medically accurate and evidence-based information before they learn mis-information from unreliable sources and accept it as the truth. One study found that out of 117 websites that provided sexual health information, “46% of those addressing contraception and 35% of those addressing abortion contained inaccurate information” (Buhi et al., 2010). Providing teens with a well-rounded curriculum that teaches valuing self and others, healthy decision making, respect, responsibility, tools for safer sex, and risks and benefits of sexual activity and contraception will help them make better decisions about nurturing themselves, engaging in sexual activity or deferring until later on, and doing so in a responsible manner. Choosing to address sexuality as an aspect of life instead of a taboo in our society has the potential to create an environment where youth can feel comfortable asking questions, making healthy decisions, and seeking assistance when it is needed. As evidenced through research literature, as well as this evaluation of sexuality education programs in Delaware, comprehensive education seems to be the best approach in providing teens with medically accurate information, encouraging open discussions, and helping youth to make smart decisions regarding sexuality.

Limitations

Although this research study examined a variety of schools and non-profit organizations across New Castle County, Delaware, the researcher was not able to meet with every school or non-profit organization that teaches sexuality education. Because sexuality education is not standardized across schools and organizations in the state of Delaware, the results of this study cannot be considered representative of sexuality education in every school across the county. However, while talking with professionals in this field, the researcher did develop an understanding of how many of the Delaware schools and organizations approach sexuality education.

Another methodological limitation is that the sampling for this study was not random, but rather used a snowball effect to recruit other participants. Therefore, it is possible that interviewees recommended colleagues of similar beliefs as potential interviewees. Even though snowball sampling was used, all potential participants in New Castle County were pursued through utilizing a comprehensive list of public, private and religious schools, and non-profits that addressed sexuality education. However, many of these professionals who were contacted did not respond. It is possible that the professionals, especially teachers from school districts that did participate, are more highly motivated and involved teachers in the sexuality education field, while those that did not respond may not be as involved in the advancement of the sexuality education field. Therefore, the actual participants in the study may not be representative of all sexuality education professionals, especially those not as involved or committed to the curriculum. Similarly, the sample size of professionals from each type of organization was not evenly distributed. There were four public schools represented, two private schools, and only one religious school. It is important to note

that both the private and religious schools were the most difficult from which to gain participation.

Additional research is needed to learn about the relationship between the statistics of teen sexual activity in Delaware, and the sexuality education these teens are receiving. Sexuality education professionals are encouraged to look at the resources section included at the end of this paper to find additional resources that may be used in addressing sexuality education in their schools or non-profit organizations.

The results of this research study provide insight into the state of sexuality education in New Castle County, Delaware. Findings show that comprehensive education is more frequently used than abstinence-only education, but sexuality programs are inconsistent both within and across public, private, and religious schools. Research studies over the past 15 years across the United States were reviewed which provided numerous examples of comprehensive sexuality education programs that have been effective in delaying onset of sexual activity, reducing the number of partners of sexually active youth, reducing teen pregnancy rates, or reducing the transmission of sexually transmitted diseases. The results from the interviews conducted for this study provide examples of the many sexuality education programs and resources available to Delaware youth, parents and professionals. The next step in addressing the sexual activity statistics of Delaware is encouraging youth, parents, and professionals to take advantage of the resources available to them and have multiple discussions about sexuality in both school settings and at home, encouraging healthy expression and behaviors across the lifespan.

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Appendix A

ANNOTATED BIBLIOGRAPHY OF RESOURCES FOR EDUCATORS AND PARENTS

A Door of Hope. (2012). *A door of hope pregnancy center*. Retrieved from

<http://www.adoorofhope.org/>

A Door of Hope has two locations: in Newark and Wilmington, and provides consultations for women who are pregnant and considering their options. A Door of Hope also has an education center that provides lessons to youth in schools and communities in the tri state area, teaching about relationships, abstinence, and personal integrity.

Advocates for Youth (2008). *Advocates for youth: Rights, respect, responsibility* .

Retrieved from <http://www.advocatesforyouth.org/index.php>

Advocates for Youth is a national organization that encourages comprehensive sexuality education and open communication to adolescents regarding reproductive and sexual health. Their website provides a parent resource center, a sexuality education resource center for professionals and teachers, information about public policy and advocacy, and resources for youth and teens.

AIDS Delaware. (2013). *AIDS Delaware*. Retrieved from <http://aidsdelaware.org/>

AIDS Delaware is a non-profit organization that provides confidential HIV testing, medical services to those diagnosed with HIV, support groups, and education in schools and communities across the state of Delaware. There are three offices: located in Wilmington, Rehoboth, and Seaford.

BrainPOP. (2012). *Health: Your body and how it works*. Retrieved from

<http://www.brainpop.com/health/>

BrainPOP is a website that was recommended by one of the private school teachers in Delaware. Included on the website are interactive games and activities to teach children about health, among other subjects. The health topics included on the website include body systems and how they work; information about genetics, growth, and development; physical fitness, personal health and growth and development.

Center for Disease Control and Prevention. (2012). *Youth online: High school YRBS*.

Retrieved from <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx>

This is an interactive website in which users can compare the statistics and results of the Youth Risk Behavior Survey among different states.

Children and Families First. (2012). *ARC: Adolescent resource center*. Retrieved from

<http://www.cffde.org/services/supportingteens/arc.aspx>

Depending on the day of the week, ARC is located in various locations across Delaware including Wilmington, Newark, and Dover. ARC provides confidential medical services including HIV/STD testing, STD treatment,

pregnancy tests, contraception, education services in schools and community settings, and counseling services.

Christiana Care Health System. (2012). *Alliance for adolescent pregnancy prevention*.

Retrieved from <http://www.christianacare.org/aapp>

The Alliance for Adolescent Pregnancy Prevention provides different sexuality education programs for youth in the community. Christiana Care is also involved in overseeing the wellness centers in the state of Delaware. More information on these programs are provided on this website.

Darkness to Light (2010). *Darkness to light: End child sexual abuse*. Retrieved from

http://www.d2l.org/site/c.4dICIJOkGcISE/b.6243681/k.86C/Child_Sexual_Abuse_Prevention_Training.htm

Darkness to Light is a child abuse prevention program, which provides workshops for parents and adults across the United States. In addition to information about finding a workshop locally, the website provides tools for organizations, parents, and individuals.

Delaware Right to Life (2012). *Delaware Right to Life: The first state for life*.

Retrieved from <http://www.derighttolife.org/>.

This is a website of Delaware Right to Life, that advocates a pro-life stance on abortion. The website provides information about events, volunteer opportunities, as well as newsletters and statistics.

Guttmacher Institute. (2012). *Facts on American teens sources of information about*

sex. Retrieved from <http://www.guttmacher.org/pubs/FB-Teen-Sex-Ed.html>

This website provides information about sexual and reproductive health through research publications, statistics, and policy information.

I-safe. (2013). *I-safe: The leader in e-safety education solutions*. Retrieved from <http://isafe.org/wp/>

I-safe is an Internet safety program for adolescents that can be used to teach youth in schools how to safely use the Internet. The website provides information on the I-safe program for schools, educators, and youth.

Nass, Y. (2010). *Yvonne Nass: Certified Parent Educator*. Retrieved from <http://yvonnenass.com/>.

Nass is a certified Adlerian Family Counselor, and a certified Delaware Level II Parent Educator. She provides workshops for parents about how to talk to kids about sexuality as well as positive parenting strategies, classroom management training, how to encourage self confidence, and parenting young children.

Nemours (2013). *Kids Health from Nemours*. Retrieved from <http://kidshealth.org/kid/>

This website, developed by Nemours was recommended by multiple sexuality education professionals. It includes information and activities for kids and teens about aspects of health including how the body works, puberty and growing up, health problems of kids and grown ups, how to stay safe and healthy, sexual health, drugs and alcohol and more. The website is split up into three different sections, providing information separately for parents, kids, or teens.

Planned Parenthood of Delaware (2013). *Planned Parenthood of Delaware*. Retrieved from <http://www.plannedparenthood.org/delaware/>

Planned Parenthood has three locations in Delaware: Newark, Wilmington, and Dover. Planned Parenthood provides reproductive health services including STD and pregnancy testing, contraception, wellness exams, and abortion services. They also provide teacher training and professional development, and sexuality education to youth in schools and communities.

SIECUS. (2012). *For parents*. Retrieved from

<http://www.siecus.org/index.cfm?fuseaction=page.viewPage&pageID=632&nodeID=1>

This is a webpage by SIECUS that provides parents with external links, newsletters and information about how to talk to their children about various sexuality topics. All newsletters are also provided in Spanish.

SIECUS. (2012). *Sexuality information and education council of the United States*.

Retrieved from <http://www.siecus.com/>

SIECUS is a national organization that supports comprehensive sexuality education throughout the lifespan, and provides educational resources, fact sheets, national and statewide statistics and information about policies and advocacy.

SIECUS. (2012). *SexEd library*. Retrieved from

<http://www.sexedlibrary.org/index.cfm?pageId=721>

SexEdLibrary.org is a website that provides lesson plans and resources for educators on a variety of sexuality education topics including human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. It also provides opportunities for continuing education and professional development for educators.

State of Delaware. (2012). *Health education*. Retrieved from

http://www.doe.k12.de.us/infosuites/staff/ci/content_areas/health.shtml

This is a resource center provided by the Delaware Department of Education that includes Delaware health education standards, model instruction units, and resources for educators.

Evidence Based Programs

Advocates for Youth (2008) *Science and success: Programs that work to prevent teen pregnancy, HIV & sexually transmitted infections in the United States*.

Retrieved from <http://cachedsimilarwww.themediaproject.com/for-professionals/programs-that-work>

This article provides information about twenty six sexuality education programs that are considered successful, because of meeting one or more of the following outcomes: postponement or delay of sexual initiation, reduction in the frequency of sexual intercourse, reduction in the number of sexual partners or increase in monogamy, increase in the use or consistency of use of effective

methods of contraception and/or condoms, reduction of the incidence of unprotected sex, or showed effectiveness in reducing rates of pregnancy, STIs, or HIV in intervention youth.

Barth, R. P. (2004). *Reducing the risk: Building the skills to prevent pregnancy, STD, and HIV*. (Fourth ed.). Scotts Valley, California: ETR Associates.

This is a program mentioned in Advocates for Youth's twenty six programs that work, and also one of the programs that Planned Parenthood has access to. This program provides a comprehensive approach to sexuality education for high school students in both rural and urban areas.

Coyle, L., Douglas, J., Gardner, C., Sterner, L., Walker, J., & Williams, V. (2011). *All 4 you: Preventing HIV, other STD and pregnancy among young people in alternative education settings*. ETR Associates.

This program is a comprehensive sexuality education program that addresses protective factors, positive health behaviors, and prevention of HIV, STD, and unintended pregnancy. The target population for this program is high school aged youth in alternative education settings.

DiClemente, R. J., Wingood, G. M., Harrington, K. F., Lang, D. L., Davies, S. L., Hook, E. W., . . . Robillard. A. (2004). Efficacy of an HIV prevention intervention for African American adolescent girls: A randomized controlled trial. *JAMA* 292(2) 171-179.

This comprehensive sexuality education program is one of Advocates for Youth's twenty six programs that work, and is entitled, SiHLE (sisters

informing, healing, living and empowering). The program is aimed at African American adolescent girls ages 14 to 18 who live in either an urban or suburban setting. The program includes a requirement that both professional and peer educators are also African American females.

East, P., Kiernan, E., Chavez., G (2003). An evaluation of California's adolescent sibling pregnancy prevention program. *Perspectives on Sexual & Reproductive Health* 35(2) 62-70.

This comprehensive sexuality education program is targeted at the specific population of siblings of pregnant and parenting teens, ages 11 to 17. Other characteristics of the target population include Hispanic or economically disadvantaged youth. This program was one of Advocates for Youth's twenty six programs that worked.

Jemmott, L. S., Jemmott, J. B. I., & McCaffree, K. A. (2012a). *Be proud! Be responsible! An evidence-based intervention that reduces the risk of HIV, STDs and teen pregnancy*. (Fourth ed.). New York City: Select Media, Inc.

This program is one of Advocates for Youth's twenty six programs that work and also is implemented in the state of Delaware by Planned Parenthood. This comprehensive program includes six sessions, is aimed at urban high school youth, and addresses relationships, goals, values, contraception and condoms, STDs and HIV transmission and prevention, and negotiation and refusal skills.

Jemmott, L. S., Jemmott, J. B. I., & McCaffree, K. A. (2012b). *Making Proud*

Choices! An evidence-based, safer-sex approach to teen pregnancy, STDs and HIV prevention. (Fourth ed.). New York City: Select Media, Inc.

This comprehensive education program has a target audience of middle school students ages 11 to 13, and is a program implemented by Planned Parenthood and mentioned in the Advocates for Youth report. The program addresses the same topics as “Be Proud! Be Responsible!” and can be adapted for use with high school students if necessary.

Kirby, D. B., Baumler, E., Coyle, K. K., Basen-Engquist, K., Parcel, G. S., Harrist, R., & Banspach, S. W. (2004). The “Safer Choices” intervention: Its impact on the sexual behaviors of different subgroups of high school students. *Journal of Adolescent Health 35*(6) 442-452.

This comprehensive sexuality education program was listed in the Advocates for Youth report of twenty six programs that work. The research study was unique in that it tested outcomes among different categories including gender, race, ethnicity, prior sexual experience, and prior sexual risk taking. The target population is high school students and components included lessons in school, parent involvement, and community linkages.

Kirby, D., Korpi, M., Barth, R. P., & Cagampang, H. H. (1997). The impact of the postponing sexual involvement curriculum among youths in California. *Family Planning Perspectives 29*(3) 100-108.

This comprehensive education program, found in the Advocates for Youth

report, is aimed at seventh and eighth grade economically disadvantaged, urban, high risk, and sexually inexperienced youth. Notable components include that the program is implemented over a two year span, is led by trained peer educators from the 10th and 11th grades, and has outside health professionals working in each school.

Lederman, R., Williams, S., Chan, W., & Roberts, C. (2003). *PARE: Parent Adolescent Relationship Education*. Santa Cruz, California: ETR Associates.

This comprehensive sexuality education program, found in Planned Parenthood's library of programs, and is an after school program for middle school youth and their parents. It includes weekly sessions in which parents and their children meet with trained facilitators who encourage family interaction and dialogue regarding responsible sexual behavior.

Marin, B., Coyle, K., Gomez, C., Jinich, S., & Kirby, D. (2003). *Draw the line respect the line: Setting limits to prevent HIV, STD and pregnancy for grade 6*. Scotts Valley, California : ETR Associates.

This comprehensive sexuality education program, used as a resource by Planned Parenthood is designed for a classroom setting for use with sixth graders, but also has curriculum for seventh and eighth grade students as well. Notable components include role play and refusal skills, and all materials can also be found in Spanish.

O'Donnell, L., Stueve, A., O'Donnell, C., Duran, R., Doval, A. S., Wilson, R., Haber, D., Perry, E., & Pleck, H. (2002). Long term reductions in sexual initiation and

sexual activity among urban middle schoolers in the reach for health service learning program. *Journal of Adolescent Health* 31(1) 93-100.

This comprehensive program, entitled “Reach for Health” can be found in Advocates for Youth’s twenty-six programs that work. The program includes classroom instruction combined with three hours of community service per week, and is implemented over the course of two years to seventh and eighth grade, disadvantaged, and urban youth.

Rotheram-Borus, M. J., Koopman, C., Haignere, C., & Davies, M. (1991). Reducing HIV sexual risk behaviors among runaway adolescents. *JAMA* 266(9) 1237-1241.

This comprehensive education program, entitled, “Adolescents Living Safely: AIDS Awareness, Attitudes and Actions” can be found in Advocate’s for Youth’s twenty-six programs that work. This target population is runaway African American and Hispanic runaway youth living in shelters.

St. Lawrence, J. S. (2005). *Bart: Becoming a Responsible Teen, an HIV risk-reduction program for adolescents*. (Revised ed.). Santa Cruz, California: ETR Associates.

This comprehensive program can be found in the Advocate’s for Youth report, and is also used as a resource for Planned Parenthood. The program includes eight sessions that address the topics of HIV transmission and AIDS, developing and using condom skills, learning and practicing assertive

communication skills, meeting people with HIV, and learning how to protect yourself and educate others.

University of Maryland Department of Pediatrics. , Wayne State University Department of Pediatrics, Children's Hospital of Michigan, & West Virginia University Department of Pediatrics, (2009). *Focus on youth: An HIV prevention program for African American youth*. ETR Associates.

This comprehensive education program is one of the resources used by Planned Parenthood. The target population is African American youth ages 12 through 15 who are at risk for HIV infection. The program consists of eight sessions which include group cohesion activities, learning about communication, values, and goal setting, condom demonstration, and information about contraception and safer sex.

Villarruel, A. M., Jemmott, L. S., & Jemmott, J. B. I. (2009). *Cuidate: A culturally based program to reduce HIV sexual risk behavior among Latino youth* . (First ed.). New York City: Select Media, Inc.

This comprehensive sexuality education program targeted at Latino youth and implemented in either Spanish or English is used as a resource for Planned Parenthood and found in the Advocates for Youth twenty-six programs that work. “Cuidate” means take care of yourself, and the program includes six modules that address HIV knowledge and attitudes, condom use and skills, and negotiation and refusal skills.

Zabin, L. S., Hirsch, M. B., Smith, E. A., Streett, R., Hardy, J. B. (1986). Evaluation of a pregnancy prevention program for urban teenagers. *Family Planning Perspectives* 18(3) 119-126.

This comprehensive sexuality education program, entitled, “Self Center” is found in the Advocates for Youth report of twenty six programs that work. In addition to providing education about abstinence and contraception in schools, the program offers free reproductive and contraceptive health care to students at a school- linked health center. The program’s target population are urban, black, and economically disadvantaged female high school students.

Appendix B

INFORMED CONSENT

Inventory of Sexual Education and Reproductive Health Resources in Upper Delaware

June 2012

Dear participant,

This is a consent form for my research project entitled, “Inventory of Sexual Education and Reproductive Health Resources in Upper Delaware.” Participation in this research study is voluntary and you may choose to drop out at any time, and refuse to answer any questions you do not want to answer. You were chosen for this research project because of your status as a professional involved in some aspect of sexual education. My goal is to compile a paper, which includes the various programs and strategies used to teach sexual education in schools, non-profit agencies, and youth programs in upper Delaware. I will be asking you a series of questions about your school or agency in hopes of learning more about the approach your program uses, the other agencies you collaborate with, and the effectiveness of your program to the youth or audience you are trying to reach. The approximate time commitment to complete the interview is about 1.5 hours. The approximate number of participants in this research study will most likely be around 10-15 people.

In order to accurately report the information provided in this interview, I will be using my laptop to audio record our conversation. I will be coding the interviews on my laptop using numbers so they will not be linked to your names on the same document. I will then transcribe the interviews onto a separate document, which will also be coded so they are not directly connected to any participants. Consent forms as well as a copy of the transcriptions will be stored on campus in my advisor’s office in a locked filing cabinet. The audio recordings will be destroyed by June 2013, but the transcriptions will be kept for three years in my advisor’s office for audit purposes. If you do not wish to be audio recorded, you may sign below and your interview will not be recorded.

If possible, I would like to connect the information you provide with either the name of your school, the district of your school, or the type of school (public, private, religious) you are categorized under. If you are a non- profit agency or organization, I would like to connect the name of your organization with the information you provide.

The reason I would like to provide identifiers is that when I report this information in my final paper, I would like to provide a comprehensive list of the types of services each organization provides. A potential risk with including the name of the organization or school that you represent is that there is a possibility a participant could be identifiable by association to that institution.

_____ If you do not wish to be identified by name, please initial here.

_____ If you do not wish to be identified by the name of your school or organization, please initial here.

_____ If you do not wish to be identified by your school district, please initial here.

_____ If you do not wish to be identified by your type of school, please initial here.

_____ If you do not wish for your interview to be audio recorded, please initial here.

Reminder: participation in this research study is voluntary. Participants can drop out at any time or ask for information to not be used with no penalty. If you have any questions or concerns about your rights as a participant in research feel free to contact the institutional review board chair for the University of Delaware at 302-831-2137.

If you have any questions regarding my research study, please contact me using the contact information provided below.

Name: (Please Print) _____

School/Agency _____

Signature _____

Date _____

Best regards,
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Appendix C

INTERVIEW QUESTIONS AND PROMPTS

- What is your (school, agency, personal) policy regarding the type of sexual education that is taught to individuals seeking advice?
- What types of services are available? (i.e. pamphlets and other materials distributed, amount and length of classes, outside resources used, parent involvement, peer leadership and involvement, health services offered)
- Have you experienced any opposition from students, parents, clients and/or administrators regarding your policy or program?
- Have you conducted any evaluations to test the effectiveness of the program(s) you have developed/ used? What indicators do you see as showing success in sexuality education?
- What is your approach with parents in regards to their input in type and use of sexual education?
- What type of resources/ textbooks/ media have you used to develop your program?
- Who developed the program that you use? Do you have any information on other programs that have influenced your curriculum?
- Do you have partnerships with any others schools/ agencies in regards to education and distribution of information or products?
- For non-profit agencies and youth groups, who is your audience that you are trying to help? How do you make your audience aware of your program?
- What is the confidentiality policy when a teenager seeks advice/ guidance on sexual issues?
- What is your (school, agency, personal) policy regarding the dispersing of birth control and/ or emergency contraception?
- What advice would you give communities or schools who want to have more effective sexuality education programs?

- Which domains of sexuality education do you consider important and worth including in any program and why? (i.e. relationships, biological knowledge, technology and medical information, gender equity, fertility and reproductive choice, communication, decision making and risky behavior, impaired judgment, birth control and access to birth control)
- What support and resources would you like to see developed and made available?
- Does your program/ curriculum address diversity? If so, how does it approach diversity? (I.e. sexual orientation, gender, ethnicity, race, religion, etc.)
- Can parents choose to not allow their kids to participate in the sexuality education provided by your school/ program?
- Do you encourage the students in your program to use outside sources such as their friends, family, or the Internet for more information on sexuality education? Are you aware of students receiving false information from any of these sources?

Appendix D

DELAWARE HEALTH EDUCATION STANDARDS

1. Students will *understand essential health concepts* in order to transfer knowledge into healthy actions for life.
2. Students will *analyze the influence* of family, peers, culture, media, technology and other factors on health behaviors.
3. Students will demonstrate the ability to *access information*, products and services to enhance health.
4. Students will demonstrate the ability to use interpersonal *communication skills* to enhance health and avoid or reduce health risks.
5. Students will demonstrate the ability to use *decision-making skills* to enhance health.
6. Students will demonstrate the ability to use *goal-setting skills* to enhance health.
7. Students will demonstrate the ability to *practice health-enhancing behaviors* and avoid or reduce health risks. (self-management)
8. Students will demonstrate the ability to *advocate* for personal, family and community health.

Source: State of Delaware (2012) *Health Education*. Retrieved from http://www.doe.k12.de.us/infosuites/staff/ci/content_areas/health.shtml