THE EXPLORATION OF ADOLESCENT SEX EDUCATION PROGRAMS
TAUGHT IN PUBLIC SCHOOLS

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THE EXPLORATION OF ADOLESCENT SEX EDUCATION PROGRAMS
TAUGHT IN PUBLIC SCHOOLS

A Project

by

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Division of Social Work
Abstract

of

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by

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The purpose of this project was to explore the curricula and sexual health education programs taught to adolescents in public schools. This researcher reviewed the literature that has been documented on sex education programs taught nationally, along with the required Educational Codes, Sections 51930-51939, that a public school must follow if it chooses to teach sexual health education to the students in California. This researcher explored the sexual health education programs primarily by interviewing four teachers and one principal, who all work in public schools in Northern California. The teachers interviewed were the sources of data for this study, and the information gathered during the interviews were complied and analyzed. The information gathered from the interviews helped this researcher create a comprehensive sexual health education curriculum that meets all of the state requirements, and was designed to be taught by social workers rather than teachers.

_______________________, Committee Chair

Dr. Santos Torres, Jr.

_______________________

Date

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Chapter 1

INTRODUCTION

The United States has one of the highest rates of sexually transmitted diseases (STDs), teen pregnancies, and teen birth rates when compared to most other industrialized countries (Kohler, Manhart, & Lafferty, 2008; McKee, 2008; Clapp, 2009). On average, every year in the U.S. 750,000 adolescent females become pregnant. It has been estimated that more than four million teens and more than six million youth ages 20-24 annually contract a sexually transmitted infection (STI). It is also estimated that “by age 24, at least one in three sexually active people will have contracted an STI” (Advocates For Youth [AFY], 2008). Sendziuk (2008) states that 47 percent of U.S. adolescents have sexual intercourse before leaving high school, and found that 37 percent of sexually active high school students did not use a condom the last time they had engaged in sexual intercourse. Failure to use condoms could be the reason for so many STDs, STIs, and pregnancies among adolescents. Even though Anderson and Muller (2008) report that condom use has gone up in the past decade, the experts want to see the numbers increase even more.

Millions of dollars are spent each year on abstinence-only based education in public schools, and research is proving that it is not an effective program (Manlove, Romano-Papillo, & Ikrahmulla, 2004; Kirby 2001; Hauser, 2008; Irwin, 2006; Santelli, Ott, Lyon, Rogers, Summers, & Schleifer, 2006; AFY, 2009; Fortenberry, 2005; Kohler et al., 2008; Sendziuk, 2008; Spriggs et al., 2008; Saul, 1998; Ott, Pfeiffer, & Fortenberry, 2006; Ito, Gizlice, Owen-O’Dowd, Foust, Leone, & Miller,
Abstinence-only programs have been taught in public schools since the 1980’s and research has shown that the program in place is no longer working. The information that is taught through abstinence-based education is not preventing the youth of our nation from engaging in sexual intercourse nor helping them to protect themselves if they do decide to have sexual intercourse before marriage. The sex education programs are only delaying the age of sexual debut. The abstinence-based programs in public schools have been supported by the federal government and have been longstanding in the curricula that is taught to our youth, but research seems to prove the programs to be inaccurate in their teachings and ineffective overall (Sendziuk, 2008; Spriggs et al., 2008; Santelli et al., 2006; Saul, 1998; Ott, et al., 2006; Kohler et al., 2008; Ito, et al., 2006; Fortenberry, 2005; McKee; 2008; Mulrine, 2002; AFY, 2008; Manlove, et al., 2004; Kirby 2001; Hauser, 2008; Irwin, 2006; Santelli, et al., 2006).

These findings leave this researcher to question our longstanding programs, the research, and people who support it. It may be time to ask why these programs still exist, and why comprehensive sex education is not considered or utilized more often. The research on pregnancy, STD and STI infection rate is stifling, and this researcher finds it hard to believe that some politicians, school administrators, and parents are still standing by the programs that are not relevant to the current adolescent sexual behaviors. This leads this researcher to question if politicians and program planners are aware of the current information, and if they are aware of how badly our
adolescents need proper education on the subject matter. The education that the students are being given is informing them to wait to have sexual intercourse, but not always providing proper and accurate information that would provide protection for when they do choose to engage in sexual intercourse.

**Background of the Problem**

It has been reported that about 90% of all public schools teach some form of sexual education, typically taught once in middle school and once in high school. Abstinence based programs are still being used in some of our public school systems to teach the youth of our nation about health, monogamous sexual activity within marriage, and reproduction (Ito, et al., 2006). Abstinence can be defined through behaviors such as “postponing sex” or “never had sexual intercourse.” Ott et al. (2006) found in a study that many adolescents knew that abstinence referred to something about sex, but most of the participants in the study could not come up with an exact meaning of the word. Santelli et al. (2006) states that abstinence can be defined in different ways, and program planners and policy makers do not make the definition of the word clear when teaching about the subject.

Over the past couple of decades, teens have been increasingly engaging in a culture of “hooking up” rather than dating, which consists of teens engaging in sexual activities with one another randomly, and at times, with many different partners (Mulrine, 2002; Basu, 2005, O’Connell, 2005; Jayson, 2005; Hall, 2003). Claire Brindis, a professor of pediatrics at the University of California at San Francisco,
states that oral sex is a major social norm with about 50 percent of young people engaging in the activity (Sessions Stepp, 2005). Much of the “hooking up” consists of oral sex, and these activities are occurring in teenagers as young as 13 years old. Many are engaging in these sexual activities to maintain “technical virginity” since abstinence is the message that is being given to them (Mulrine, 2002, Teens are having more sex section, para. 22). Many teens do not consider oral or anal sex as sex, and some are thinking that they are remaining abstinent when engaging in these behaviors (Mulrine, 2002; Sessions Stepp, 2005; Jayson, 2005; Hall, 2003). What needs to be taken into account when defining and teaching abstinence is that some adolescents do not define some sexual behaviors such as, “touching, kissing, mutual masturbation, oral sex, and anal sex” as being a part of the definition of sexual intercourse (Mulrine, 2002, Definitions of abstinence section, para. 1). The issue with this is that STDs and STIs can still be transmitted through these activities, and most adolescents seem to be unaware of this due to the lack of information that is taught through the abstinence only sex education (Sendziuk, 2008; Ott et al., 2006; Santelli et al., 2006; Mulrine, 2002; Sessions Stepp, 2005).

This new knowledge is shocking and frightening to many adults. Parents are shocked that such intimate sexual activity is casually practiced many teens. Many parents are concerned that these risky behaviors may be a reason for the spreading of so many STDs and STIs (Jayson, 2005; O’Connell, 2005). Many teens report thinking that engaging in oral sex is less risky to their health compared to vaginal sex (Basu,
Another fear of many adults is that teens are not engaging in relationships and therefore not learning how to trust, love, or relate in a monogamous relationship. Intimacy seems to be devalued and not viewed as an important aspect of sexual relationships (Jayson, 2005). Intimacy and monogamous relationships are societal values that are believed to important by some. Not everyone may agree to these values, but parents are concerned that if teenagers are not learning how to relate in sexual relationships they are experiencing at such a young age, then the teenagers may never learn to connect to another human in a way that is valued by those parents as a necessary aspect of life. Parents need to talk to their teens about relationships, sex, and the emotional aspects of the two since it is not a subject that is discussed at school during sex education (Basu, 2005; Jayson, 2005).

Many teen girls have expressed that they are willing to participate in hooking up and oral sex, but they at times feel manipulated into doing so and then feeling guilty and used afterwards (Lelchuk, 2007; Meltz, 2007; Brody, 2007). Research has found that more girls than boys feel this way due to a chemical in the brain, called oxytocin, which is produced during sex that promotes feelings of connection and love. Boys also produce the chemical, but testosterone is also released during sex that suppresses oxytocin. Therefore girls feel these feelings after sex more so than boys, and they are left feeling “hollow and empty” after a hookup and do not know how to handle the emotions (Meltz, 2007, Hooking up section, para. 6). Boys have reported to feel more confident and popular after hooking up. Although talking about the
emotional consequences of sexual activity with adolescents is very important, it is something that is typically left out of sexual health education (Meltz, 2007; Lelchuk, 2007).

Research studies have concluded that many teens feel that the sexual education they are taught in school is inadequate and does not relate to what they are experiencing themselves (Fears, 2009; Lelchuk, 2007; Hall, 2003; Dailard, 2001). They are also uncomfortable going to speak to the school nurse, who is typically the one that students are directed to talk to about sex at school. Along with feeling like they are speaking to their mom when seeking help from the school nurse, students fear that the nurses are judgmental and untrustworthy. With the economic times being difficult and the increase in cut backs and layoffs, there is less availability to seek help from the school nurses and adolescents do not have anyone else to turn to for advice (Fears, 2009).

Through examination of studies and reports of what sexual behaviors adolescents are engaging in today and examining the research on the types of programs that are taught to students, this researcher feels that there is a gap between the actual behaviors and the subject matter of the sex education programs taught in schools. This researcher feels that those who are in charge of creating the programs for adolescent sex education are not keeping the program curricula up to date by not taking into account the true life experiences that today’s adolescents are facing. By not knowing the current research and information about adolescent sexuality and
behaviors, the youth are not receiving information that could be helpful in the prevention of contracting potentially harmful or fatal diseases and infections. Research also shows that some teens do not trust or feel comfortable with the school personnel who are responsible for informing them of the dangers of some behaviors (Fears, 2009).

There is a need for change, and this researcher feels that there is nothing to do but make an honest effort to make the changes that are needed to support our youth in becoming healthy, aware, and informed adults. The learning environment needs to be taken into account including thoughts about who will be implementing the information. All of society may not agree with the sexual behaviors of the youth today, but everyone cannot continue to ignore the fact that adolescents are engaging in sexual activity and putting themselves at risk for STDs, STIs, and pregnancy on a regular basis. Those who are responsible for adolescent education need to come together, put differing opinions aside, face the reality of what behaviors some adolescents are engaging in, and bring forward the information our youth need to protect themselves from potential harm.

Studies are continuously showing that adolescents are not waiting until marriage to engage in sexual intercourse, so the new direction of sex education needs to acknowledge the reality of adolescent sexual behaviors and make necessary changes to the existing abstinence-based programs (Santelli et al., Irwin, 2006; Sendzuik, 2008; Ott et al., 2008; Fortenberry, 2005; McKee, 2006; Jones, 2008; AFY, 2009, Kirby,
If our country is going to continue to ignore the fact that adolescents are participating in sexual activities before marriage, then STDs and STIs will continue to spread and endanger the health of our youth. Parents appear to understand how important sexual education is for their children, and studies have shown that parents would like to see more education in schools about contraceptives and other ways to prevent STDs, STIs, and unplanned pregnancies (Santelli et al., 2006; Burlingame 2003; Jones, 2008; Ito et al., 2006). Studies repeatedly show that there is no scientific evidence that supports that abstinence-only based education delay the initiation of sexual intercourse (Santelli et al., 2006; AFY, 2008; Dailard, 2001; Mulrine, 2002).

Furthermore, abstinence-based education can have profound negative effects on the well being of adolescents who identify their sexual orientation as gay, lesbian, bisexual, transgender and questioning (GLBTQ). Most of the programs that follow the abstinence-based education guidelines omit information about sexual orientation, and many times the information taught about homosexuality is inaccurate and stigmatizes homosexuality as a deviant and risky behavior. Many states have laws that ban same-sex marriage, so those youth who identify as GLBTQ may feel left out and view life long abstinence as impossible. This places those youth to be held at different and unrealistic standards than fellow heterosexual classmates (Santelli et al., 2006; AFY, 2008). There is a need to make all students feel comfortable and included in the education being taught in the public school system. Where is the justice in omitting information about a basic human right, and discriminating against some
adolescents and not others? Who is to judge what types of sexuality and sexual behaviors are to be considered normal or acceptable?

What also needs to be taken into account is that the adolescent brain is still developing, and the rationale used to engage in risky behaviors is different from the rationale that an adult would use. Programs need to address this rationale difference and openly have conversations with adolescents about it and why risky sexual behaviors are a concern for adults. Adolescents are engaging in adult-like behaviors and therefore should be treated like adults when discussing the topic. They need to be told the truth, and be given a chance to ask questions and speak about the struggles and challenges they are facing when choosing to engage in risky sexual behaviors. There needs to be conversations with them about how they are being affected by engaging in these behaviors at such an early age.

Teenagers are at a critical period in their lives where they are dealing with exploring who they are and who they want to be, along with learning to deal with all of the physical changes occurring in their bodies. Chapman and Werner-Wilson (2008) suggest there be navigation in helping youth who are dealing with the physical, cognitive, emotional, and social changes that occur during adolescence. The authors acknowledge that most adults deal with teenage sexuality by simply ignoring it or attempting to suppress it, and neither way has been successful in effectively handling the situation. The media sends out messages to adolescents about what is expected of them by society, which many times conflicts with the messages from their parents and
religious teachings. As reported by Chapman et al. (2008), “there is a pressing need to understand, nurture, and regulate the flowering of sexuality during adolescence in ways that are consistent with current realities, social values, and individual freedoms. It is essential that we understand the role that adolescent sexuality plays in the creation of sexually healthy and competent adults” (p. 506).

**Statement of the Problem**

The current abstinence-based sexual education that is taught to the adolescents of today has been proven through various studies to be ineffective, inaccurate, confusing, and discriminatory towards some youth (Manlove et al., 2004; Kirby 2001; Hauser, 2008; Irwin, 2006; Santelli et al., 2006; AFY, 2009; Fortenberry, 2005; Kohler et al., 2008; Sendziuk, 2008; Spriggs et al., 2008; Saul, 1998; Ott et al., 2006; Ito et al., 2006; Fortenberry, 2005; McKee; 2008; Mulrine, 2002). Furthermore, what little information that is taught about contraception, prevention from STDs, STIs, and pregnancy is typically outdated information. The information taught is typically not congruent or relevant to the types of behaviors adolescents are engaging in and experiencing. The current abstinence-based programs and curricula are lacking information that can be applicable in the situations and challenges that most adolescents are facing surrounding the subject of sex. Program planners and policy makers need to pay attention to the studies being done on the influences and reasons for why adolescents are engaging in sexual activities at such an early age. There are many factors that need to be taken into account when creating the curricula for sex
education programs that teach the youth of today, and there is a call for comprehensive sex education programs to be put into all of our school systems. The current programs need to be explored and tested for effectiveness and the relevance of the information to the typical adolescents.

**Purpose of the Study**

Comprehensive sexual health education has been proven to be effective, and changes need to be made so that all sex education programs are comprehensive and not abstinence-based. Alternative methods of teaching sexual health information to adolescents need to focus on teaching relevant information in a way that is long lasting and help adolescents make future choices that are protective and preventative. Teaching information that adolescents can relate to will encourage them to learn, and will increase the likeliness of them using the information in the future. The programs need to focus on what the true need is for adolescent sex education, and take into account the development of their brain and how it plays into decision making when it comes to sexual behaviors. The focus needs to be on the reality that adolescents are having sexual intercourse before marriage, and that the current programs are only delaying sexual debut and not preventing it from occurring altogether. There also needs to be awareness that adolescents are engaging in other types of sexual activities that are thought to be safer and not considered a sexual act by the adolescents. Due to this rationale, adolescents think that they are able to preserve their virginity and remain abstinent if they are not actually engaging in sex.
The state of California chooses to take funding for only comprehensive sex education, and if a school chooses to teach sex education there are requirements and Educational Codes that must be followed. This study aims to take the research that has been found regarding comprehensive sex education, and speak to those who choose and implement the curricula for sexual education in the school settings in Northern California. This study also aims to explore the curricula that has been used by many different schools and get an inside viewpoint about what is currently being taught about sexual education to our adolescents, if the teachers are trained on the subject material, how often the material is updated and revised, and how the material is evaluated and measured for effectiveness and success. This researcher plans to create a comprehensive sexual health education program that will encompass all of the aspects thought to be effective in preventing future teen pregnancies and adolescents from contracting STDs and STIs. The model program that will be created by this researcher will also focus on talking about real life experiences of adolescents and improving self-esteem so that they feel confident in using protection every time they engage in a sexual activity or feeling confident in saying no to others.

**Theoretical Framework**

Adolescents are at a stage of life where they are forming their own identity and becoming aware of the world around them. They are beginning to think for themselves and make decisions on their own that may potentially impact the rest of their life. Some adolescents engage in sexual behaviors and activities either before or
at the same time they begin to learn about and become aware of their own bodies and sexuality. They are learning how to act and behave physically, emotionally, and sexually. They become curious of their own bodies and begin to react to the new hormones that have begun to surge through their bodies. It is those around them who have the most influence and impact on their lives and what they learn about how to handle the changes that are occurring within themselves and those around them.

One theory that can help in understanding and dealing with these issues is the social cognitive theory. This theory is based on learning taking place due to the reinforcement of behaviors from the people and environment that surrounds an individual (Schriver, 2004; Mbulo, Newman, & Shell, 2007). The basic assumptions and principles of theory are deterministic orientation, and when individuals are subject to environmental forces a focus is on exploring past experiences and the cognitive responses to those experiences. Social cognitive theory holds the belief that individuals can be active participants in their environment, and that interventions using this theory need to take into consideration thoughts, beliefs, feelings, and past experiences that are having an impact on the individual’s present behavior(s) (Guadalupe, 2009; Mbulo et al., 2007).

Meanings are created from each experience through thoughts, perceptions, beliefs, and values that create a reaction of feelings and emotions around that experience, and in turn the individual has a behavioral response to the experience (Guadalupe, 2009). The theory emphasizes a difference between moral competence
and moral performance. One can understand that a behavior is morally wrong, which
is the moral competence, but if there are strong enough incentives or rewards one
might go forward and behave immorally, which is the moral performance. Albert
Bandura, an American psychologist, believed that in trying to understand moral
development, one needed to take into account social, cognitive, and environmental
factors. Bandura also believed that self-efficacy plays a large role in how one behaves
(Guadalupe, 2009; Mbulo et al., 2007).

When relating an adolescent’s sexual behavior to this theory, this researcher
feels that the theory provides a lens that helps explain thoughts and reasons for
particular behaviors surrounding this issue. Adolescents are going to have many
experiences around the topic of sex, and how they will feel about the experience, and
in turn react to it, will depend upon how they perceive it based upon previous
experiences. Since the adolescent brain is not fully developed, adolescents may have a
good moral competence, but they may still choose to engage in risky sexual behaviors
due to the incentives and rewards of such behaviors. Sexual education should provide
a solid foundation of information for students, and educators need to have
conversations with adolescents about the issues and challenges that they are facing
surrounding sexual activities. There needs to more open lines of communication
between educators and adolescents surrounding sexual behaviors, the incentives to
engage in sexual behaviors, the potential consequences of such behaviors, and how to
handle the physical or emotional responses to engaging in sexual behaviors.
Another theory that should be taken into consideration surrounding this topic is the fuzzy-trace theory. This theory explains that decision-making has nothing to do with memory that has been stored from verbatim information, but everything to do with what is called gist, which refers to emotional meaning or affective interpretation to information. Therefore, the supporters of this theory believe that decisions, judgments, and behaviors are not based on verbatim information, but based on the meaning behind previous experiences or thoughts about the decision one is confronted with (Reyna, 2008; Reyna & Farley, 2007; Renya & Adam, 2003).

This relates to adolescent sexual behaviors in the same way as the social cognitive theory does, further acknowledging that just teaching information will not be effective. Adolescents need to be taught in a way they can relate to and make meaning of the information. Adolescents, according to both theories, need to have positive experiences with having conversations about sex with adults. If the past experiences were negative, then there will be no reason to want to continue those same experiences; adolescents will not seek help from adults when they have questions regarding sex, if they want to know how to protect themselves, how to handle situations when they need help, or just need some advice from a trusted source.

**Definition of Terms**

*STD/STI*: sexually transmitted disease and sexually transmitted infection (California Department of Education [CDE], 2008).

*HIV*: Human Immunodeficiency Virus (CDE, 2008).
**AIDS:** Acquired Immunodeficiency Syndrome (CDE, 2008).

**Abstinence-only sex education:** sexual health education where in abstinence until marriage is taught. Abstinence is taught to be the only preventative method of contracting an STD or STI or becoming pregnant. Teaching about contraceptives is only done to show how ineffective they are in preventing pregnancy or STDs and STIs (AFY, 2008).

**Comprehensive sex education:** sexual health education where in factual, medical, and accurate and age appropriate information is taught to students. Students will be taught non-biased information about the value of abstinence, STDs, Federal Drug Administration (FDA) approved methods of reducing the risk of contracting STDs, all FDA approved types of contraception, and skills on making responsible decisions about sexuality. In California students will be given information about California’s newborn abandonment law Safe Surrender Law EC 51933[12] and Penal Code 271.5 (CDE, 2008).

**GLBTQ:** Gay, Lesbian, Bisexual, Transgender, and Questioning (AFY, 2008).

**Peer led education:** Teaching or sharing of information, values, and behaviors by members of similar age or status group (Kim et al., 2008).

**Teacher led education:** information that is taught to students by teachers (AFY, 2008).

**Sexual debut:** The first time someone has sexual intercourse (AFY, 2008).

**Self-efficacy:** a belief in one's own ability to perform a task or get a desired result (AFY, 2008).
**Gist:** Representation of vague and qualitative information capturing the bottom-line meaning of information and it is a subjective interpretation of information based on emotion, education, culture, experience, worldview, and level of development (Reyna, 2008).

**Verbatim:** Representation of information that is precise and quantitative that captures the exact surface forms of the information (Reyna, 2008).

**Assumptions**

One of the basic assumptions of this study are that abstinence-based education is ineffective in the sense that it only delays adolescents from engaging in sexual intercourse, and when they do engage in sexual intercourse, they tend to not use protection. Adolescents are also engaging in sexual activities other than sexual intercourse and are again not using protection; therefore comprehensive sexual education may be more effective in promoting abstinence along with providing information on how an adolescent can protect him/herself when he/she chooses to engage in a sexual activity. Adolescents are typically not having conversations with their parents about the topic, and if they are not getting information from school or their parents, they are more than likely not getting accurate information about sex, STDs and STIs, contraception, and pregnancy.

Another assumption is that teachers do not always feel comfortable teaching the subject matter, or have a difficult time teaching without giving their own biases on the subject matter. Social workers may also struggle with the same issues, but social
workers are trained to be aware of their personal biases and not allow them to interfere with their work. If social workers were contracted by schools through one agency to teach at all of the schools, there could be a universal curricula that all the social workers could be trained on and used at each school.

The last assumption is that not all schools are following the same curricula, therefore the content being taught to students is not consistent and that evaluations are not done to ensure the effectiveness of the program. The training taught by social workers could be consistently used, and use of student evaluations after each time the program is taught would help ensure the effectiveness of the program. Therefore, social workers trained to teach unbiased, consistent, and accurate curricula for sexual education would be great educators on the subject matter.

**Justification**

The social work profession focuses on providing social justice and empowering our clients. The adolescents of our country are being robbed of basic rights of education on a topic that is often avoided due to a sense of uneasiness and personal beliefs about the subject matter. Many of the people who are in charge of creating the programs for adolescent sexual education do not feel that it is appropriate to teach the youth about information on the benefits of contraception, the forms of sexual activities teens are engaging in, teen pregnancy, the option of abortion, and sexual orientation. Adults may think these topics are inappropriate to teach, but adolescents are still engaging in sexual activities and finding information from other
sources that may be inaccurate. Many parents want their children to be more informed and do not feel they are educated enough themselves to educate their children on the topic. Sexual health education should require that a portion of the curriculum have parental involvement so they can become educated themselves, and in turn, adolescents then become more comfortable turning to their parents for advice.

Research is constantly coming up with new information and statistics about sex, STDs, STIs, and pregnancy. Public schools should teach students the updated information about how to prepare themselves to prevent the possible consequences of engaging in unprotected sex. The youth of today are entitled to have access to accurate information around the topic of sex, how to protect themselves, and the consequences of having multiple partners, as well as engaging in risky sexual behaviors that may prevent them from leading healthy lives. Too many adolescents are contracting STDs, STIs, and/or becoming pregnant, and all too often the consequences of having unprotected sex are seen as taboo and are not discussed. Adolescent sexual health education in the public school system needs to change, and it needs to be taught consistently by trained educators.

It is believed by this researcher that social workers would be the best educators to teach students a well-rounded comprehensive sexual health education. Social workers can be trained to provide accurate and consistent information to students. Another benefit of social workers educating students, instead of teachers, is social workers would be outside educators who do not have previous relationships or
knowledge of the students. Social workers would be educators that students do not know and may be more likely to engage in conversations and participate in the class. If there is no previous relationship between the student and the educator, then the students may have more respect for the educator and pay more attention to what is being said. The students may also not feel embarrassed asking questions or talking about subjects with the social worker if the student knows they will not have continuous contact with that person. Some students may be hesitant to participate if they know the educator well or if the educator is in constant contact with a student’s parents. Social workers can be educators who will feel comfortable talking to the youth and will not have to worry about teaching information they do not personally feel should be taught in schools. At many schools teachers do not volunteer to teach the subject matter. Most of the time teachers are assigned to teach the class that is designed to teach sex education, and they do not have a say in the decision. Having social workers as the educators would eliminate the problem of having a teacher forced to teach a subject that he/she may not comfortable teaching to students.

**Limitations**

This researcher will be speaking and interviewing individuals who are apart of the school district and public schools. This writer will be speaking to these individuals about the current program and curriculum that is in place at the district level, and inquiring if there is a difference in what is taught between districts in the same area and the schools in those districts. This researcher will also be speaking with these
individuals about how they view the effectiveness of the programs in place, inquiring about the components of the curriculum, where they get their information for the curriculum, how often the curriculum is updated, and how they test the effectiveness of the program. This researcher will not be in contact with adolescents or their parents. The focus of this study will be on the subject matter of what is taught to the adolescents in the public schools.
Chapter 2

REVIEW OF LITERATURE

Introduction

The focus of this chapter is to provide an overview of the literature found on adolescent sex education. This chapter will begin with a review the literature found on the different types of sex education that is being taught to adolescents and how they compare to one another. The second section that will be explored will be some of the existing programs and prevention strategies that are currently being taught to adolescents. The third section will be an exploration of the differences of teacher-led programs in comparison to peer-led programs. The fourth section is a review of alternative strategies and creative ideas of how to teach prevention to adolescents. The fifth section will be a review of the literature of findings on the influences and their role in adolescent sexual activity. The final section will be on the current government and educational codes and laws that a school must follow if they choose to teach sex education to the students of that school.

Sexuality Education in the United States

History of sex education

According to the Sexuality Information and Education Council of the United States (SIECUS), “the primary goal of school-based sexuality education is to help young people build a foundation as they mature into sexually healthy adults,” and “assist young people in understanding a positive view of sexuality, provide them with
information and skills for taking care of their sexual health, and help them make sound
decisions now and in the future” (What are the goals of school-based section, para.1).
Over the years there have been four types of sexuality education programs that have
been offered in schools and communities throughout the nation. These are
Comprehensive Sexuality Education, Abstinence-only, Abstinence-only-until-
mariage, and Fear-based (SIECUS, 2009).

The Title X Family Planning Program was enacted in 1970 as a part of the
Public Health Service Act, and it began as the only federal grant program that
provided comprehensive family planning and related preventive health services. The
support for abstinence-based education began in 1981 with the formation of the
Adolescent Family Life Act (AFLA) as Title XX of the Public Health Service Act,
which was created from the foundation of the Title X Family Planning Program (U.S.
Department of Health and Human Services [USDHHS], 2009; Santelli et al., 2006;
SIECUS, 2009). The AFLA program funds grants that support research on the causes
and consequences of adolescent premarital sexual activities, pregnancy, and parenting
(USDHHS, 2009). Over the years there have been slight changes in the AFLA
program, such as focusing on abstinence-based education and the prohibition of
abortion. The funding provided for programs were required to only go to programs
that adopt the guidelines and requirements, and restricted any funding from going to
programs that taught abortion as a method of family planning (USDHHS, 2009).
President Regan’s alternative for family planning for teenagers was conservative and acceptable by the public health and reproductive rights communities. The program became a true abstinence-based education in 1996 along with President Clinton’s welfare reform, the Personal Responsibility and Work Opportunities Reconciliation Act, also known as Title V of the Social Security Act (Saul, 1998; Santelli et al., 2006; Hauser, 2008). This Act provided an eight-point definition of abstinence-only education and required that the programs exclusively promoted abstinence outside of marriage. The Act also prohibited programs from advocating for contraceptive use and methods except to emphasize their failure rates (Santelli et al., 2006). California was the only state for the first five years of this new welfare reform to not participate in the program. In the early 1990’s, California had experimented with it’s own creations of abstinence-only programs (Hauser, 2008).

The George W. Bush Administration supported and advocated for Faith Based Action concerning sex education for adolescents. The Bush Administration had used religion as a vehicle to teach teenagers about choosing abstinence over sexual intercourse, and the thought was if teenagers were practicing abstinence then there was no need to educate and inform them about contraceptives and STDs (Solinger, 2001). According to Santelli et al. (2006), in 2000, there was an expansion of the welfare reform enacted by Clinton called Community-Based Abstinence Education projects that was “funded through an earmark in the maternal child health block grant for Special Projects of Regional and National Significance (SPRANS) program” (Current
Federal Policy section, para.1). All programs that are funded by SPRANS are required to teach all eight components of the federal definition of abstinence, they must have a target population of 12 to 18-year-olds, and cannot teach information about contraceptives except for their failure rates (Santelli et al., 2006).

The AFLA program provided funding for abstinence-only-until-marriage programs in schools, and until 2009, it was the smallest of the three funding sources, at that time, for sex education programs. The second funding source, up until 2009, was Community Based Abstinence Education (CBAE). Most of these grant-funded organizations were crisis pregnancy centers, hospitals, schools, and faith-based organizations, and some organizations also heavily relied on the federal abstinence-only-until-marriage funding to run their organizations. In 2009, an appropriations bill eliminated all of the funding for the CBAE grant program and the part of the AFLA program that was linked to the definition of abstinence-only programs (SIECUS, 2009).

The third form of funding, which is still in existence today, is the Title V Maternal and Child Health Services Block Grant, of the Social Security Act. This was passed and abstinence education was approved for federal funding for five years, 1998-2002. The program has been extended year after year, and in 2008 the program was extended again until June 30, 2009. Each state had the option to take the funding, but had to abide by the requirements of abstinence education. At first, the only states that chose to opt-out were California, Maine, and Pennsylvania, but over the years
close to half of the other states have also chosen to opt-out. States can take funding for any type of program that they would like to offer in their educational settings, but they just have to follow the laws that are created for those programs in order to obtain the funding (SIECUS, 2009).

In 1992, the Office of Adolescent Health (OAH) was created as part of the Preventive Health Amendments of that year. OAH was in charge of creating and coordinating all of the activities that related to adolescent disease prevention, health promotion, and education. Funding was never given to OAH until 2009, so the office was never fully established until then. As of 2009, over 100 local, state, and national organizations have been asked to support the funding of OAH and will be overseeing new adolescent pregnancy prevention initiatives (SIECUS, 2009).

The Office of Adolescent Pregnancy Programs is responsible for administering the abstinence-based program, and the program was funded at $29.8 million in the 2008 fiscal year. According to the U.S. Department of Health and Human Services (2009), the goals of the program are to support projects that develop, test, and use curricula that provides education and activities to encourage adolescents to postpone engaging in sexual activity until marriage. The goals are also to develop interventions with pregnant and parenting teens, their infants, male partners, and family members in an effort to ameliorate the effects of having children as a teenage parent. Abstinence education can be described as “appropriate, mentoring, counseling, and adult supervision that promotes abstinence from sexual activity, with a focus on those
groups which are most likely to bear children out-of-wedlock” (SIECUS, 2009; Social Security Administration, 2010).

In 2009, President Obama signed into law the first ever, in the nation’s history, cut to abstinence-only-until-marriage programs. The President also has called for the nation to move away from failed programs, such as the abstinence-only-until-marriage programs, and move towards evidence-based interventions, such as comprehensive sex education. Advocates for sexual and reproductive health care rights were proud of the new cuts, and happy that the government has begun to take the proper steps in promoting and funding programs that improve adolescent sexual and reproductive health. Even though there have been steps made in the right direction, there are still some critics that stated that Congress should have included health issues surrounding STDs and HIV/AIDS with promoting a true comprehensive sex education program (SIECUS, 2009).

In 2009, Congress has also passed into a bill, that falls under the OAH within the Office of the Secretary of Health and Human Services, that at least $25 million must be set aside for research and grants to developing new strategies for teen pregnancy prevention. In the same appropriations bill, the President increased the Title X program funding by $10 million. This leaves the program to be the only current federal program that “exclusively dedicated to family planning and reproductive health services and offers low income women voluntary contraceptive services, prenatal care, treatment for sexually transmitted diseases and other services”
The bill also increased funding for the CDC that year, but the CDC estimates that it will need “an increase of $877 million every year for five years in order to reduce HIV transmission by half by 2020” (SIECUS, 2009). The bill passed an increase in funding for the Ryan White Care Act that funds primary healthcare and supports services for “low-income people living with HIV/AIDS, and an increase in the AIDS Drug Assistance Program” (SIECUS, 2009).

The federal government does not have a direct role in sexuality education in each school, but because the federal government controls the funding for many of the educational programs it can influence the programs that are being taught in schools. At the state level, there can be mandates sexuality education and the state can set statewide guidelines for topics, curricula, and approval of textbooks that can be used in the classroom. The majority of the decisions about education policy are made at the local level in many states such as by school boards, administrators, and teachers. Some school districts have created special advisory committees, comprised of teachers, public health officials, parents, and students, who review materials that are used in school health and sexuality education classes. The committees typically make recommendations to the school board, which will reject or accept the recommendations. Any mandates made locally can expand upon but may not violate any state mandates (SIECUS, 2009).
Current California law

California has chosen to opt-out of the government funding for abstinence-only based education, and it is not a requirement to teach sex education in the California public school system; however if a school district decides to teach sex education, then the school district is required by law to comply with the California Education Code sections 51930-51939, also known as the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act. These Education Codes help guide the creation of the curriculum since abstinence-only education is not permitted in California public schools. According to the California Department of Education (CDE, 2009), these codes have two primary purposes of providing students with the knowledge and skills to help protect overall health from the dangers of unintended pregnancy and STDs, and to encourage students to develop healthy attitudes and beliefs towards topics such as growth and development, body image, gender roles, sexual orientation, dating, marriage, and family.

What type of curriculum that is used is left up to the decision of each individual school district, as long as they follow the requirements of the Education Code, the Sexual Health Education Accountability Act, best practices based on research and evidence, and the recommendations of the Health Education Content Standards. The Health Education Content Standards have been created to provide a framework for schools to follow, but currently they are not required to be implemented into the curriculum. The CDE provides different types of curriculum
that meets all of the legal requirements that any school is allowed to use if they choose to do so (H. Deme, personal communication, December, 12, 2009).

Currently there is no program that monitors sex education programs to ensure fidelity of Education Code requirements, but the CDE is required to intervene if complaints are made regarding a school not following the Education Code requirements. Due to HIV/AIDS education being mandatory, there is oversight that is provided by the Safe and Healthy Kids Program Office of the CDE. The program in place is called the Categorical Program Monitoring (CPM) and it occurs randomly with different counties every three years (H. Deme, personal communication, December 12, 2009; CDE, 2009).

The role of religion

Saul (1998) criticizes the education programs that are used to teach adolescents by saying that the grants provided go to far right and religious groups, and they support fear-based curricula that distorts information on abortion and the effectiveness of prevention methods and contraceptives. Lawsuits have been filed over the years to prevent “religious overtones and medical inaccuracies” from being in the curricula supported by the AFLA (Saul, 1998, p. 10). These lawsuits have allowed agencies such as Planned Parenthood to be funded by the program, although before they were not allowed. Over the years, studies have not been able to find support for the program, and yet federal money continues to fund the programs. The AFLA evaluations completed and funded by the federal government have been found time
after time to have flaws and problems with hypotheses, assumptions, study design, methodology, data analysis, and data interpretation (Saul, 1998; Santelli et al., 2006). Studies done by various groups and researchers repeatedly prove that there is no scientific evidence that supports that abstinence-based education delays the initiation of sexual intercourse (Santelli et al., 2006).

**Effectiveness of abstinence-based sex education**

Abstinence-based education has been taught in public schools since the 1980’s, and until recently federal funds continued to be allocated to programs without proof that these programs are truly effective (Fortenberry, 2005; McKee, 2008; Santelli et al., 2006). Recent studies show that most Americans first have sexual intercourse during adolescence with the median age for girls at 17.4 years old, and for men at 17.7 years old. The same studies show that the median age for marriage is 25.3 years old for women and 27.1 years old for men (Santelli et al., 2006). Irwin (2006) has also found that the majority of adolescents become sexually active in their late teens or early twenties.

Part of the abstinence-based program is to have students pledge to wait to have sexual intercourse until they are married, but studies are showing that students will pledge in high school and then break the pledge sometime in college before they get married. According to Sendziuk (2008), these programs appear to help in delaying sexual intercourse in some high school students until college, but the importance of the use of contraceptives are not being stressed. Sendziuk (2008) found in a study of
527 college students that more than 60% had reported to pledge to remain abstinent until marriage. Of the 60% of students, 55% reported to remain virgins, but they did participate in other risky sexual activities. Studies have shown that adolescents will engage in oral sex to avoid the risks that have been linked to engaging in vaginal sexual intercourse (Irwin, 2006).

Studies have found that adolescents are remaining abstinent from sex, but instead are participating in other forms of sexual activities such as oral sex and touching. These activities are not always considered sexual intercourse to the adolescents and so they feel that they are remaining abstinent. Adolescents will also engage in anal sex instead of vaginal sex to prevent pregnancy. These forms of sexual activity can be just as dangerous for the risk of contracting STDs in comparison to engaging in vaginal sexual intercourse (Ott et al., 2008). The consequences of obtaining STDs can include infertility, tubal pregnancy, fetal and infant death, chronic pelvic pain, and cervical cancer (Santelli et al., 2006). Data has been found to support that those students who take an abstinence pledge eventually do engage in sexual intercourse before marriage, and they are less likely to use any form on contraceptives (Santelli et al., 2006; Fortenberry, 2005; McKee, 2008; Jones, 2008). The same population of students tends to fail to report seeing a doctor for concerns of STD and are less likely to receive testing for STD as a preventative measure (Santelli at al, 2006).
Advocates for Youth (2009) state that youth, even when they intend to remain abstinent, need to be informed about contraceptives, and how using them can prevent unintended pregnancies and contracting HIV and STIs for when they do become sexually active. Abstinence-based programs tend to teach about the failure rates of contraceptives, and that having sex outside of marriage can have harmful social, psychological, and physical consequences. This type of education stigmatizes and places shame and guilt on those youth who are engaging in sexual activities outside of marriage. The GLBTQ community is also stigmatized and discriminated against since they cannot legally marry in most states in the U.S. The Advocates for Youth (2009) expresses that instead of abstinent-based education programs, there should be comprehensive sex education that provides information not only about contraception, but also information about the benefits of remaining abstinent. It is stated that abstinence-based programs are ineffective, unethical, and an example of poor public health.

The National Abstinence Education Association (NAEA) conducted a telephone survey of parents of children ages 10 to 16 years old. The samples were randomly drawn from telephone CDs of a national listed sample. Zogby International surveys employed the sampling strategies in an attempt have selection probabilities be proportional to the population size of area codes. The margin of error was +/- 3.2 percent, and it was found that 8 out of 10 parents want their teens to be abstinent until they are married, 6 out of 10 parents prefer abstinence education over comprehensive
sex education, 8 out of 10 parents support the overall approach and core teaching components of abstinence education, 2 out of 3 parents believe that promoting alternatives to intercourse encourages sexual activity, over half of parents believe that demonstrating condom use encourages sexual activity, 9 out of 10 parents think that teens should be taught about the limitations of condoms in preventing STDs and pregnancies, and 6 out of 10 parents think that more government funding should be given to abstinence education instead of comprehensive education (National Abstinence Education Association, 2007).

There has been much debate over what type of sex education should be taught in schools, and yet up until 2009, the federal and state government continued to put money into abstinence-only-until-marriage education. A study was done to assess the parental opinion about sex education in public schools in North Carolina, where there is mandated abstinence-only sex education. The method of the study was done by computer assisted telephone surveys of 1306 parents of public school students, grades kindergarten through twelfth. The parents were questioned about their support of sexuality education in public schools and twenty other sexuality education topics.

The results showed that parents in North Carolina overwhelmingly (91%) supported sexuality education in public schools, and of the 91%, 89% supported comprehensive sexuality education. Those who did not support sexuality education were opposed to teaching about sexual orientation, oral sex, and anal sex. More than 90% of the participants of the study felt that parents and health professionals should be
the ones who determine the content of sexuality education instead of politicians. The study concluded with finding that parents’ preference for comprehensive sex education did not match the current state mandated abstinence-only education that is taught in North Carolina public schools (Ito et al., 2006).

One qualitative study was done to interview 42 adolescents aged 11-17 years about how they conceptualize sexual abstinence based on the fact that most programs that are taught to adolescents are on how adults conceptualize sexual abstinence. The study resulted in much confusion about the definition of the word “abstinence”, but what was understood about the word was that it meant to choose not to have sex. All of the participants agreed that abstinence was part of a continuum of life and that all people remain abstinent for some period of time and then engage in sexual activity when they are ready. Readiness for sexual activity was defined by the participants as age, life events, physical maturity, social maturity, finding the “right” person, having a committed relationship, moral and religious beliefs, and the balance of health, social, and family risks and benefits. The participants had interpreted sex as something that is powerful, and something that can be a transition or rite of passage into adulthood. It was found that the conceptualization of abstinence was different between adults and different ages of adolescents (Ott et al., 2006).

After the Title V programming was implemented into schools across the nation, Advocates for Youth conducted eleven evaluations using a simple pretest/posttest survey design and using a comparison group. These evaluations
resulted in showing very few short-term benefits and no long lasting positive impacts over time from the programs. Some programs showed a mild success proven by improving attitudes and intentions to abstain from sex, but all programs were least likely to have a positive affect on the participant’s sexual behaviors (Hauser, 2008).

In 1994, Kirby conducted a review of sex education programs, and he assessed all of the studies available at the time of school-based, abstinence-only programs. The programs received a peer review, which measured attitudes, intentions, and behaviors. It was found that none of the abstinence-only programs were effective in producing a statistically significant impact on sexual behaviors of participants in those programs. In 1997 and 2007, Kirby again reviewed evaluations from abstinence-only programs, and again found no programs that produced a statistically significant impact on sexual behaviors of participants in those programs (Hauser, 2008; Santelli et al., 2006).

The effectiveness of comprehensive sex education

Advocates for Youth (2009) believe that adolescents have a right to a comprehensive sex education which gives accurate information about sexual health, that provides confidential reproductive and sexual health services, and gives adolescents a voice in making decisions about their health and their future. Youth in Europe use contraceptives and condoms more consistently when compared to U.S. youth, and it is stated that in other countries such as France, Germany, and the Netherlands that young people are seen as assets, and not as problems like they are perceived in the U.S. In those countries, the government strongly supports the
education of youth and expects them to make responsible decisions. Most of the time it is common for families to have open, honest, and consistent conversations with each other about sexuality. They also tend to support educators to teach their youth about sexual health information. Parents support health care providers that have services available to youth when needed. Advocates for Youth (2009) state that there can be a middle ground, and that comprehensive sex education is a holistic approach to teach youth about sexual health, which can offer culturally, age appropriate, medically accurate information.

A study was done among never-married heterosexual adolescents aged 15-19 years on formal sex education they received prior to their first sexual intercourse. There was a comparison between the sexual health risks of adolescents who received abstinence-only education and comprehensive sex education to those who received no formal sex education. The researchers were curious about the role that sex education played in the initiation of sexual activity and risk of teen pregnancy and STDs. The results of the study showed that the adolescents who received comprehensive sex education were significantly less likely to report teen pregnancies than those who received no formal sex education, and there was no significant effect with those adolescents who received abstinence-only education. Neither abstinence-only or comprehensive sex education had a significant reduction of the likeliness of reported STD diagnoses (Kohler et al., 2008).
It was also found that abstinence-only education did not reduce the likeliness of adolescents engaging in vaginal intercourse, but comprehensive sex education was marginally associated with a lower likeliness of adolescents reporting having engaged in vaginal intercourse. The study findings concluded that teaching about contraception was not associated with increased risk of adolescent sexual activity or contracting STDs. The study also found that adolescents who received comprehensive sex education had lower risks of pregnancy than adolescents who received abstinence-only education or no sex education (Kohler et al., 2008).

A study done in 1997 was done on a pregnancy prevention program called In Your Face, which focused on increasing access to contraception. The study found that when combined with case management, it was successful in significantly increasing contraception use and decreasing the pregnancy rate. The In Your Face programs was created and implemented in 1992, in four junior high schools in New York City. The program had surveyed 3,500 students in attempts to identify students who may be “at risk” for teen pregnancy. The risk factors indicators were admission of sexual activity, drug and alcohol use, having run away from home, or having some underlying mental health problem such as suicide attempts or chronic depression. The participants of the study were referred to a family health clinic for counseling and contraception. In addition, small support groups consisting of five to ten students were formed and asked to meet weekly throughout the school year. The groups provided education from health educators and peer support, which were also at the clinic. The health
educators acted as case managers for the students, and this created a trusted relationship for the students who felt comfortable accessing contraception (Lipshutz, McCarthy, Tietz, Vaughan, & Wroblewski, 1997).

The results of the program were positive. Of the students who participated in the program, the proportion of who visited the clinic increased from 11% to 76% over three years, and pregnancy rates among teens younger than 15 decreased by 34% over a four year period. The study did not use a control group, but one of the schools that originally were going to participate in the program had dropped out due to funding problems. In the fourth year of the study, the school that had dropped out had a pregnancy rate almost three times higher than the average of the other schools that remained in the study at 16.5 per 1,000 female students verses 5.8 per 1,000 female students (Lipshutz et al., 1997).

Two reviews were conducted, one by Kirby (2001) and the other by Manlove, Romano-Papillo and Ikramullah (2004), to examine the evidence that supported abstinence-only programs and comprehensive sex education programs that were designed to promote abstinence from sexual intercourse. Both reviews found comprehensive sex education to effectively promote abstinence along with some other protective behaviors. Kirby (2001) reviewed 28 comprehensive programs and found that nine were successful in delaying initiation of sexual intercourse, 18 showed no impact, and one stopped the initiation of sexual intercourse. Manlove et al. (2004) had identified three different types of comprehensive sex education programs, and found
that six of nine sex education programs delayed the onset of sexual intercourse, five of seven HIV/STI prevention programs delayed the onset of sexual intercourse, and four of four youth development programs delayed the onset of sex (Hauser, 2008).

Existing Programs and Prevention Strategies

An evaluation was conducted of a program called Sexual Awareness for Everyone (SAFE), which attempts to curb recurrent contractions of STDs among high-risk teenage girls. The study was done on a group of 14 to 18-year-old Mexican-American and African-American girls who participated in the SAFE program. It was found that after the program the girls were less likely to engage in risky sexual behavior and had lower incidences of recurrent Gonorrhea and Chlamydia infections in the first six months (Liebert, 2008).

The SAFE program was designed for the girls to meet in small groups and participate in role-playing, interactive videos, group discussions, and for them to receive informational handouts. The topics of discussion were abstinence, mutual monogamy, correct and consistent use of condoms, the importance of taking prescribed STD medication as directed, avoiding sexual intercourse until all of the STD medication has been taken, not douching, and seeking help from a medical provider when they suspect having contracted a STD or STI. The overall goals of the SAFE program were to have the participants recognize their risk of contracting an STD and HIV, commit to changing risky sexual behaviors, and gain skills needed to
be successful. After participating in the program, the re-infection rate was 24%, and the re-infection rate for those in the control group was 40% (Liebert, 2008).

In the UK, Bath and North East Somerset (BANES) Primary Trust developed a mobile sexual health and contraceptive service for youth ages 11 to 18 years. Those who run the services are school nurses who have been trained in family planning, and are experienced in working in contraception, sexual health clinics, and child protection. The nurses are able to issue oral contraceptives, emergency contraception, condoms, and provide services for Depo-Provera injections, and give pregnancy and STI tests. The study suggests that the health needs of young people are not being met by primary care alone, and that it has been found that young people do not always take advantage of the services that are offered to them in local clinics. It has been found that the cause of this is many young people do not trust the supposed confidentiality of standard health services; they are worried that their parents will find out that they are sexually active (Clapp, 2009).

Many youth who did participate in the mobile service sought out advice not only on contraception, but also about friendship issues, acne, exams, and binge drinking. The service began carrying pamphlets and information regarding all sorts of health information to attempt to meet the needs of the youth seeking the services. It was found that just having posters and conversations about STIs, smoking, healthy eating, drugs and alcohol led to further conversations about the importance of cervical smear tests, breast and testicle examination, and the use and disposal of condoms. The
school nurses were surprised by the amount of response from the students, but their
greatest challenge was gaining permission to operate their service on school sites.
There was much success in the beginning, but BANES stated that there will be a
continuous evaluation of the program in hopes of finding future evidence of the
service lowering rates of teen pregnancies and contraction of STDs and STIs (Clapp,
2009).

The World Health Organization (WHO) has set an international goal of
reducing unplanned teenage pregnancies and contractions of STIs by one third by the
year 2020. The WHO did evaluations of many studies on sex and relationships
education (SRE), and found that much literature on the topic was in English or Dutch.
The WHO feels that it is important to have literature that reflects various cultures and
attitudes towards sexuality and health among young people, so others have
information to guide their practice that is relatable to more than one culture or set of
values. One U.S. study found that the current high school prevention strategies did not
delay initiation of sexual intercourse or improve the use of contraceptives among
adolescents. A UK study found that the students felt that SRE was provided too late,
was not informative enough, and was too technical regarding the content (Jones,
2008).

Studies done in Wales and the U.S. found that teachers did not feel prepared
enough to teach SRE and were not supported by parents, which resulted in a lack on
confidence. A study done in the Netherlands found that they have the lowest teenage
pregnancy rate in Europe, and it is thought to be due to teaching about sexuality as early as age five. Research based programs are used at the appropriate age levels throughout the child’s education, and there is no parental right to withdraw a child from the education. It was also found that many parents did not receive proper SRE when they attended school as children. It has also been found that the younger the age of a child when SRE is implemented, then there are fewer problems in communication between parents and children regarding sexual health. It was suggested that if there were sex education programs for parents in the community, then parents might feel more comfortable and confident when talking to their children about sexual health. The WHO stated that the evaluation of programs resulted in concern for inconsistent or lack of proper SRE in schools throughout the world (Jones 2008).

The American Civil Liberties Union of Northern California (ACLU) (2003) did a study to find out if students are learning in school what they need to know regarding sex education. The study states that sex education is not a requirement in every school, but if a school chooses to teach it then they must meet certain requirements. The legal requirements are intended to ensure that schools are teaching current, medically accurate information that is age appropriate on how students can protect themselves from pregnancy or STIs, and that they are giving the parents the opportunity to remove their children from the education if they choose to do so (Burlingame, 2003).
The ACLU surveyed 1,056 school districts. More than half of which were elementary school districts, and they targeted unified school districts comprised of grades K-12. The survey was administered by volunteers who were only able to gather information from 153 of the districts in California. Of the 153 districts included in the study, all but four of the 58 counties in California were represented. The information was gathered by telephone from either administrators or teachers. It was found that the districts vary in how their sex education and HIV/AIDS prevention education programs are structured. Some have programs that are structured at the district level, and others give the primary responsibility to the schools themselves (Burlingame, 2003).

The results found that most schools recognize the importance of teaching sex education, but some of the education is very minimal and simply a part of health classes. Some schools teach about sex education for significant amounts of time and for several years, and other schools may do less than five hours of instruction only once each in high school and middle school. It was found that there seems to be complicated requirements to teach sex education, and many schools do not clearly understand all of them, 85% of the schools in violation of the Educational Code. Of the 85% of schools in violation, the ACLU found that: 48% failed to teach the required topics, 58% have no teacher training requirements for HIV/AIDS prevention teachers, 39% have improper parental notification and consent policies, and 13% do not teach HIV/AIDS prevention in middle school or high school or both. The ACLU
concluded their study with results proving that students in California are receiving the proper sex education they deserve and is required by California law (Burlingame, 2003).

**Peer-Led vs. Teacher-Led Programs**

Primarily it is teachers or other school personnel who teach the sex educational programs, but many studies have come to show that peer-led programs can have positive benefits and can be more effective than teacher/adult-led programs. Peer-led education has been defined as “teaching or sharing of information, values, and behaviors by members of similar age or status group” (Kim et al., 2008, p. 144). It is well known that teenagers influence one another’s attitudes and behaviors, which is the reasoning behind peer-led education. Peer educators may influence social behaviors and attitudes towards sexual health by way of being credible role models to one another, and collectively the youth can define and create resolutions to the challenges and problems that are universal to all youth with regards to sexual activities and staying healthy (Kim et al., 2008; AFY, 2008).

Between 1998 and 2005, a study was conducted to evaluate interventions that were designed to promote adolescent sexual health by using peer-educators. Thirteen interventions were evaluated resulting in no clear evidence that peer-led sex education promoted condom use, reduced the chances of pregnancy, or having multiple partners. However, the evaluation did show that some interventions were highly successful in some areas of prevention. One intervention showed a reduction of Chlamydia
infections, another showed an increase in females remaining abstinent, and most interventions showed positive effects when measuring the knowledge, attitudes and intentions of adolescents. The researchers, Kim et al. (2008), cautioned viewing results, as it was not always clear how many variables were measured or the length of time between the intervention and the outcome assessments in most of the studies evaluated. The researchers also warned that not all of the interventions evaluated had poor methodological quality, which Kim et al. (2008) stated could result in bias in the study results. In addition, some of the studies had missing information, which was not explained.

Kim et al. (2008) concluded that even though they did not find statistically significant information to support peer-led education, the researchers do not propose to abandon the type of program or intervention. Instead, they state there is a need for some fine-tuning within the programs, since there are promising results for the programs. Kim and Free feel that many of these programs are designed without much thought or detail, and future program designs should reflect on the shortcomings of past designs (Kim et al., 2008).

A study was conducted in England by a group of researchers known as the RIPPLE Team, which involved seven secondary schools whose sex education programs were allocated at random to be designed as peer-led or teacher-led programs. The study was based on the effects of the peer-led programs, which were taught by 16 and 17-year-olds. The results of the study found school administration to believe
peer-led programs to be more time intensive due to continuous trainings needed to be done with the peer-led groups. Peer-led programs were commonly seen as more threatening by school administrators to have peer-led programs taught to students. Despite the feelings of school personnel, peer-led groups were more popular and there were more interaction within peer-led groups in comparison to teacher-led groups. The study findings were inconclusive regarding the effectiveness when comparing the two programs, even though peer-led groups held more interest and interaction with students than teacher-led groups (Ross, 2008). Many youth report learning more from education when it is interactive and enjoyable (Stephenson, et al., 2008; Ross, 2008; AFY, 2008).

The RIPPLE Team found peer-led educators were not only more popular with the participants, but the effects of the program may have resulted in fewer live births to teenage girls who had participated in the program. The RIPPLE Team did come to the conclusion that most teens felt that no matter who taught the information the it was being taught too late in age for teens, and the information was presented in terms of being too biological or technical. The teens felt that they could not relate to some of the information. Thoughts for future programs are having teachers with relevant expertise and respect for the students, who hold similar values about sex as the students, who use familiar language which students can understand and relate to, who is not moralistic, and who can make the education entertaining and fun. The study also found the need to increase evidence to support good sex education which delays the
onset of sexual activity, and many programs are in need of redesign and rethinking about what is effective or not (Stephenson et al., 2008).

Advocates for Youth (2008) found that success of peer-led programs is a result of teens being more likely to personalize messages and change behaviors and attitudes when they hold a belief that is similar to what is being taught by one of their peers. Teens take comfort in knowing that the peer-educator may be facing the same challenges and struggles that they face. Studies have shown when some youth believe their peers are using condoms, then they will be more than twice as likely to use condoms in comparison to those who do not believe their peers are using condoms. Many studies are continually showing throughout the nation that peer-led programs are increasing condom use, and fewer sexually active youth are reporting to be engaging in unprotected sex. Studies have shown that becoming a peer-educator can be beneficial, in itself, to the peer-educator. Peer-educators receive training in making decisions, clarifying values and acting upon them, receiving extensive sexuality information, being recognized as leaders by their peers, having direct involvement, having a voice and some control in designing the programs, and becoming committed to responsible sexual behaviors (AFY, 2008).

**Alternative Program Ideas**

Some people are becoming creative in attempts to reaching out to youth through unconventional ways of education. The city of San Francisco, and the counties of Riverside and San Bernardino in California, created sex education
programs through the form of text messaging from cell phones. San Francisco teens can text “SEXINFO” to a certain phone number, and they can receive basic information about STIs and HIV along with referrals for places to go in person for further help or questions. The contact information was put on palm cards, posters, and bus shelter ads, which were given to youth during a focus group which was conducted by Internet Sexuality Information Services Inc. (ISIS-Inc.) and San Francisco Department of Public Health (SFDPH) in the spring of 2006. These ads were placed in strategic places throughout the city, many in neighborhoods primarily populated by African-American youth. This strategy was used due to the increase in STIs among African-American youth ages 15 to 19 years (Levine, McCright, Dobkin, Woodruff, Klausner, 2008).

The ISIS-Inc. and SFDPH founded this program based on the research findings of 33% of U.S. adolescents, ages 12 to 14 years, and 66% of high school seniors own cell phones. The thought was to reach the youth through their primary mode of communication. From April of 2006 to October of 2006, there were more than 4,500 inquires through the service of SEXINFO. The top three inquiries were contraception failure, STD information, and if a youth thought she was pregnant. Those youth who participated in the study reported that the posted ads caught their attention primarily because the program was cell phone based, and that the program was easy to use. The ISIS-Inc. and SFDPH discovered text messaging to be a feasible and culturally
acceptable way to reach out to at risk youth as a prevention and education program (Levine et al., 2008).

Riverside and San Bernardino counties did not do research surrounding their program, but those working at those Public Health Departments believe that STDs and teen pregnancies are becoming an epidemic among 15 to 17-year-olds in poverty stricken areas. The employees working at the Public Health Departments created a line of communication for those at risk youth in a way that is convenient and relatable for them. It has been found some low income youth have better access to cell phones than they do to computers, so creating a prevention program based on text messaging, similar to the program in San Francisco, will better reach a greater number of adolescents (Straehley, 2009).

Parents and teenagers have stated they like the idea of the program, and they think it is a great way to communicate information about sex without having an awkward conversation between parents and teens. Some teens have difficulty talking to their parents about sex, and some parents do not always feel they have the correct information to give to their kids. One parent stated she would feel more comfortable with her teenage kids getting information about sex through text messages, than having them searching the Internet where they may come across inappropriate content. Riverside and San Bernardino counties are encouraging the use of their text-messaging program to other counties, and they have received good feedback finding that many teens are making good use of the program (Straehley, 2009).
A group of researchers, Ito et al. (2008), found that typical prevention programs could be timely, labor intensive and costly, so they came up with a different approach to educating youth. Ito et al. (2008), designed a pilot program designed with an interactive CD-ROM that included “preventative information, models skills for negotiating abstinence and consistent condom use, teaches medial literacy, and allows the user to choose a culturally appropriate host to guide them through the CD-ROM” (Ito et al., 2008, p. 78). The goal of the study using the CD-ROM was to teach prevention of STIs to forty-seven female adolescents attending a health department clinic. The study found that the CD-ROM was an acceptable and feasible way for the females using the program to learn. The STI and HIV knowledge of the participants was found to increase significantly after using the CD-ROM, and close to all of the adolescents had stated that they intended to use condoms the next time they engaged in intercourse (Ito et al., 2008).

The CD-ROM allowed the participants to choose a host for the program based on age, sex, and race. The study found most of the participants chose a host on the CD-ROM that had been sexually active due to being able to relate to them, and thinking that they may have more knowledge from the experience. The study also found that most participants, even if they had already contracted an STD or STI, did not think that they would contract one in the next year. Most participants stated that they intended to use a condom the next time they engage in intercourse, but it was questioned if intention is strong enough to ensure that the participants would follow
through with the intention. The study did not do a follow up with any of the participants to inquire if they stuck by their intentions. Overall, the participants of the study were receptive to the CD-ROM, and the information increased their knowledge of STDs and STIs. This was seen as success in the eyes of the researchers, and it was beneficial that the program was more cost effective and conserved time and energy in comparison to the typical sex educational settings (Ito et al., 2008).

Influences and Their Role in Adolescent Sexual Activities

Sources of sexual information

Sexual socialization has been defined as the process of how adolescents receive knowledge about sex and the values related to sex. It is thought that sources of information regarding sex are parents, friends, and the mass media. It has been found that adolescents ages 8-18 years engage in use of many types of media for an average of 6 hours a day. It was found that the media being consumed was full of sexual images, talk, and behaviors. Many types of media adolescents typically have access to are Internet, music, movies, magazines, and television. One study acknowledged that media contains sexual content and models sexual behaviors, but it rarely depicts the risks and negative consequences of those sexual behaviors. The study focused on the sources of information adolescents have access in which to gain knowledge of sex, how these sources are associated with adolescent’s beliefs about sex, and what types of media are associated with their beliefs about sex. The study’s participants consisted
of 547 adolescents, ages 14-16 years, who completed an online survey. (Bleakley, Hennessy, Fishbein, & Jordan, 2009).

The study found the most frequent sources for sexual information were friends, teachers, mothers, media, and doctors. The most informative media was reported to be television and movies, followed by the Internet, magazines, and music. It was found that getting information from a friend or a cousin about sex was associated with a belief that having sex within the next 12 months would result in positive outcomes and would not result in getting an STD or HIV. Getting information from friends and cousins was also associated with beliefs that peers were having sex, and beliefs that peers would approve of them having sex in the next 12 months. Getting information from fathers was found to be associated with beliefs that peers would not approve of them having sex in the next 12 months. Getting information from mothers was associated with beliefs that one was more likely to get an STD or HIV. It was found that using the media as a source of information was associated with adolescents believing they could overcome any barriers in order to have sex, and the older the adolescent the more they relied on media as a source of information (Bleakley et al., 2009).

The researchers concluded their study with stating that adolescents use many sources to receive information about sex, but not a single source was found to influence all types of beliefs that are associated with having sex. The researchers stressed that when adolescents get information from their friends and cousins they are
more likely to engage in sexual intercourse, so it is important that parents and authoritative figures in an adolescent’s life communicate the risks and consequences of engaging in sexual activities. The researchers also stated that it is the responsibility of the community and school-based programs to educate adolescents about sex (Bleakley et al., 2009).

**Hip-hop culture**

A study was designed to explore how adolescent males in New York City perceived and participated in the hip-hop culture, and how factors such as artistic expressions, clothing style, break dancing, graffiti, and rap music are associated with the adolescent’s condom use, condom use self-efficacy, and sense of community. The researchers surveyed 95 young men, ages 15 to 25 years, by way of an ethnographic interview. The results of the study found the hip-hop culture was a major part of 61.1% of the participant’s lives, and 84.4% of the participants had engaged in vaginal sex and 38% had engaged in anal sex. Of those who had engaged in vaginal sex, the average age of first intercourse was 14.6 years. The number of partners that a participant reported having ranged from 1 to more than 10. Of the participants, 49.4% reported consistent condom use, 23% of participants reported condom use more than have of the time, and 6.9% reported never using condoms (Munoz-Laboy, Castellanos, Haliburton, Vasquez del Aguila, Weinstein, & Parker, 2008).

Age was found to be associated with condom use. The younger the age of the participant the lower the frequency of condom use, and the higher the age of the
participant the higher the frequency of condom use. Dancing to hip-hop, rap, and reggaeton music was negatively associated with consistent condom use, and the strongest factor that was found to be associated with low condom use was a frequency of going to hip-hop nightclubs. The study concluded with the results showing a strong sense of community being positively associated with consistent condom use. The study did not find condom use to be associated with perceptions of sexuality in the hip-hop culture, but the study did find the frequency of listening to hip-hop music to be positively associated with self-efficacy of condom use. The findings confirmed the researcher’s hypothesis (Munoz-Laboy et al., 2008).

Parents

The results of a nationwide study found 47% of U.S. youth, ages 12 to 14 years, stated their parents had influenced their decisions about sex more than anyone or anything else. In addition, the study found that teens felt that having more open, honest, and engaging conversations with their parents about sex would help them postpone engaging in sexual activities or becoming a pregnant teen. Researchers, Lederman, Chan, and Roberts-Gray (2008), decided only having parents and adolescents talking was not good enough as a preventative measure for pregnancy and contracting STDs, and they thought more interactive activities between parents and adolescents surrounding sex education would be more beneficial. The researchers conducted a study to determine the effects of interactive involvement with parents and middle school students in an after-school prevention program.
The program was titled Parent-Adolescent Relationship Education (PARE), and it was composed of a series of 4 weekly small-group sessions which was followed by a single booster session in each of the following 3 semesters. The program was a total of 18 hours of preventative education, which spanned across a 2-year period. The focus of the education was on adolescent behaviors and how they are subject to social and self-controls such as direct, indirect, cognitive, emotional, or behavioral controls. The controls included communication about sex, values that were assigned to parents’ and friends’ opinions, parents’ rules, parental monitoring and involvement in youth activities. The focus of the study was on the method of delivery of the PARE program. (Lederman et al., 2008).

The results of the study showed that involving parents in prevention programs improved communication between parents and their children, and the parent component had positive effects on the knowledge and attitudes toward sexual health of the youth who participated in these types of programs. The study also found interactive activities and learning between parents and children to be the most successful intervention in comparison to only having parents talk to their kids. However, the PARE method did not have a measurable positive effect on students feeling comfortable talking to their parents about sex and other risky behaviors. This study found that many kids were afraid to talk to their parents. Adolescents were afraid that if they go to their parents about the topic that their parents will think they are having sex when in reality they are just curious, that it is embarrassing to have a
conversation with their parents, and that their parents will not understand them. The adolescents still valued their parent’s opinions, which played a role in the decisions that the adolescents made about risky behaviors. The researchers found the adolescent’s perception of their parent’s disapproval of their sexual behaviors to be associated with a delay of their sexual debut. The study also found that there may not have been an increase in adolescents talking to their parents, but there was an increase in adolescents talking to friends about sex, risk, and prevention (Lederman et al., 2008).

**Self-efficacy**

It has been thought that an adolescent’s sexual self-concept refers to the positive and negative perceptions and feelings about how he/she is when engaging in sexual behaviors. Few studies have been conducted on self-efficacy and risk taking behaviors, and one study was conducted to search for a link between self-efficacy and contraceptive use. The findings, which focused on high school aged adolescents, seemed to be consistent with both males and females. The researchers examined the social pressures and gendered expectations, and how they measured up to self-efficacy. The focus on these factors would help the researchers understand why adolescents engage in risky sexual behaviors, and how engaging in those behaviors can be prevented in the future (Rostosky, Dekhtyar, Cupp, & Anderman, 2008).

The researcher expected to find significant differences between males and females when researching their sexual self-efficacy. The participants consisted of 388
high school students from public schools, who had completed a self-administrated paper survey. The results showed females having a higher sexual situational self-efficacy, and were found to be more knowledgeable about the risks of sexual behaviors. Females were also found to have higher sexual self-esteem. Males had a lower sexual situational self-efficacy, and a lower resistive self-efficacy. The researchers advised in the future, the focus of interventions might need to be on males who do not appear to have as much self-confidence and avoiding engaging in risky sexual practices (Rostosky et al., 2008).

Sexual debut

Many studies about adolescent sexuality, have found sexual activity to be associated with substance use, lower academic achievement and aspirations, and poor mental health. Other studies have found adolescent sexual debut to be related to negative interactions with parents, a decreased sense of belonging at school, and a decrease in participation in religious activities. A relationship had been found between the age of sexual debut and contracting a STD, which decreased with age. A relationship was also found with early sexual debut and delinquency. Spriggs et al. (2008) wanted to build off of past studies and focus on the associations of adolescent sexual debut and educational progress, and aspirations and performance in early adulthood with a focus on gender differences. Their study was comprised of participants in 7th grade through 12th grade in the 1994-1995 school year. There was a follow-up interview done with the participants in 2001 (Spriggs et al., 2008).
The results showed both sexual debut timing and postsecondary education to be associated with many risk and protective factors. The study found those adolescents who had a late sexual debut to have more protective factors and less risk factors than those adolescents who debuted early or at the typical age. It was also found that those who had a late sexual debut had higher expectations for attending college when compared to those who debuted early or at the typical age. Those participants who had an early sexual debut were found to be three times as likely to smoke cigarettes when compared to those who had a late sexual debut. Overall, the results showed that many of the risk and protective factors that were found to be associated with sexual debut were also found to be associated with postsecondary education in early adulthood. The final results showed those adolescents with an early sexual debut timing to be associated with more educational risk factors and less educational protective factors when compared to those who sexually debuted at a later age (Spriggs et al., 2008).

**Substance use**

Studies have shown the use of drugs and alcohol to be associated with sexual risky behaviors among adolescents such as engaging in sexual intercourse, having 4 or more partners, and not using condoms the last time they engaged in intercourse when compared to non users of drugs and alcohol. One study evaluated the trends in adolescent sexual behavior and the role of substance use on sexual activity. The study’s participants were comprised of adolescents in the 9th grade through 12th grade
throughout the U.S. The information was gathered through self-administered paper questionnaires about the use of tobacco, alcohol, illicit drugs, sexual activity, contraception, condom use, dietary habits, and physical activity (Anderson et al., 2008).

The results showed in looking at trends from 1991-2005, lower sexual activity, increased condom use, increased contraception use, and lower levels of unprotected sex. The trends showed substance use peaking in the late 1990’s and declining steadily afterwards. The study showed more than 50% of illicit drug and alcohol users had been sexually active in the past 3 months, and they had significantly higher levels of unprotected sex during the last engagement of intercourse when compared to non-drug and alcohol users. The researchers found there to be a significant link between substance use and sexual activity, but they were disappointed to find that there were very few prevention and treatment programs which will acknowledge the link between the two behaviors. The researchers believe the programs that teach about prevention of STDs and pregnancy should also focus on the association between the risky behaviors of sexual activity and substance use (Anderson et al., 2008).

Another study was conducted searching for the relationship between adolescent’s sexual activity and substance use. Dunn, Ilapogu, Taylor, Naney, Blackwell, Wilder, and Givens (2008) wanted to explore further into the relationship with rural 6th through 8th grade students. The researchers used a sample of 10,273
students who attended 10 different public schools in rural Tennessee. The survey measured demographics, height and weight, unintentional injury, violence, suicide ideation and attempts, tobacco use, drug and alcohol use, sexual behavior, weight control, and physical activity.

The results showed 18.8% of females and 25.4% of males reported having engaged sex. It was also found a fourth of the students had tried cigarettes, a third of students have tried alcohol, about 15% of students had tried marijuana, about 16% of students had tried inhalants, 25% of males reported having engaged in sex, and 18% of females reported having engaged in sex. Males reported to have had more sexual partners than females, and the study found more than 75% of students who had reported to have engaged in sex also reported trying cigarettes, alcohol, inhalants, and IV drugs. Of those who reported to have engaged in sex, 64% reported to have used cocaine, and 63% reported to use steroids. The study was concluded with the researchers expressing concerns about substance use and sexual activity, and the researchers expressed their belief that school based prevention programs should all include education about substance abuse and the relationship with other risky behaviors (Dunn et al., 2008).

**Positive youth development theory**

The Positive Youth Development (PDY) Theory and research focuses on promoting healthy sexuality as an important developmental outcome for adolescents. PDY Theory and research also focuses on outcomes such as citizenship, leadership,
altruism, and initiative. A study was conducted in attempts to link PDY, adolescent sexuality, and the relationship between adolescents and their parents. The participants of the study were comprised of students ranging from 5th grade through 12th grade, and the study focused on sexual experience, self esteem, communication between parents and adolescents about sex, parental influence, perception of parental care, extra curricular activity participation, and attitudes regarding sex (Chapman et al., 2008).

The study found that there were overall positive attitudes regarding sex with high reports of comfort in thinking and talking about sex, but parental influence reported to show a increase in attitudes about sex to be negative instead of positive. It was found that 66% of the participants claimed to be virgins, and those who claimed to be virgins were more likely to report having more parental influence than those who claimed to be non-virgins. It was found that adolescents who lived with both parents were more likely to be more involved in extracurricular activities, and having associations with low and negative attitudes with sex and sexual experience. Self-esteem was positively associated with parental influence, but self-esteem was not significantly associated with sexual experience or attitudes regarding sex (Chapman et al., 2008).

Overall, the study found parental influence to be the one variable in the study that had the most influence on adolescent sexuality and attitudes regarding sex. The researchers suggest that there should be more parental involvement in youth programs, and advising parents and other significant adults involved in adolescents lives to be
sensitive to how they are influencing adolescent’s attitudes toward sex and their sexual identity formation. The researches also believe in the positive effects of PYD programs, and they advise others to try to understand how relationships can impact youth development and the future choices that they make (Chapman et al., 2008).

**Fuzzy-trace theory**

New studies are beginning to show that adolescents appear to engage in risky behaviors, not because they do not think of the potential consequences, but because they over estimate the risks of a particular situation. Adolescents tend to rationally weigh out the risks and benefits of risky situations that they are faced with, and since they overestimate the risks of a situation they believe that it is highly unlikely for themselves to contract a STD or become pregnant. The adolescents then engage in the risky behavior due to their thinking that the benefits out weigh the risks of a negative consequence (Brody, 2007; Reyna et al., 2007). According to Brody (2007), “the risk of pregnancy from a single act of unprotected sex is quite small, perhaps one chance in 12, and the risk of contracting HIV, about one in 500, is very much smaller than that” (Teenage risks and how to avoid them section, para. 6). Adolescents view those chances of the risks happening to them as slim, and they decide to engage in the behavior(s).

Dr. Valerie R. Reyna, a professor of human development and psychology at the New York State College of Human Ecology at Cornell, has been studying the fuzzy-trace theory, which is founded upon the idea that making decisions is based on
gist rather than verbatim representations of information. She states that gist is emotional meaning or affective interpretation of that information (Reyna, 2008). Dr. Reyna (2008) suggests that gist is built up as one goes through life, therefore adolescents do not have good reasoning skills since they do not have much life experience to be able to make good judgments when faced with a risky situation. Dr. Reyna feels that adolescents should be taught not only about the risks of sexual intercourse, but the reasons behind making good decisions and why abstaining from sexual intercourse may be life saving and protective (Reyna, 2008; Brody, 2007; Reyna et al., 2003). Dr. Reyna also feels that the adolescent brain is not fully developed, so removing adolescents from risky situations could also be helpful as a preventative method (Reyna, 2008; Brody, 2007; Reyna et al., 2007).

**Conclusion**

The purpose of this chapter was to provide an overview of the current literature and research that has been written about adolescent sex education, the different types of programs that are currently being used, what has been proven to be effective, new ideas for future programs, the influences that play a role in adolescents engaging in sexual activities, and the current laws that a school must abide by in order to teach sex education to students. There are so many different viewpoints about teaching sex education from those in politics, school personnel, and parents.

Research has shown that many adolescents are engaging in risky sexual behaviors at ages that most parents do not approve of, and they are engaging in these
behaviors even if they are taught to wait until marriage. Most teens do not realize the possible consequences of the sexual behaviors that they are engaging in, and most of the sex education programs do not include information regarding the behaviors the adolescents are actually engaging in. There are many comprehensive sex education programs that have been successful, but recent research is finding that adolescents are engaging in behaviors that no one could have predicted. The sex education programs taught to adolescents need to be restructured in a way that include subjects which are relevant to adolescents, will interest adolescents, will provide information and statistics that are medically accurate and current, and will provide adolescents a chance to speak to their parents about the subject matter.
Chapter 3

METHODS

Introduction

This researcher conducted a study to explore and examine the current curriculum that is used by public middle and high schools in the counties of Esparto, Placer, and Sacramento in Northern California. This researcher was interested in finding what type of information is taught to the students, if the curriculum follows California’s laws and requirements for teaching comprehensive sex education, the training that is required for teachers who teach the material, how often the information is updated, and if there are any policies or rules set up by the district on subject matter that is prohibited from being discussed.

Design

This researcher conducted an exploratory study on the sex education curriculum that is taught to adolescents in educational settings. This researcher examined and explored the differences and similarities between the sex education programs across various levels of educational settings involving three public middle schools and two public high schools. The schools are all located in different districts, cities, and from three different counties in Northern California. This researcher has found through research studies that sex education is not a required subject for public schools to teach, but if a school does choose to teach the subject it must follow a set of laws and requirements set out by the state of California. If a school chooses to teach
sex education, the decision is left up to the district to decide what material is included in the curriculum and then taught to students. Therefore, this researcher has interviewed expert informants from schools within different districts in attempts to obtain a broader range of information and different resources regarding sex education curricula that is taught to the students attending public schools.

This researcher has evaluated the differences and similarities of each school to understand what resources are used to create the curriculum that is taught to students, who approves the curriculum, if the teachers are trained on the subject material, how often the material is updated and revised, how the material is evaluated and measured for success, and if there are any policies or rules set up by the district on subject matter that is prohibited from being discussed. Using this type of method is necessary to disaggregate the information and identify the effective or ineffective components of each program.

**Subjects**

This researcher has collected the information through a semi-structured interview by way of an oral questionnaire conducted by this researcher. The subjects of this study were expert informants in different educational settings. This researcher intended to gain particular information from the participants by conducting a semi-structured set of field questions in each interview, see Appendix A. This researcher has allowed for flexibility during the interviews in the instances that this writer felt the need to further inquire about an answer that was provided by the participant in
response to one of the semi-structured set of field questions.

**Data Gathering Procedure**

First, this researcher initially contacted the participants by telephone and obtained a permission letter from each participant prior to the interview, see Appendix B. Each individual was asked to review a permission letter, which was emailed to the interviewee by this researcher, and was then asked to fill in the requested information on the permission letter and return the completed letter to this researcher, see Appendix B. Five permission letters have been obtained from those who were willing to participate in this research. A written consent form was obtained from each individual prior to the interview by this researcher, and the school personnel of each school granted permission to this researcher to participate in an interview regarding his or her professional knowledge of the sex education program that is taught at his or her school, see Appendix C. This researcher had contacted the school personnel by telephone, prior to the interview, to set a date and time to conduct the interview. Prior to conducting the interview, this researcher explained the written consent form to the participants, and obtained a signed copy from each participant.

This researcher conducted the interview with the school personnel in person, and the interview was audio recorded. The recorded interview was transcribed by this researcher, which helped this researcher explore themes among each school regarding the program that is implemented at each individual school. Similar studies have conducted interviews with parents, teachers, and students as participants to explore the
experiences and thoughts of effectiveness of the programs taught in schools. This researcher took into account those studies and was interested in exploring the curriculum at the core by speaking to those who are expert informants of sex education programs.

Once this researcher conducted the interviews, transcribed the interview, and found themes for each interview, this researcher evaluated each program and curriculum by disaggregating the information that was given by the participants. In addition, this researcher assessed the differences and similarities between each of the curricula from the different educational settings. Assessing the curricula and answers to the questions asked of the participants has helped this researcher form and create a comprehensive sex education curriculum that is effective, accurate, age-appropriate and applicable to the students who will be learning the information.

This researcher intends that the curriculum will be taught by social workers to ensure that the curriculum is up to date information, medically accurate, and includes subjects and challenges that adolescents can relate to. The curriculum has been designed to be taught by social workers to ensure that the instructors of the material are properly trained and comfortable teaching the content, including preparation for honest and open conversations with the adolescents about the subject material. This material can be taught by social workers who are school social workers, or who are contracted from an agency by the school.
Protection of Human Subjects

This researcher obtained the informed consent form from each participant, in person; after this writer had initiated contact with each participant by way of a telephone call, see Appendix C. This researcher informed all of the participants that participation in the study is voluntary, and that there will be no consequences for not wanting to answer a particular question or not participating at all. In the instance that any participant does feel discomfort, this researcher has provided the participant with resources to seek help if needed. Each participant, their answers to the questions, the curriculum that is used in the school they represent, and the school that is represented in this study has been labeled in such a way ensuring anonymity and confidentiality of all participants and information.

There was no expected risk of discomfort or harm involved in participating in this study. This researcher considered this study to be no risk due to interviewing expert informants about their professional knowledge, not their personal opinion, of the sex education program that is implemented at the school he or she represents. It was expected that the participants would not feel discomforted in giving a professional opinion regarding the sex education program that is taught in the school that he/she represents. This researcher expected that speaking to adults there was no expected physical, emotional, or psychological harm caused by the participation in this study.
Conclusion

This researcher has conducted an exploratory study utilizing a semi-structured set of interview questions. This researcher interviewed five different schools within Northern California to explore the sexual health curriculum that is used by each school. The method that was used allowed for this researcher to ask a set of questions and receive the answers to the intended questions, and the method allowed this researcher to ask the expert informants additional questions to their responses of the set questions. This researcher was able to gather necessary information through each interview, while protecting the confidentiality of each participant and explaining the expected risks of participating in the interview. The next step for this researcher was to analyze the information gathered from each interview by looking for themes regarding the challenges each school faces when teaching the subject, the content of the curriculum used by each school, and if schools are following state requirements and educational codes for teaching sexual health education.
Chapter 4

FINDINGS

Introduction

This researcher conducted five interviews with expert informants regarding the sex education program that is taught at the school each informant represented. This researcher evaluated each program and curriculum by exploring and analyzing the information that was given by each of the participants. In addition, this researcher assessed the differences and similarities between each of the curricula from the different educational settings. Using a semi-structured set of interview questions allowed this researcher to gain additional knowledge from the interviewees that this researcher did not intend to ask. The additional information was helpful to this researcher in understanding how the curriculum was created, updated, and presented to the students. This researcher was able to further explore the curriculum that is used by each school, and the information gained from the interview has helped this researcher understand the challenges that each school faces when teaching the subject, and what information is actually taught to the students. All of the information that was gained from the interview process has been useful to this researcher in developing a new sexual health education curriculum designed for social workers to educate students.

Demographics

The information that was collected by this researcher was obtained from two middle school Science teachers, one middle school principal, and two high school
Health and Safety teachers during the interviews. The schools these professionals represented are located in the cities of Rocklin, Roseville, Granite Bay, Orangevale, and Esparto. The districts that the schools are located in are Rocklin Unified School District, Eureka Union School District, Roseville Joint Union High School District, San Juan Unified School District, and Esparto Unified School District. Three schools are located in Placer County, one is located in Sacramento County, one is located in Yolo County, and all of the schools are located in Northern California, see Table 1.

To protect confidential information, such as names of the professionals and the schools they represent, this researcher has labeled the schools: School 1, School 2, School 3, School 4, and School 5.

Table 1

*Identifying Information of Each School*

<table>
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<tr>
<th>School</th>
<th>Name of District</th>
<th>County</th>
<th>Title of Person</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Placer</td>
<td>Health and Safety Teacher</td>
</tr>
<tr>
<td>2</td>
<td>Rocklin Unified School District</td>
<td>Placer</td>
<td>7th Grade Science Teacher</td>
</tr>
<tr>
<td>3</td>
<td>San Juan Unified School District</td>
<td>Sacramento</td>
<td>Health Teacher</td>
</tr>
<tr>
<td>4</td>
<td>Esparto Unified School District</td>
<td>Yolo</td>
<td>Principal</td>
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School 1

The professional this researcher interviewed from School 1 was a high school Health and Safety teacher. The school is located in the Roseville Joint High School District within Placer County. The teacher was open to participating in the interview, and throughout the interview she continuously stated how important she thought this subject is for students to know. She was very comfortable speaking to this researcher, and stated that she had been teaching the class for eight years. See Table 2 for her answers to the questions given during the interview.

The teacher stated that she is very interested in adolescent sexual behavior and trends of those behaviors. She feels that comprehensive sex education is very important, and she is aware of the state standards and California laws surrounding teaching the subject. She has confronted other teachers when she finds out that they are not teaching all of the components of sex education that the state requires. She states, “It is ridiculous not to teach about these topics. You have no business teaching this subject if you are not comfortable” (School 1, personal communication, March 12, 2010). She feels that students deserve the right to know this information in hopes of “delaying first time intercourse, and if that first time includes the use of protection” (School 1, personal communication, March 12, 2010).
The teacher will tell her students about Planned Parenthood, and how they can receive free condoms and birth control. “It has gotten a bad wrap for being an abortion mill, but it is a health facility, and they will do checkups even for a sore throat” (School 1, personal communication, March 12, 2010). She will tell them that they can get tested for STD’s, and she informs them about the law that allows for their reproductive health to be confidential. The teacher from School 1 stated the following:

The doctors can’t tell their parents, and I feel it’s important for them to know that. I don’t encourage them to keep information from their parents, but I state that I would rather that they get good medical care than put it off. At least they will get the medical care and possibly prevent any consequences later on. (School 1, personal communication, March 12, 2010)

The teacher from School 1 continued by stating that she is aware that some parents may not like that she tells the students this information. “It is a reality, it is their right as being a minor, and they need to have those rights pointed out to them. I really don’t think that anyone can really argue when looking at the health of a kid” (School 1, personal communication, March 12, 2010).

Health and Safety is the title of the class in which the education on the material takes place at School 1. The Roseville Joint Union High School District mandates that freshman take the Health and Safety class, which is one semester long lasting 18 weeks with 90 minute blocks of time to teach. “The teachers are not trained on the
material, but all are qualified to teach, per No Child Left Behind, you have to have a credential in health education” (School 1, personal communication, March 12, 2010). The teacher stated in regards to the curriculum and an evaluation of the material, “as a district in the last three years we have come up with common assessment as a final exam test. All of the health teachers in the district have come together and decided which standards they are going to target” (School 1, personal communication, March 12, 2010).

She stated that all of the high schools, district-wide, use the same guidelines for the curriculum, and they all use a textbook as the main text for the course. It is a state adopted book and it is based on comprehensive sex education. The teacher also stated, “HIV/AIDS prevention is required by the state and yes it is taught” (School 1, personal communication, March 12, 2010). She uses a book titled Go Ask Alice. It is based on a true story of a 14-year-old girl, who was date raped during her first time of sexual intercourse. She becomes infected with HIV, and she dies two years later. The teacher states that it is “perfect for our curriculum” (School 1, personal communication, March 12, 2010). She also teaches a unit on drugs, and in the book, Go Ask Alice, the boy who raped the girl had brought alcohol when hanging out with the girl. He slipped something in her drink that is assumed to be a drug. The teacher explains how the book relates to the course:

In class we talk about how alcohol lowers inhibitions, and talk about how a student may say they aren’t going to have sex now but alcohol lowers inhibitions and
makes it harder to say no. Sex feels good, you are kissing and groping, and before you know it you are having sex. You may not have ever intended to, but it happens and that is how alcohol messes with your mind. (School 1, personal communication, March 12, 2010)

The teacher continues to explain that the book is a great resource for the students to relate to, and it covers a lot of the topics that are taught in the class. She stated she: talks about how the character in the book never intended to have sex, but she did, and in class we really hit on making choices. In the book she lied to mom and friends, and had a guy over when her parents weren’t there. The guy was older, and she thought he was a freshman in college but he was really in his mid-twenties and that is also why she kept it a secret. Perfect for the curriculum, guides us through. It is a required reading, and she doesn’t think any other school uses it. (School 1, personal communication, March 12, 2010)

The teacher from School 1 stated that they choose to not teach about homosexuality or masturbation since it not talked about in the stated adopted textbook, and parents are usually uneasy about it. She states, “What are you going to teach about it? We acknowledge the vocabulary, and explain what it is when there is a question, but don’t advocate, preach, or say what is right or wrong, just state what it is” (School 1, personal communication, March 12, 2010). The teacher stated that, “the curriculum is decided by the health teachers within the district,” and she explains that the district will:
Look at California state health standards, and from the hundreds of standards we choose those as health teachers feel are most important. We are the experts and the district respects that, and we all seem to be on the same page and agree together. What we are doing now works, so why change things unless I want some new fresh ideas.  (School 1, personal communication, March 12, 2010)

She also stated that, “all the teachers have the credential in health education, according to state or federal law. In order to teach the subject, you have to have a health credential to teach in high school” (School 1, personal communication, March 12, 2010).

The teacher from School 1 is constantly updating her curriculum by staying current on statistics and other current information that relates to the course. “I read two papers a day, the New York Times, and I look at publications such as the Berkley Wellness Letter” (School 1, personal communication, March 12, 2010). She stated that she “loves teaching health because it’s dynamic, always changing, and showing the kids that they will be using this information for the rest of their lives. It can make or break the quality and longevity of their life” (School 1, personal communication, March 12, 2010). She stated she “really hits hard and heavy on anatomy and physiology, and teaches it in the beginning so throughout the rest of the semester they are aware and they understand and can picture what is talked about” (School 1, personal communication, March 12, 2010).
The curriculum that she uses covers all of the topics that were asked in the interview except homosexuality, gender roles, and abortion. She stated that they do talk about respecting differences in others, and will talk about homosexuality if it comes up. If it does come up the teacher explains:

I tell them there is genetic evidence out there and its not a choice. They have a difficult time with that, especially if they have been told otherwise by their church. I point out that studies have been done showing 8% of the population is homosexual, and I make them do the math. Of every 8 out of 100 in the school is homosexual, and we have over 2000 kids at Granite Bay. (School 1, personal communication, March 12, 2010)

The teacher at School 1 is also very proud that she:

Began the process of getting the Gay Straight Alliance going on campus. The principal was not okay with it at first, but schools have the right to form a student club and the students came to her about it. We rallied at the capital and when we first got the club going, the day that students sign up for clubs we had more sign ups than any other club. (School 1, personal communication, March 12, 2010)

She continued to say that she feels that “this generation feels like, so they are gay, so what? Students may not agree with it, but they feel that it is that person’s choice to live that lifestyle” (School 1, personal communication, March 12, 2010). She said that talking about respecting differences is not a hard concept for them to grasp.
The teacher stated that they do not cover gender roles, and developmentally it should be taught at the junior high level. She does cover the topic briefly when she talks about dating. She stated that she asks the students:

What is the purpose of dating? Gender roles and double standards like guys are players, girls are whores, so we talk about how that affects the girls and how they feel about it. We talk about how it’s healthy to date, and we do cover refusal skills, which goes into the communication thing. (School 1, personal communication, March 12, 2010)

The teacher also speaks about peer pressure and she:

Ties it into alcohol. I come on heavy about alcohol. It’s awful the number of kids who are drinking and loosing their virginity due it to, and how damaging it can be. How it can lead someone to be depressed because they had sex when they didn’t want to. I also teach about other drugs, but at this age they are using pharmaceuticals and alcohol. (School 1, personal communication, March 12, 2010)

In response to asking if she teaches about abortion she stated, “we don’t teach it, but kids want to know what goes on with abortion. They want to know what’s involved. They have heard of it, but they don’t know what exactly happens during the procedure. I don’t go into detail, unless it’s asked” (School 1, personal communication, March 12, 2010). She stated that she needs to be careful about what she says, but she will “talk about the three choices if a woman becomes pregnant: keep the child, have an abortion, or give it up for adoption. If they ask specifically about
abortion then she will tell them, but she does not specifically teach what it is all about” (School 1, personal communication, March 12, 2010).

Overall, the teacher from School 1 stressed the importance of informing students with accurate and scientific knowledge, using the correct vocabulary, and respecting differences in others. She evaluates her students by reading their notes, and she said that she could tell if she is reaching them by what they are writing, and the questions that they are asking. There is a question box and she stated that she feels that the students are “pretty savvy” (School 1, personal communication, March 12, 2010). She thinks the students already know a lot about the subject, but she wants to make sure that they know the correct information. She enjoys having the open conversations with the students when they ask questions. She feels that they have a very comprehensive curriculum and enjoys teaching the class.

Table 2

*Interview Question Numbers and Answers from School 1*

<table>
<thead>
<tr>
<th>Question #</th>
<th>Answers from School 1</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Health and Safety</td>
</tr>
<tr>
<td>4</td>
<td>Freshman Year</td>
</tr>
<tr>
<td>5</td>
<td>1 semester/ 18 weeks/ 90 minutes at a time</td>
</tr>
<tr>
<td>6</td>
<td>Need to have credential in Health Education</td>
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<td></td>
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<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Health and Safety teachers in the district</td>
</tr>
<tr>
<td>8</td>
<td>Health and Safety teachers in the district</td>
</tr>
<tr>
<td>9</td>
<td>Textbook, other book, other various sources</td>
</tr>
<tr>
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<td>Textbook, other book, other various sources</td>
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</tr>
<tr>
<td>12</td>
<td>Clear</td>
</tr>
<tr>
<td>13</td>
<td>You can't, how can you? Year-end test.</td>
</tr>
<tr>
<td>14</td>
<td>Teacher</td>
</tr>
<tr>
<td>15</td>
<td>Uses same curriculum, just updates the info.</td>
</tr>
<tr>
<td>16</td>
<td>Constantly</td>
</tr>
<tr>
<td>17A</td>
<td>Yes</td>
</tr>
<tr>
<td>17B</td>
<td>Yes</td>
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<tr>
<td>17C</td>
<td>Yes</td>
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<td>17D</td>
<td>Yes</td>
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<tr>
<td>17E</td>
<td>Yes</td>
</tr>
<tr>
<td>17F</td>
<td>When students ask questions</td>
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<td>17G</td>
<td>Yes</td>
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<tr>
<td>17H</td>
<td>No</td>
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<tr>
<td>17I</td>
<td>No</td>
</tr>
<tr>
<td>17J</td>
<td>Yes</td>
</tr>
<tr>
<td>17K</td>
<td>Yes</td>
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</table>
School 2

The expert informant that this researcher interviewed at School 2 was a 7th grade Math and Science teacher. The school is located in the Rocklin Unified School District within Placer County. To see the answers to the questions that were answered during the interview with the teacher from School 2 see Table 3. The teacher from School 2 was very open with this researcher during the interview, and she has been teaching Math and Science for eight years. “The sex education is done as part of the life science curriculum, in 7th grade it’s the unit on Family Life is what we call it. They have a final test and everything” (School 2, personal communication, March 10, 2010). The Family Life unit “is only taught in 7th grade in the middle school level. It’s about 20 hours, for 3 weeks, and the class period is 47 minutes, so it’s about 15
hours and some of the classes I do block so I would say it’s about 20-25 hours” (School 2, personal communication, March 10, 2010). She is very comfortable with teaching the subject matter, and explains how she tries to get the students to also be comfortable:

I start out the unit and say penis, penis, penis, vagina, vagina, vagina, and the kids go ewe and are laughing. I say that they are just words. I find the more direct I am with them the sooner they see the words as scientific words and realize they are just words. (School 2, personal communication, March 10, 2010)

The teacher stated that there is no formal training for the teachers who teach the Family Life unit. “We get an informal training, but there is no formal training. We do have a lesson plan that other teachers have developed and we can follow that as a guide, or we can do our own thing” (School 2, personal communication, March 10, 2010). She continues to explain the materials that are used:

I have been here, this is my 8th year, and we have been using the same videos since then, so maybe we have been using the videos for the last 10 years. They are kind of dated, and I have not heard of them updating them. We just update statistics from the CDC website. (School 2, personal communication, March 10, 2010)

Regarding the curriculum the teacher stated:

We have seven different videos that we show. One is a specific video on AIDS. It’s a teenager’s story. It is told as a story through the whole process with her finding out and having to tell her boyfriend, and having to do a support group, it’s
good the kids can relate to it. It’s a little bit out of date, but not as out of date as we used to see. (School 2, personal communication, March 10, 2010)

The teacher stated that “our district is pretty strict because of parents…we have constraints, such as the videos, and one teacher got information off the CDC website for each of the diseases” (School 2, personal communication, March 10, 2010). She stated that “the decisions of the content is up to the school board, it is district wide, and every 7th grader is getting this information” (School 2, personal communication, March 10, 2010).

The teacher explains who is responsible for teaching the subject:

Any teacher could be responsible for teaching the subject. I know that in other classes the science teacher isn’t teaching it the math teacher is, because they are more comfortable doing it, but 7th grade science is responsible for teaching it. It’s not a California State Standard for Life Science; it just fits with our curriculum. (School 2, personal communication, March 10, 2010)

The teacher stated that the “evaluation is the test at the end and we give them quizzes along the way, and then there is a website called quizlet we also give them all of the terminology so they can take quizzes and see how they are doing” (School 2, personal communication, March 10, 2010). She also stated:

My kids have a science notebook, they are interactive notebooks. They will keep all of the handouts and stuff, so any notes they take glue it in here. They will have that as part of their grade too. We will evaluate what they have done in their
notebooks, so that and their final test. (School 2, personal communication, March 10, 2010)

The teacher stated that they do have a question jar and “when questions come up we will talk about that stuff and they usually enjoy talking about this stuff, once they get over the embarrassment” (School 2, personal communication, March 10, 2010).

The teacher shares how she enjoys seeing in the transition over the year with the students:

It’s great because at the beginning they are all embarrassed, but by the end, at first when you fling out the words they are all giggly and laughing and at the end when I am saying them I say see they are just scientific words and it’s fun to see that transition with them. (School 2, personal communication, March 10, 2010)

She enjoys teaching the subject, but she feels that it is important to:

Tell them, that the education from us, since I am the science teacher I am giving you the science facts. Your parents give you your family beliefs and your church and religion can give you the moral beliefs about all of the stuff, but I am going to give you what is scientifically going on with you. (School 2, personal communication, March 10, 2010)

The teacher spoke about utilizing resources and integrating the information into an activity for the students to learn from:

One teacher got information off the CDC website for each of the diseases and we put them into groups and give them an STD. I tell them I am going to infect you
with an STD today and you guys are going to become the experts on it. They switch so each group has one person knowing about each disease and they teach each other and fill out the sheet and they love it. It’s the best thing of the year. They’re like totally into it. (School 2, personal communication, March 10, 2010)

She feels that when the students teach one another about the STDs they really learn the information, and that it is a way for the students to have fun and learn at the same time.

During the interview, the teacher from School 2 stated that the curriculum covers all of the topics that this researcher inquired about except gender roles, and homosexuality because it never comes up. In response to asking if the course includes speaking about abortion she stated:

You know it’s never come up, in the years I have taught this, maybe because they are younger. If it came up I might go over what is happening, but then say this is a parent and a religion thing, but this is the science of it. If they are wondering what is it, then I would definitely go over it because there is a scientific process that is happening. (School 2, personal communication, March 10, 2010)

In regards to decision making the teacher stated:

Yes it’s covered, we emphasize abstinence but we also talk about everything because we want them to realize that there are choices, and there are consequences for all of their choices. It’s sort of how you choose to not be abstinent, and you choose to do this, then these are the consequences that can happen. They are
realizing this is happening based on a choice they are making. (School 2, personal communication, March 10, 2010)

She stated that they also cover contraception and condom effectiveness. She stated that:

They are immature, and hopefully not many of them are having sex, and I have done this long enough you can tell the kids who are sexually active because their questions are different. They know things that, luckily most of the kids are not doing things yet, at least in 7th grade. Who knows what’s happening in 8th grade. (School 2, personal communication, March 10, 2010)

She points out that the 8th graders do not get a Family Life Unit, but she feels that they may be the ones who are engaging in sexual activities more so than the 7th graders. She feels that they may need a refresher in 8th grade, but it “it just fits with our curriculum. That’s why they chose 7th grade rather than 8th grade, because 8th grade is Physical Science and Chemistry. It fits in better with Life Science” (School 2, personal communication, March 10, 2010).

The teacher stated that they cover teen pregnancy, and “a little bit of marriage, it kinda goes along with abstinence but it’s not really covered. It’s pretty weak” (School 2, personal communication, March 10, 2010). She stated that “communication is huge, so when we talk about sexually transmitted diseases we emphasize communicating who has it and who ever finds out, and who ever has it doesn’t want to tell the other person, and so they really go through how to do that.
That’s really a strength in the videos that they watch” (School 2, personal communication, March 10, 2010).

Drugs and alcohol are also covered in the Family Life unit at School 2. “We talk about them being at a party and making a bad choice, and touch on that about making bad choices that lead to other bad choices” (School 2, personal communication, March 10, 2010). She stated that they do talk about dating and peer pressure during the Family Life unit:

It is in one of the videos, What Teens Want to Know About Sex, it's a girl and guy who write for a magazine so people ask them questions and they answer, and so there are questions about someone trying to pressure someone else to have sex. It teaches them that yes they can say no and yes people will still like you, and if they don’t then you have to make another hard choice. (School 2, personal communication, March 10, 2010)

The teacher stated that they talk about oral sex and she will:

Talk about what sex is. A lot of the questions that come up, because they don’t consider that if it is not intercourse it is not sex. We make that distinction of what it is and that still is considered sex, and that it is something you don’t have to do and you can say no, and we do talk about that. It comes up more in questions then it does in the videos. (School 2, personal communication, March 10, 2010)

She is not uncomfortable talking about oral sex with the students. She feels it is important for them to know that STDs can be transmitted through any type of sex. “I
talk about if someone has sores on their penis and you put your mouth on their penis you will get the sores in your mouth, and they are grossed out. I say the same thing as if you put your penis in a vagina that is infected you become infected too” (School 2, personal communication, March 10, 2010). She feels that parents understand the importance of talking about this and she never has to defend herself for talking about the topic.

The teacher states that she feels there are no challenges or limitations to teaching the Family Life unit. She stated that if she wanted to add anything to the curriculum:

It’s not a big deal. I would have to get permission and I always do that with my principal and he trusts me. If I gave something new to him and previewed it and he usually would trust my judgment, but I wouldn’t take anything that was way out there to him. (School 2, personal communication, March 10, 2010)

She feels that some of the struggles for students:

The big things for the girls that comes up in middle school is that where they fit in. Not wanting to be considered loose but not wanting to be too conservative. Either way you get a bad reputation, and so they start realizing that in 7th grade and that’s where, I think we can influence them on making wise choices. (School 2, personal communication, March 10, 2010)

She does not have a difficult time talking with the girls, and she will tell them:
you don’t need to do anything with your boyfriend that you are uncomfortable doing. If he tells you that he is going to leave you then let him leave you because he is a jerk. You don’t want to be with that guy anyway, so that’s the truth and they will find someone else who will. (School 2, personal communication, March 10, 2010)

Overall, she feels that the curriculum is important to teach to the students, and she stated that the students seem to really like the subject. She finds it easy to teach, and she feels that her school is doing a good job of covering the important aspects of the subject matter.

Table 3

Interview Question Numbers and Answers from School 2

<table>
<thead>
<tr>
<th>Questions</th>
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<tbody>
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<td>Yes</td>
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<tr>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Life Science/Family Life Unit</td>
</tr>
<tr>
<td>4</td>
<td>7th Grade</td>
</tr>
<tr>
<td>5</td>
<td>3 weeks with a total of 20-25 hours</td>
</tr>
<tr>
<td>6</td>
<td>Informal training</td>
</tr>
<tr>
<td>7</td>
<td>The school district</td>
</tr>
<tr>
<td>8</td>
<td>The Math and/or Science teachers</td>
</tr>
<tr>
<td>9</td>
<td>Textbook/CDC website/videos approved by district</td>
</tr>
<tr>
<td></td>
<td>Textbook/CDC website/videos approved by district</td>
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<tr>
<td>---</td>
<td>-----------------------------------------------</td>
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<tr>
<td>10</td>
<td>Yes</td>
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<tr>
<td>11</td>
<td>Clear</td>
</tr>
<tr>
<td>12</td>
<td>Test at end of the unit</td>
</tr>
<tr>
<td>13</td>
<td>Teacher</td>
</tr>
<tr>
<td>14</td>
<td>10 years with updates in stats.</td>
</tr>
<tr>
<td>15</td>
<td>Not often, mostly the stats. from the CDC website</td>
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<tr>
<td>16</td>
<td></td>
</tr>
<tr>
<td>17A</td>
<td>Yes</td>
</tr>
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<td>17B</td>
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<tr>
<td>17C</td>
<td>Yes</td>
</tr>
<tr>
<td>17D</td>
<td>Yes</td>
</tr>
<tr>
<td>17E</td>
<td>Yes</td>
</tr>
<tr>
<td>17F</td>
<td>No, it has never come up</td>
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<tr>
<td>17G</td>
<td>Yes</td>
</tr>
<tr>
<td>17H</td>
<td>No</td>
</tr>
<tr>
<td>17I</td>
<td>Yes when speaking about abstinence</td>
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<tr>
<td>17J</td>
<td>Yes</td>
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<tr>
<td>17K</td>
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This researcher interviewed the high school Health and Safety teacher from School 3. School 3 is located in the San Juan Unified School District located in Sacramento County. To see the answers the teacher from School 3 gave during the interview, see Table 4. The teacher stated that she loves teaching the class, and she feels that it is an important class for students to take while in high school. The course taken at this school is titled the Health and Safety class, and “the sex education unit is about two weeks, out of a nine week course. We are on a block schedule, and they have one and a half hours a day in this class” (School 3, personal communication, March 19, 2010). The teacher explained the transition that the school is currently in to switch the grade level that the class is required to take. She stated:

We are in transition year. It used to be sophomores, but we are switching it to freshman. This year all sophomores and all freshman are taking it, and starting next year it will be just freshman. It’s due to master scheduling they wanted to
balance the schedule with more requirements for sophomores and less for freshman. (School 3, personal communication, March 19, 2010)

She stated that she is not happy about the transition in grade levels:

I find that the freshmen have a little bit more difficulty placing themselves in situations that they are not in yet. They tend to lean towards thinking that won’t happen to me. Sophomore year was great, but freshman year they don’t have the maturity or life experience. (School 3, personal communication, March 19, 2010)

When asked about teachers being required to be trained on the material she responded:

It is required that teachers are retrained every two years. The trainings are mostly on the laws of sex education and what California law says we are supposed to do. Then there are updates on STDs and HIV. I think it’s district policy, and we usually have someone from the California Board of Education comes in and does the training. (School 3, personal communication, March 19, 2010)

The teacher has been teaching the course for four years and she has been to the training twice. She feels that it is important to be continuously updated about the new trends and statistics on STDs. For an evaluation of the course, she will conduct “testing at the end, a multiple test and I kinda do a class evaluation. It’s kinda like an open forum like a college teacher does, what would you tell your friends about this class? What do you like about the teacher? What things stood out to you? What could change?” (School 3, personal communication, March 19, 2010). The teacher feels that
the students understand the material they are being taught, and the evaluation allows for her to hear from the students about what is working, or what they like about the course. She feels it is important to change anything that is not helpful to the students.

The teacher from School 2 stated that the decisions for content of the course are “based on the approved text book that the district adopted based on the standards and framework for health education” (School 3, personal communication, March 19, 2010). She stated that a couple of years ago the school district put together a committee to talk to a parent committee about the content and materials for the course. She stated that the parent committee wanted to approve all the supplementary materials for the course, and they wanted to have an approved list of things that can be used. The teacher was upset by what was being asked by the parent committee. She felt they were trying to restrict the material she felt was an important aspect in the course. “In the last training we had from the state, the trainer said that’s not the way it should be, and that you should be able to use anything that is medically accurate to supplement what you have in the classroom” (School 3, personal communication, March 19, 2010).

The teacher felt empowered by the trainer from the state Board of Education, and felt that she would be backed by the state if parents were to become upset by what is being taught to the students. She feels that she should not deny the students of important information because a few parents do not approve. She stated that the
school has an opt-out form for those parents who do not want their child participating in the sex education portion of the course.

Occasionally I have a parent say no or I have a parent ask to see the material. I will send the textbook home and send them an email explaining the basis of the curriculum. When I have back to school nights I explain to them that it is abstinence based but we have to teach other thing. (School 3, personal communication, March 19, 2010)

For the most part, most are able to participate in the entire course and not have to miss out on the information.

The teacher from School 3 stated that they talk about decision-making and “about how pregnancy occurs, the reproductive system, then okay how do we prevent this, and go through all the contraceptive methods. California State law requires comprehensive sex education, and we can’t teach abstinence only” (School 3, personal communication, March 19, 2010). She uses a book to help guide her through teaching all of the contraceptives and their failure rates. She then will “highlight that abstinence is the only way that has no failure rate. It is 100%, foolproof, no risk at all” (School 3, personal communication, March 19, 2010). She will talk about condom effectiveness, and she will show the students how to put on a condom by using a banana. The teacher feels that it is just as important as talking about it.
The teacher stated:

Abortion is brought up as they have questions about it, but it’s not formally mentioned in the text. I do bring it up talking about fetal development. At what point when the fetus can live outside the mother and that is the cut off for abortions because of that. That is usually as far as it goes. (School 3, personal communication, March 19, 2010)

She stated that gender roles are talked about when they “talk about relationships with males verses females, and what their expectations are. Not too much in their roles per say. We talk about double standards when we talk about body image, mostly” (School 3, personal communication, March 19, 2010). She stated that “marriage is in the text but I usually don’t get to it. I don’t have a lot of time to talk about marriage. You know it is brought up with monogamy and that so it kinda gets in there but not really” (School 3, personal communication, March 19, 2010). She wishes she had more time to cover more topics. “We have nine weeks to cover 22 chapters. I want to spend more time on relationships, families, healthy and unhealthy relationships basically” (School 3, personal communication, March 19, 2010).

The teacher stated that they talk about the:

Influence of drugs and alcohol, the influence of media, and homosexuality is brought up as students have questions. We talk about it when we talk about HIV and usually when kids talk about it being a homosexual disease. I talk about the
increased risks of anal intercourse as opposed to vaginal intercourse. (School 3, personal communication, March 19, 2010)

She feels that clarifying the student’s misconceptions is important, and highlights that students can be influenced by their religion or the fact that they are sheltered growing up in a small town that is not very diverse. “Sometimes kids have questions about homosexuality and are they born that way or is it a choice? So I deal with it from a scientific perspective that this is what science tells us” (School 3, personal communication, March 19, 2010). The curriculum at School 3 covers all of the topics that were asked about by this researcher during the interview with addition to oral and anal sex. The curriculum appeared to be very comprehensive and met all of the standards and requirements of the state of California.

With regards to the district having policies about topics to be avoided or not discussed the teacher responded by saying, “I think I have a lot of freedom to do what I feel is appropriate. At first I was more apprehensive about things, but now I will whip out a banana with a condom. They need to know how to do this” (School 3, personal communication, March 19, 2010). At first she thought that the School Board and the district where going to make her stop doing things, such as the condom demonstration, but she attended the training that allowed her “to feel empowered by the state, that no I can do what I want as long as it is medically accurate. So I think I have a lot of freedom to do what I need to do” (School 3, personal communication,
March 19, 2010). She feels supported by those around her, and she is happy about that.

The teacher feels there are not many challenges in teaching the course.

This unit is my favorite subject to teach, and I feel like I am supported by the district. The only challenge is the younger kids not being able to think ahead into the future. That is what bothers me most. With the younger kids I feel like I am spinning my wheels they may not remember this a few years from now. (School 3, personal communication, March 19, 2010)

She wishes that the course could be taught again in the student’s senior year. “They have more questions as seniors. I have lot of seniors who come back and go what did you say about that again? They need a refresher” (School 3, personal communication, March 19, 2010). Overall, the teacher is happy to teach the course, and she feels that the school does a great job of informing the students with important information regarding sex education.

Table 4

*Interview Question Numbers and Answers from School 3*

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</tr>
<tr>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Health and Safety Class</td>
</tr>
<tr>
<td>4</td>
<td>10th grade but transitioning into 9th grade</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>5</td>
<td>9 weeks 1 1/2 hours each day</td>
</tr>
<tr>
<td>6</td>
<td>Every 2 years teachers are retrained on material</td>
</tr>
<tr>
<td>7</td>
<td>District</td>
</tr>
<tr>
<td>8</td>
<td>Health and Safety teachers</td>
</tr>
<tr>
<td>9</td>
<td>Textbook/videos/CDC website</td>
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<tr>
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<tr>
<td>13</td>
<td>Test at the end and an informal evaluation</td>
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<tr>
<td>14</td>
<td>Teacher</td>
</tr>
<tr>
<td>15</td>
<td>4 years</td>
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<td>16</td>
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</tr>
<tr>
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<td>Yes</td>
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<td>17C</td>
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<td>17F</td>
<td>Yes, if it comes up</td>
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<tr>
<td>17K</td>
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</tr>
<tr>
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</tr>
<tr>
<td>19</td>
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<tr>
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<td>Freshman don't seem to be able to relate to the information</td>
</tr>
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<td>21</td>
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</table>

**School 4**

The fourth interview this researcher conducted was with a school principal from a middle school in Esparto Unified School District located in Yolo County. The teacher who teaches the subject was unable to participate in the interview, so the principal participated in his place. To see the answers that were provided to this writer by the principal of School 4, see Table 5. The principal stated that his school is located in a very rural and conservative area, and there is not much emphasis that is put on the sex education material. “The course is taught in one week, very minimum. It is not a state tested subject so it’s not tested on in the schools. It is taken minimum
time and the teacher uses it as a filler at the end of the year” (School 4, personal communication, March 23, 2010). The total amount of time spent on the subject is about ten hours, within the one week of education. The principal feels that there are many challenges that are faced with teaching this subject. He said it is not a tested subject area, and within the school district “if it’s not tested it is hard to cover. This is not tested at all” (School 4, personal communication, March 23, 2010). He feels that the teacher and the district does not feel that it is an important subject to teach, and so the teacher does the minimal teaching that he can.

During the interview, this researcher found that School 4 covers most of the topics that were asked about, but the curriculum does not cover contraception, condom effectiveness, abortion, gender roles, marriage, or homosexuality. This researcher was surprised to find that the teacher teaches about pregnancy, fetal development and how a baby is made, decision-making, and STDs, but not about actual sexual intercourse and how to prevent STDs or pregnancy. The principal is surprised by this also, and stated that he knows that the teacher is uncomfortable teaching the subject. He is the only Science teacher at the school, and that is the course that the district has decided to teach the sex education material.

This researcher discussed with the principal how the school is not following the regulations set by the state of California when a school decides to teach sex education. Oddly, the principal stated that the teacher told him that he feels that the California laws and health standards are clear to him. With the teacher reporting that
he feels he understands the laws and standards, the teacher is either ignoring them by omitting certain topics, or he truly does not understand the laws and health standards. The principal understands and personally feels that more should be done about it, but he feels his hands are tied. He stated that the district is “ultra conservative” and the parents of the students do not feel the same way he does (School 4, personal communication, March 23, 2010). He feels he cannot do anything about it.

In regards to the topics that are not discussed, the principal stated, “it’s not that they are not allowed to discuss them, this teacher would probably just move on if there were to be a question, and not address the question” (School 4, personal communication, March 23, 2010). This again the principal stated is because the teacher is uncomfortable with the subject matter, and that he is very introverted. The principal stated that the teacher had come to him one day and “complained that a student used the p word (penis)” (School 4, personal communication, March 23, 2010). The principal knows it is difficult at the middle school level to have a teacher teach the subject and be comfortable, and he feels that not many teachers are comfortable. He thinks that despite the fact that they are uncomfortable with the subject matter, they are teachers and should find a way to be comfortable teaching the material. The principal explained:

Staff has difficulty handling some inappropriate dress code issues because they bring in their values, and they shouldn’t. If you start bringing in your own morals it becomes problems. We don’t hire to teach morals, we hire to teach standards,
and so this information should be covered. (School 4, personal communication, March 23, 2010)

The principal feels that the teacher’s morals are what get in the way of a teacher being comfortable, and he feels that those morals should not be something that gets in the way.

The principal from School 4 stated:

The teacher just uses information out of the science book, and that way it’s state adopted and state approved curriculum…every six years the curriculum changes because he uses the state adopted book, and the state adopts new books and new curriculum every six years. There are not necessarily new standards, but new books that come out and you have to buy the new books. (School 4, personal communication, March 23, 2010)

The school feels that they are doing the correct thing by using the state adopted book, but the teacher seems to pick and choose what he feels comfortable teaching out of the state adopted book in what he actually teaches to the students. The principal has concern since “now the health class is an elective, and so not all kids even get the sex education information” (School 4, personal communication, March 23, 2010). He feels that there may not be a lot of emphasis on all of the material since the course is not a required course for all of the students.

Overall, School 4 does not follow the comprehensive sex education requirements laid out by the state of California. The teachers within the district are not
trained on how to teach the material or what to teach, and this could be something that would help improve the education of the material if the district required their teachers to be trained. The Science teacher reported to the principal that he does not feel there are any policies that prevent him from teaching particular subjects, and that there are no challenges or limitations to teaching the material. The teacher appears to not have any restrictions along the lines of teaching the subject, but the teacher’s statement conflicts with the principal stating that the district is very conservative and does not want particular subjects to be talked about. This researcher feels that the school being in violation of the laws and requirements shows that the state does not have an effective way of making sure that all schools are following the laws if they choose to teach sex education.

Table 5

*Interview Question Numbers and Answers from School 4*

<table>
<thead>
<tr>
<th>Question #</th>
<th>Answers from School 4</th>
</tr>
</thead>
<tbody>
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<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Sex Ed in Science &amp; HIV/AIDS in Health Elective</td>
</tr>
<tr>
<td>4</td>
<td>7th grade for Science and 7th and 8th for Health</td>
</tr>
<tr>
<td>5</td>
<td>1 week about total of 10 hours</td>
</tr>
<tr>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>School Board</td>
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<tr>
<td></td>
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<td>---</td>
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</tr>
<tr>
<td>8</td>
<td>Science teacher</td>
</tr>
<tr>
<td>9</td>
<td>State adopted textbook</td>
</tr>
<tr>
<td>10</td>
<td>State adopted textbook</td>
</tr>
<tr>
<td>11</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>Clear</td>
</tr>
<tr>
<td>13</td>
<td>Test at the end</td>
</tr>
<tr>
<td>14</td>
<td>Teacher and Principal</td>
</tr>
<tr>
<td>15</td>
<td>3 years</td>
</tr>
<tr>
<td>16</td>
<td>Every 6 years</td>
</tr>
<tr>
<td>17A</td>
<td>Yes</td>
</tr>
<tr>
<td>17B</td>
<td>Yes</td>
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<tr>
<td>17C</td>
<td>Yes</td>
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<tr>
<td>17D</td>
<td>No</td>
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<tr>
<td>17E</td>
<td>No</td>
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<tr>
<td>17F</td>
<td>No</td>
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<td>17G</td>
<td>Yes</td>
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<tr>
<td>17H</td>
<td>No</td>
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<tr>
<td>17I</td>
<td>No</td>
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<tr>
<td>17J</td>
<td>Yes</td>
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<tr>
<td>17K</td>
<td>Yes</td>
</tr>
<tr>
<td>17L</td>
<td>No</td>
</tr>
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</table>
The fifth and final interview that this researcher conducted was with a middle school Science teacher at School 5, which is located in the Eureka Union School District in Placer County. To see the answers that were given by the teacher from School 5, see Table 6. The teacher from School 5 appeared to be hesitant about participating in the interview, and he stated many times that he preferred to call the program Family Life and not sex education. He stated, “I definitely think it is a valuable program, out of everything we teach it’s the easiest to keep their attention. They are all into it, and most of them, I think it clarifies some information for them” (School 5, personal communication, March 26, 2010). When asked about the education material and how it is taught at his school, the teacher responded “if you wanted to define it as the Family Life curriculum it is approximately ten days of
instruction with a day being a 42 minute period” (School 5, personal communication, March 26, 2010). He stated, “the other junior high in the school district runs a similar program through the science department” (School 5, personal communication, March 26, 2010). He also stated:

We interestingly enough do it the last few weeks of school. It is a topic that they are very willing to listen to. At their level they’re not going to want that much depth. As you can see we talk about the male and female reproductive structures and functions and things and we watch a couple of videos. It moves along fairly well. (School 5, personal communication, March 26, 2010)

When asked about if he feels that the California laws are clear or confusing, his response was, “we are comfortable with them. We go through some of the legislation on the various materials and how parents should be informed. It works” (School 5, personal communication, March 26, 2010). He stated that the district designed the curriculum. The teacher stated:

I have been at this district for ten years, and when I got here I could tell that the curriculum was typed on a typewriter, so we knew it had been a while since it was last updated. We just went through it I like about four or five years ago. We sat down with parents and administrators and teachers and we reworked it. (School 5, personal communication, March 26, 2010)

This researcher asked how often the school or district updates that material or curriculum, and he responded by saying that they update the information with nurse’s
input. “Periodically we were invited to go to a county STD seminar, and the nurses usually go and that keeps us updated on those particular statistics and things of that sort” (School 5, personal communication, March 26, 2010). When asked if the teacher felt it was challenging to fit all of the information into the ten days he stated:

We, as a school, think that we do have the time and it fits in very, very well, the biology aspect of it. The hardest part of it, there is also kinda of a ethical or moral issues that kinda need to be brought in like respect and those types of things which aren’t science but more mental health concerns. (School 5, personal communication, March 26, 2010)

He stated that they have to be careful around certain topics and try to stick to the scientific aspects of the subject.

When this researcher asked if it was a requirement for the teachers to be trained the teacher responded:

Yes and no. It’s understood that if you are teaching 7th grade Science that you are familiar with human anatomy, and we try to emphasize the fact of the science behind it more than a lot of things. The truth of the matter is that we don’t have any formal training in the content area or how to present it. (School 5, personal communication, March 26, 2010)

When asked if the school has a HIV/AIDS program the teacher responded by stating, “not per se. We talk in general terms about sexually transmitted diseases the kids are most familiar with HIV some of them do not understand that it is a STD
however so we talk about modes of transmission” (School 5, personal communication, March 26, 2010). When asked about the topics that are covered throughout the ten days the teacher stated that they do talk about decision-making, and sexual intercourse. The teacher explained:

The video that we watch does a really good job, because it talks about sex drive and attractiveness and things like that and they are beginning to understand that it is part of their biology that they are attracted to members of the opposite sex and your bodies are gearing up for that and those types of things. (School 5, personal communication, March 26, 2010)

The teacher stated that is as far as they go when talking about sexual intercourse.

When the teacher was asked if they talked about abstinence he replied, “we don’t, we’re not so much pushing abstinence. That is going to be more of a moral decision and there are strong parent groups. You need to be very careful but we are not going to say don’t or no” (School 5, personal communication, March 26, 2010). He continued to state:

Basically what we are talking about is this is what you’ve got, this is why it works the way it does, this is what it accomplishes, and if you do these activities then this can happen. We want them to know that. Our point is that a lot of it is the fact that there are consequences to your actions. (School 5, personal communication, March 26, 2010)
When this writer asked if they talk about contraception, the teacher responded by saying:

No, only in the most vague and general terms when we are talking about things that would prevent, but we aren’t really describing them in detail. Occasionally the kids will get us to a point were we do use the word condom or something like that. It really doesn’t go that far. (School 5, personal communication, March 26, 2010)

The teacher continued to say more about what they do talk about in regards to contraception.

We are not describing various types; we just say that there are methods out there that can be used to prevent transmission of these things. We have a question box, and sometimes the kids will ask about what are the methods and we take the questions and go through them and try to figure out how we can phrase things so that they can, if they are thinking and listening they can put the pieces together. But we don’t formally address it. (School 5, personal communication, March 26, 2010)

The teacher thinks that how they teach the material works for the school, and that they do not need to change anything.

The teacher stated that they do not cover condom effectiveness, and in response to asking about talking about abortion he stated, “not at all. I think the kids are familiar with it we don’t get into it. It’s the choice of the district” (School 5, personal communication, March 26, 2010). In regards to teen pregnancy the teacher
stated, “well, we don’t look at statistics on that particularly, but they are made aware
once ovulation begins and eggs are present and those things then pregnancy can occur.
We kind of let them know how the machinery is working and things can happen”
(School 5, personal communication, March 26, 2010). They do not cover marriage or
communication, dating or homosexuality. When asked about peer pressure the teacher
stated:

It kind of fluctuates year to year, we have been in the past have been supported by a
nurse, and when the other science teacher and I had taught at the same period we
would split up by gender and talk a little bit more about the roles and peer pressure
and things of that sort, but it’s kinda been dwindling over the past couple of years.
(School 5, personal communication, March 26, 2010)

When this researcher asked if there are any policies in place that surround what
topics can be covered or how to answer questions from the students he responded by
saying:

It’s not; there is not a lot of pressure to not talk about certain things. The thing is
there is a great reliability on good judgment and in the past we have had some
inexperienced teachers that they did too much because they weren’t hand held and
told where to draw the line. They, the 7th graders knew to take advantage of the
situation. (School 5, personal communication, March 26, 2010)

He continued to say that there are some topics such as:
Homosexuality, masturbation, and those types of things we kind of know to stay away from them. If they come up, one of the very first things we do is to talk about resources such as school nurses, administrators, psychologist, we talk to them about if they have questions about things they can’t get answered here to talk to those people. (School 5, personal communication, March 26, 2010)

He stated that the teachers will “often to refer to the fact that a lot of these kids are a part of religious affiliations and that can often be a good place to go, at least we hope” (School 5, personal communication, March 26, 2010).

The teacher stated that “one of the biggest challenges is you are looking out into an audience of 33-36 kids, and you know that the most immature boy and the most mature girl are light years apart so it’s difficult because you are just shooting down the middle” (School 5, personal communication, March 26, 2010). He also stated that, “it is a challenge for me as a male teacher to be covering this stuff sometimes in front of the girls” (School 5, personal communication, March 26, 2010).

When the teacher was asked if he felt there were any limitations to teaching the material he stated that the district:

Feels comfortable to place this burden on us. I am not sure they want to do much more than they do with it. The kids can opt out of part or all of this, so you are usually talking about out of a class of 250 students, maybe about 4 of 5 that are opting out. So apparently we aren’t going too far. (School 5, personal communication, March 26, 2010)
He feels that sometimes the parents have problems with the content:

Out of all the things we are asked to do it is the trickiest; the whole thing is the parent meeting. You know they are listening very intently, and at the end of the meeting I had two parents come up and basically approaching it from 2 different things. One says you are doing too much the other is saying you aren’t doing enough. It is hard to please everyone. (School 5, personal communication, March 26, 2010)

The teacher stated that they do not do an evaluation of the program. “I don’t think it’s ever been approached from an aspect of concerned, it’s more we feel we are doing a good job with the program, the kids are attentive, they are asking questions. We believe the kids understand” (School 5, personal communication, March 26, 2010). He also stated, “not having to test them or grade them in the last couple of weeks is kinda nice too. I think we spend an adequate amount of time on the material” (School 5, personal communication, March 26, 2010). The teacher does feel that they are doing a good job, and he seemed the most concerned about parental approval of the content. He stated that he felt comfortable with the California laws and requirements, but he is not covering all of the required topics within the curriculum that is used.

Table 6

Interview Question Numbers and Answers from School 5

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<th>Question #</th>
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</tr>
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<td>2</td>
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</tr>
<tr>
<td>3</td>
<td>Science Class/ Family Life Unit</td>
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<td>12</td>
<td>Clear</td>
</tr>
<tr>
<td>13</td>
<td>Don't, the teachers feel it is effective</td>
</tr>
<tr>
<td>14</td>
<td>No one</td>
</tr>
<tr>
<td>15</td>
<td>5-6 years</td>
</tr>
<tr>
<td>16</td>
<td>Not often</td>
</tr>
<tr>
<td>17A</td>
<td>Yes</td>
</tr>
<tr>
<td>17B</td>
<td>Yes</td>
</tr>
<tr>
<td>17C</td>
<td>Yes</td>
</tr>
<tr>
<td>17D</td>
<td>No</td>
</tr>
<tr>
<td>17E</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>17F</td>
<td>No</td>
</tr>
<tr>
<td>17G</td>
<td>Not really</td>
</tr>
<tr>
<td>17H</td>
<td>No</td>
</tr>
<tr>
<td>17I</td>
<td>No</td>
</tr>
<tr>
<td>17J</td>
<td>Yes</td>
</tr>
<tr>
<td>17K</td>
<td>No</td>
</tr>
<tr>
<td>17L</td>
<td>No</td>
</tr>
<tr>
<td>17M</td>
<td>No</td>
</tr>
<tr>
<td>17N</td>
<td>No</td>
</tr>
<tr>
<td>17O</td>
<td>Yes</td>
</tr>
<tr>
<td>17P</td>
<td>Yes</td>
</tr>
<tr>
<td>18</td>
<td>Yes</td>
</tr>
<tr>
<td>19</td>
<td>Yes</td>
</tr>
<tr>
<td>20</td>
<td>Immaturity and some topics, not fully comfortable</td>
</tr>
<tr>
<td>21</td>
<td>No</td>
</tr>
</tbody>
</table>

**Conclusion**

In gaining the information from the method used by this researcher during the interview with each participant, this researcher was able to take the information given and analyze the similarities and differences of each school. By doing this analysis, this researcher was able to find themes throughout each interview regarding
the challenges each school faces when teaching the subject, the content of the curriculum used by each school, and which schools are in violation of the state requirements and educational codes for teaching sexual health education. After reviewing the information that was gathered from all of the interviews this researcher has come to the conclusion that none of the schools that were interviewed met all of the criteria laid out in the Educational Codes set by the state of California. California has chosen to be a comprehensive sex education state, and if a school chooses to teach sex education to it’s students the school must follow the guidelines laid out in the Educational Codes sections 51930-51939. See Appendix D for the details of these Educational Codes. The schools that appeared to be the most knowledgeable, with required training or not, comfortable teaching, and had the most well rounded curriculum were Schools 1 and School 3.

Schools 1 and 3 were both high schools, and the teachers are required to have a credential in Health and Safety in order to teach health at a high school. The other three schools were middle schools, and the teachers interviewed were all Science teachers. At the middle school level the school districts, of the schools that were interviewed, choose to have the sex education taught in the Life Science class in 7th grade. Teachers who teach kindergarten through 8th grade are only required to have a multi-subject credential, and not a specialized health credential. All of the schools stated during the interview that they found the California Health Standards and laws surrounding teaching sexual health education to be clear. What this researcher found
to be the most interesting was that even though all of the schools reported to find the regulations to be clear, none of them incorporated all ten of the Sexual Health Educational Codes, Sections 51930-51939, that are set by the state of California.

School 1 incorporates seven of the ten sections of the Sexual Health Education Codes into its curriculum. It leaves out Sections 51930 and 51931. School 2 incorporates five of the ten sections of the Sexual Health Education Codes into its curriculum. It leaves out Sections 51930, 51931, 51935, and 51936. School 3 incorporates nine of the ten sections of the Sexual Health Education Codes into its curriculum. It leaves out only Section 51936. School 4 incorporates three of the ten sections of the Sexual Health Education Codes into its curriculum. It leaves out Sections 51930, 51931, 51933, 51934, 51935, and 51936. School 5 incorporates two of the ten sections of the Sexual Health Education Codes into its curriculum. It leaves out Sections 51930, 51931, 51933, 51934, 51935, and 51936.

Assessing the curricula and answers to the questions asked of the participants in the interview has been helpful to this researcher to form and create a comprehensive sexual health education curriculum that is applicable to the students who will be learning the information, and meets all of the Education Codes, Sections 51930-51939, required by the state of California. While creating a curriculum for social workers to teach to students, this researcher took into account all of the information that was given during all of the interviews such as what was working for each school, what challenges each school faced, and how comfortable each expert informant felt.
about teaching all aspects of sexual health education. While creating a curriculum, this researcher also took into consideration the fact that California is a comprehensive sexual health education state, and this researcher has created the curriculum to incorporate all of information that has been laid out in the Educational Codes.

This researcher has designed a comprehensive sexual health education curriculum that has been designed for social workers to use as a guideline to teach the information. California requires that sexual education must be taught at least once in middle school, and once again in high school. This researcher has designed the curriculum so that it meets all of the California requirements, and it can be taught once in middle school, and taught once again to high school students. The only information that would need to be altered would be to tailor any of the materials to the appropriate target age group. To do this, one would need to review the California State Standards and expectations for each grade level. This information can be accessed on the California Department of Education website. See Appendix E for the comprehensive sexual health curriculum created by this researcher. After reviewing the information gathered from the interviews, analyzing the data, and creating a curriculum, this researcher is left to reflect on the comparisons of what was found within the literature reviewed by this researcher and what was found by conducting the interviews. This researcher is also left to think of implications for future researchers and the limitations that had an effect on this researcher’s study.
### Table 7

*The Sections of the Educational Codes That Each School is in Compliance*

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Educational Codes out of sections 51930-51939 (Total of 10) which the school is in compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>School 1</td>
<td>51933-51939 (Total of 7)</td>
</tr>
<tr>
<td>School 2</td>
<td>51933, 51934, 51937-51939 (Total of 5)</td>
</tr>
<tr>
<td>School 3</td>
<td>51930-51935 &amp; 51937-51939 (Total of 9)</td>
</tr>
<tr>
<td>School 4</td>
<td>51937-51939 (Total of 3)</td>
</tr>
<tr>
<td>School 5</td>
<td>51937-51938 (Total of 2)</td>
</tr>
</tbody>
</table>
Chapter 5

CONCLUSIONS AND IMPLICATIONS

Conclusions

After this researcher evaluated the information gathered from the interviews, this researcher then compared the information to what was found in the literature review. A study reviewed by this researcher found 85% of California schools to be in violation of the Educational Codes, and when his researcher compared the topics included in the curricula from each school that participated in the interviews, this researcher found that not all of the schools follow all of the Educational Codes, sections 51930-51939. This researcher found that four out of five of the schools that were included in the study are in violation of at least two sections of the Educational Codes, not counting section 51936. Section 51936 provides guidelines for a school to follow if a school elects to have an outside person come into the classroom and help educate the students, and does not negatively affect the students if a school chooses to not use an outside resource. Only School 1 took advantage of this section of the Educational Codes the state of California requires to teach sexual health education. This researcher’s thought to have social workers teach the sexual health education would be utilizing section 51936, and the curriculum designed by this researcher meets all of the other requirements of the Educational Codes, sections 51930-51939.

This researcher also found, through conducting the interviews, that none of the schools are teaching abstinence-only based education, but School 4 and School 5 do
not teach a comprehensive sex education like the state of California requires of public schools. The interviews that were conducted revealed that four out of the five schools that participated in this study are in violation of more than one of the ten sections of the required Educational Codes. There appears to be no program in place that monitors the education taught in these public schools. None of the schools mentioned an outside source that evaluates their curriculum for the subject.

This researcher found in the review of the literature an evaluation program designed to be enforced by the state of California, titled Categorical Program Monitoring. This program was designed to monitor the HIV/AIDS programs every three years, and either the program evaluates schools less than every three years or the evaluation program is not effective to ensure that schools are teaching the required material for sexual health education. Unfortunately the students are not getting the education that they are entitled to, and these results show a need for a more effective evaluation program enforced by the state of California. A new program should be designed to mandate that all schools choosing to teach comprehensive sex education have the teachers of that subject be trained on a regular basis with a similar training for all teachers in the state of California. The teachers should be trained on the Educational Codes and requirements, which would help ensure that no school would be in violation of any requirements. The only thing that this researcher found to help ensure proper and effective education, based on sections 51930-51939 of the Educational Code, is having the requirement of high school Health teachers to have a
credential in Health and Safety. Both of the high school teachers that were interviewed by this researcher met the most of the requirements to teach the subject, and these high school teachers appeared to be the most informed and confident teaching the subject.

Studies found during the literature review, showed results stating that abstinence-only based education is ineffective, which is the reason why the state of California has chosen to be a comprehensive sex education state. This researcher found that School 4 and School 5 do not teach about contraception or prevention of STDs or pregnancy, therefore the schools are not providing a well-rounded and effective education. Those schools are seen by this researcher to only be adding to statistics of teen pregnancies and the infection rates of STDs and STIs, rather than preventing and decreasing the rates as the state of California has intended.

While reviewing the literature found on sex education, this researcher found in various studies the curriculum of sexual health education to vary widely in content and material, and the amount of time spent teaching the information. This researcher found the same variety when conducting the interviews. The most consistent schools, having the most variety of information and spent the most time teaching the information, was the two high schools. This researcher feels that this may be due to the requirements of a specialized credential by the instructor of the course, and those instructors made the choice to obtain the specialized credential to teach the subject. The middle school teachers that participated in the interview are the 7th grade Life
Science teachers who teach the subject. According to the schools districts of all three middle schools that participated in the interview, sex education fits best into the Life Science curriculum. By conducting the interviews, this researcher also found that none of the middle schools had any formal training in order to teach the sex education portion of their class.

The interviews conducted by this researcher found resulted to show that only the high schools that were interviewed addressed the associated risks with oral and anal sex. The literature that was reviewed by this researcher found that teaching about the risks of oral and anal sex, at the high school level, might be too late for some adolescents. Some of the literature reviewed by this researcher, included studies with results showing preventative education is most effective when taught to adolescents prior to them engaging in sexual activities. Teaching about prevention methods at a younger age was found to be the most effective way to ensure that adolescents will use protection while engaging in future sexual activities.

None of the teachers interviewed by this researcher mentioned that they provide contraceptives to students on the school campus, such as condoms. The teacher from School 1 did mention that she informs her students about the Planned Parenthood clinic in the area where the students can obtain contraceptives, get tested for STDs, and obtain other information related to sexual behaviors. One study reviewed by this researcher looked at the comfort level of adolescents when obtaining contraceptives. The study results showed that adolescents’ comfort level increased
when they became familiar with the location making the contraceptives available. This finding leads this researcher to be curious if all schools provided contraceptives on campus or informed the students of where to go to obtain contraceptives in a medical setting if more students would utilize the resources.

Literature explored by this researcher produced findings of countries, outside of the United States, having higher rates of use of protection by adolescents, and the parents in those countries were found to be more supportive of sex education than parents within the United States. The literature reviewed by this researcher also included one study that found many teachers of sex education who do not feel supported by parents of the students, and this makes them loose a sense of confidence teaching the subject. Many of the teachers who participated in the interviews conducted by this researcher stated that some parents have either complained about the content of the curriculum, or the teachers are worried about what the parents may think of some of the content in the curriculum. Studies have also found that prevention programs that did involve parents had positive effects on the knowledge and attitudes towards sexual health of students. Having the parents participate in interactive activities with their child, rather than just having a conversation, was the most effective method. None of the schools that participated in the interviews with this researcher mentioned having parents as a part of the education of their child. This researcher feels there may be a need for more outreach to the parents, who are concerned about their children learning particular topics in school. The parents may be
lacking information of what types of sexual activities adolescents are engaging in, and how young some adolescents begin to engage in sexual activities. Further informing the parents may help more students to become educated on critical sexual health education.

After gathering all of the information from the interviews, this researcher found only one school, School 1, that talks to the students about dating, relationships, and discusses what the purpose of dating is, and discusses how dating relates to their personal goals. The other high school teacher that was interviewed, from School 3, stated she wishes she had more time to teach about healthy and unhealthy relationships. The literature reviewed by this researcher found many adolescents today to be engaging in more sexual activities outside of relationships with that partner. Many of these behaviors have resulted in negative consequences for the adolescents, and more problems were found to occur with the adolescent girls than boys. Taking this information into consideration, this researcher feels that schools should incorporate the topic of dating and relationships into sex education to help students learn how to make healthier choices with less negative consequences.

Various studies have been conducted, and the results point towards the effectiveness of peer-led education. This researcher only found one of the schools, which participated in the interviews, to mention any type of peer led instruction as a part of the curriculum used. The teacher from School 2 has her students learn about STDs and teach each other about them, and she says that it is the student’s favorite
part of the Family Life Unit. She feels that the activity provides a great opportunity for the students to learn valuable information from one another. This researcher feels that more schools should utilize peer-led education, since studies have found students to be more comfortable learning from another student due to feeling they can relate to one another.

Some studies reviewed by this researcher found schools teaching sex education by taking advantage of technology that students are familiar with, and found that this was an effective method of teaching students. Using technology as resources, such as texting information or having the students learn by animated, computerized learning tools. This method appears to help the students learn with technology they are comfortable with, and it is easy for them to access the information since they are familiar with using phones and computers. Today’s adolescents are part of a rapidly increasing technologically advanced society, and it might be smart of schools to education students in a way they find fun and interesting in order to increase the student’s engagement in the classroom. The interviews conducted by this researcher found that only two schools used videos to help inform the students, but one of the schools was using very outdated videos. This researcher feels that using outdated material may actually loose the interest of students if they feel they cannot relate to the material.

The literature review conducted by this researcher resulted in many studies finding the greatest influences on adolescent sexual behaviors to be friends, family,
and media. The media influences that were found to influence teens are television, Internet, movies, magazines, and music. The studies found that these media sources model sexual behaviors and do influence the decisions adolescents make in regards to what type of sexual behaviors to engage in. The studies stress that there are many influences in an adolescent’s life, and this researcher feels that it would be smart for discussions about these influences to occur in the classroom. This would allow for students to hear what other students are thinking, and how much they are influenced by the various sources in their lives. This researcher only found that two of the teachers who were interviewed to mention that they talk about influences, but due to time constraints one of the schools does not get to touch on the subject as much as she would like to.

Various studies have been found linking sexual activity to substance use, aspirations, and poor mental health. The high schools that participated in the interview with this researcher were the only schools that talked about the possible risks associated with substance use and sexual behaviors, and only one of the high schools and one middle school talked to the students about goals in life and how decisions related to sexual behaviors affect those goals. Only one teacher from one of the high schools mentioned during the interview that she talks about mental health issues related to sexual behaviors, such as depression.
Implications

This study had led this researcher to find the good intentions behind the choice of the state of California to choose to be a comprehensive sex education state. The interview process of this study allowed this researcher to capture a glance of what types of education the students of Northern California are getting by interviewing school officials from three different counties in Northern California. This researcher found it difficult to obtain consent to participate in the interviews from many schools and school officials that were contact by this researcher, and would suggest for future studies to attempt to have more participants to provide a broader range of results.

The study conducted by this researcher did provide this researcher with the information that is taught to students at the various schools, who teaches the subject, who makes the decisions for the curriculum, the training required of teachers, how often the course material is updated, and how the program is evaluated and measured for success. All of this information has helped inform this researcher to help create an effective sexual health education curriculum which meets all of the state requirements, and having social workers from one agency contracted to teach the curriculum would ensure that the students would receive consistent and accurate information at all times and at all schools. Sexual health education is a critical piece of education for adolescents of today’s society. Proper and effective prevention methods for our youth can put a stop to the rise of STD rates and teenage pregnancies, and informing the
youth of the United States make better choices to ensure life-long health will benefit everyone in the long run.

**Summary**

To summarize, in Chapter 1 this researcher stated the problem in regards to abstinence-based sexual health education, which appears to be ineffective in most findings of research on the subject. The current abstinence-based sexual education that is taught to adolescents today has been proven through various studies to be ineffective, inaccurate, confusing, and discriminatory towards some youth. This researcher calls for a need to change the education that adolescents receive so that all sexual health education programs are comprehensive rather than abstinence-based. Alternative methods of teaching sexual health information to adolescents needs to focus on teaching relevant information in a way that is long lasting, and helps adolescents make future choices that are protective and preventative. This researcher feels teaching information that adolescents can relate to will encourage them to learn, and will increase the likeliness of them using the information in the future with regards to sexual behaviors.

Chapter 2 focused on a review of the literature previously found on the history of sexual health education, current programs and prevention strategies, a comparison of peer-led verses teacher-led programs, alternative program ideas, and the influences that play a role in adolescent sexual activity and behaviors. The literature review allowed this researcher to understand that the state of California chooses to take
funding for comprehensive sex education, and if a school chooses to teach sex education there are requirements and Educational Codes that must be followed. This study, conducted by this researcher, aimed to speak to expert informants who implement the curricula for sexual health education in school settings within Northern California. Chapter 3 explored the methods that this researcher used in collecting the information from each expert informant regarding the curriculum that is used at the school represented. This researcher gathered the information through a face-to-face interview with each participant, and this researcher used a semi-structured set of interview questions with hopes to gather the most information from each expert informant.

In Chapter 4, this researcher compared the information that was gathered from each of the interviews to the research that has been found in previous studies regarding comprehensive sex education. This study aimed to explore information such as, the curricula used by different schools, the training that is required of each teacher on the subject material, how often the material is updated and revised, influences of sexual behaviors of adolescents and how it is reflected in the curriculum, and how the material is evaluated and measured for effectiveness and success. This researcher created a comprehensive sexual health education program that encompasses all of the aspects thought to be effective in preventing future teen pregnancies and adolescents from contracting STDs and STIs. While creating the curriculum, this researcher took into account previous research, the literature that was reviewed, and the information
that was gathered from the interviews. Chapter 5 has allowed this researcher to make final conclusions of the study, and lay the foundation for what may be needed in future studies. This researcher has found valuable information regarding the sexual health education that adolescents are receiving in public schools, and has gained information in regards to what improvements can be made to the programs that will help better the sexual health education of adolescents. With hopes of a better educational program, there is hope that adolescents can improve the chances of making better decisions, and being more mindful of preventative measures that can be used when engaging in sexual activities and behaviors.
APPENDICES
APPENDIX A

Field Interview Questions
1. Do you have a sex education program?
2. Do you have an HIV/AIDS prevention education program?
3. What class(es) is the sex education and/or HIV/AIDS prevention program taught in?
4. What grade(s) is the sex education and/or HIV/AIDS prevention program taught to the students at this school?
5. How many hours are spent teaching the curriculum?
6. Is it a requirement that the teacher implementing the sex education program trained on the current material that is used for the program curriculum?
7. Who makes the decisions for the content of the sex education curriculum?
8. Who teaches the sex education curriculum?
9. What resources does this school use as a guide to develop the sex education program?
10. What resources does this school use as a guide to develop the HIV/AIDS prevention program?
11. Does the sex education program that is taught at this school meet the California law and health standards?
12. If yes to question above, do you find the California laws governing sex education and HIV/AIDS education clear or confusing?
13. How does your school evaluate or measure the success of the sex education program that is taught to the students?
14. Who is responsible for evaluating the program that is implemented?
15. How long have you been using this curriculum?
16. How often do you update the instructional materials?
17. What topics do you cover in the curriculum?
   a. Decision making Y/N
   b. Abstinence Y/N
   c. HIV/AIDS prevention Y/N
   d. Contraception Y/N
   e. Condom effectiveness Y/N
   f. Abortion Y/N
   g. Teen pregnancy Y/N
   h. Gender roles Y/N
i. Marriage Y/N  
j. Reproductive anatomy Y/N  
k. Communication Y/N  
l. Homosexuality Y/N  
m. Dating Y/N  
n. Sexual intercourse Y/N  
o. Sexually transmitted diseases/infections Y/N  
p. Social/peer pressure Y/N

18. Does your school have any policies about how teachers can respond to questions from students?  
19. Does your school have any topics that teachers are not allowed to mention?  
20. In your professional opinion, are there any challenges regarding the sex education program that is used in your school?  
21. Are there any limitations or challenges to making improvements or changes in the program or curriculum?  
22. Is there anything else that has not been covered in this interview that you feel would be helpful to this researcher’s study?
APPENDIX B

Letter of Authorization
Date:

Division of Social Work  
California State University, Sacramento  
6000 J Street  
Sacramento, CA

Researcher:  
Danielle Crowley  
(530) 277-4786  
drcrowley23@yahoo.com

Thesis Advisor  
Santos Torres  
(916) 278-7064  
torres@csus.edu

To Whom It May Concern:

I grant permission to Danielle Crowley, a student at California State University, Sacramento, to speak via in person or telephone to the designated person of our school in specific regards to the sex education program that is implemented at our school. The designated person will schedule the contact at a convenient time for them to participate in an interview in person or by telephone. I understand this information is for the direct purpose of the above named researcher to conduct a thesis/project, which is an examination of middle and high school sex education programs taught in schools in the greater Sacramento area. The purpose of the discussion would be only in relation to my professional knowledge of the program that is taught at the school I represent. If the interview is done in person, I understand that the interview will be audio recorded for the purpose of collecting information that will only be accessible to this researcher. The information will be destroyed once this researcher has collected the needed information from the interview.

Name of School Contact:  
Name of School:  
Title:  
Address:  
Telephone:  
Email:
APPENDIX C

Consent to Participate in Research
You are being asked to participate in research in which will be conducted by Danielle Crowley, a graduate student in Social Work at California State University, Sacramento. The purpose of this study is to explore the current adolescent sex education programs that are being taught in public schools.

The purpose of this interview is to explore your professional knowledge of the sex education program that is used in the school setting that you represent. You will be asked to answer questions through an oral interview conducted by Danielle Crowley regarding the sex education curriculum that is taught to students in the school that you represent. The interview may require up to an hour of your time.

Your answers to the questions and the curriculum that is taught in the school that you represent will be evaluated by this researcher, and will be beneficial to this writer in creating a comprehensive sex education curriculum that can be implemented by trained social workers. You will not personally benefit from participating in this research.

Confidentiality will be protected by having any identifying information labeled in the results of this study as numbers. The consent forms will be stored separately from the interview notes. With your permission, the interview will be audio-recorded. The audio-recorded information will be destroyed once the information has been transcribed.

It is anticipated that you should experience no risk in participating in this study. The items in the interview are not personal in nature, and ask about your professional knowledge of adolescent sex education that is taught at the school you represent. This study does not ask intrusive personal questions of its subjects nor does it ask about personal experiences involving implementing the sex education program that is taught in the school that you represent. However, if you are uncomfortable answering any of the questions you may discontinue participation without consequence. If for any reason, you become distressed while answering questions, or any period after you have completed the interview, you can contact the following referral resources listed on the attached page.

If you have any questions about this research, you may contact Danielle Crowley at (530) 277-4786 or by email at drcrowley23@yahoo.com or her Thesis Advisor Santos Torres (916) 278-7064 torres@csus.edu.

Your participation in this research is entirely voluntary. Your signature below indicates that you have read this page and you agree to participate in this research.

____________________________________                           ____________________
Signature of Participant        Date
Referral Resources

If at any time, during or after the interview, you become distressed as a result of the interview questions, please contact the following referral resources:

Placer County Mental Health
Auburn at DeWitt Center:
11512 B Avenue
Auburn, CA 95603
(530) 889-7240

Roseville:
101 Cirby Hills Drive
Roseville, CA 95678
(916) 787-8800

Sacramento County Mental Health
2150 Stockton Boulevard
Sacramento, CA 95819
(916) 875-1055
APPENDIX D

California Sexual Health Education Codes
Sections 51930-51939
California Sexual Health Education Codes Sections 51930-51939

California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act - (1) General Provisions and Definitions
Law Section #: EC51930 - EC51932

51930. Purpose.
The legislation described in this chapter amends, repeals, and adds to existing education codes and is known and cited as the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act. The purpose of this legislation is to:
(1) Provide students with the knowledge and skills to prevent unintended pregnancy and STDs; (2) Develop healthy attitudes concerning adolescent growth and development, body image, gender roles, sexual orientation, dating, marriage, and family.

51931. Definitions.
The following definitions apply to all education codes contained this chapter (EC51930–51932; EC51933; EC51934; EC51935-51936; EC51937-51939):
(a) "Age appropriate" refers to use of methods aligned with cognitive, emotional, and behavioral capacity typical of particular ages or age groups of children and adolescents.
(b) "Comprehensive sexual health education" means education regarding human development and sexuality, including education on pregnancy, family planning, and STDs.
(c) "English learner" is a student who does not speak English or whose native language is not English, or who currently is not able to perform ordinary classroom work in English.
(d) "HIV/AIDS prevention education" is instruction on the nature of HIV/AIDS, methods of transmission, risk-reduction strategies, and social and public health issues related to HIV/AIDS. Within the context of this chapter, "HIV/AIDS prevention education" is not comprehensive sexual health education.
(e) "Instructors trained in the appropriate courses" are instructors with knowledge of the most recent medically accurate research on human sexuality, pregnancy, and sexually transmitted diseases.
(f) "Medically accurate" means verified or supported by research conducted in compliance with scientific methods and published in peer-reviewed journals, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the Centers for Disease Control and Prevention, the American Public Health Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.
(g) "School district" includes county boards of education, county superintendents of schools, the California School for the Deaf, and the California School for the Blind.

51932. This chapter does not apply to descriptions or illustrations of human reproductive organs that may appear in a California adopted physiology, biology, zoology, general science, personal hygiene, or health textbook. In addition, it does not apply to instruction or materials that discuss gender, sexual orientation, or family life and do not discuss human reproductive organs and their functions.

(Introduced as Senate Bill 71 (SB 71), 2003.)

California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act - (2) Authorized Comprehensive Sexual Health Instruction
Law Section #: EC51933

School districts are not required to teach comprehensive sexual health education in kindergarten to grade twelve classes. If this course is offered, whether taught by trained instructors from the school district or outside consultants, it shall meet the following criteria:

1. Be age appropriate
2. Provide factual information that is medically accurate and objective
3. Be available on an equal basis to English learners;
4. Be appropriate for use with students of all races, genders, sexual orientations, ethnic and cultural backgrounds, and pupils with disabilities;
5. Be accessible to students with disabilities, including, but not limited to, the provision of a modified curriculum, materials and instruction in alternative formats, and auxiliary aids;
6. Encourage students to communicate with their parents or guardians about human sexuality; and
7. Teach respect for marriage and committed relationships.

Additionally, instruction and materials commencing in grade seven shall:
8. Teach that abstinence from sexual intercourse is the only certain way to prevent unintended pregnancy and STDs. Information shall be provided about the value of abstinence while also providing medically accurate information on other methods of preventing pregnancy and STDs.
9. Provide information about STDs, including how STDs are and are not transmitted, the effectiveness and safety of all FDA-approved methods of reducing the risk of contracting STDs, as well as information on local resources for testing and medical care for STDs.
10. Provide information on the effectiveness and safety of all FDA-approved contraceptive methods including, but not limited to, emergency contraception.
(11) Provide students with skills for making and implementing responsible
decisions about sexuality; and
(12) Provide information on the law on surrendering physical custody of a minor
child seventy-two hours or younger, pursuant to Health and Safety Code 1255.7 ((a) a
child seventy-two hours or younger may be surrendered to qualified staff of a safe-
surrender location designated by the county board of supervisors or within a public or
private hospital, using required procedures and confidentiality and (b) the child may
be reclaimed within fourteen days after filing a written petition and participation in an
assessment by the child welfare services agency) and Penal Code 271.5 (no one who
has lawful custody of a child seventy-two hours or younger may be prosecuted for
abandonment, failure to furnish necessary clothing, food, shelter, or medical care if the
child is surrendered to personnel at a safe-surrender site).

A school district that elects to offer comprehensive sexual health education earlier
than grade seven may provide age-appropriate and medically accurate information on
any of the general topics contained in criteria (8) to (12). A school district providing
comprehensive sexual health instruction shall not teach or promote religious doctrine
nor provide instruction or materials that reflect or promote bias against any person on
the basis of any category protected by EC 220 (sex, ethnic group, race, national origin,
religion, color, mental or physical disability, or sexual orientation).
(Introduced as Senate Bill 71 (SB 71), 2003.)

California Comprehensive Sexual Health and HIV/AIDS Prevention Education
Act - (3) Required HIV/AIDS Prevention Education
Law Section #: EC51934

A school district shall ensure that all students in grades seven to twelve receive
HIV/AIDS prevention education at least once in junior high or middle school and at
least once in high school. Instructors trained in the appropriate courses shall provide
HIV/AIDS prevention education. Instruction, whether taught by school district
personnel or outside consultants, shall meet all criteria described in sections one
through six of EC 51933 and instruction and materials may not teach or promote
religious doctrine nor reflect or promote bias against any person on the basis of any
category protected by EC 220 (sex, ethnic group, race, national origin, religion, color,
mental or physical disability, or sexual orientation).

HIV/AIDS prevention education must be consistent with the latest information and
recommendations of the U. S. Surgeon General, Centers for Disease Control, and the
National Academy of Sciences. This instruction must also include:
(1) Information on the nature of HIV/AIDS and its effects on the human body;
(2) Information on how HIV is and is not transmitted and high-risk activities
(3) Discussion of methods to reduce the risk of HIV infection, emphasizing that monogamy, avoiding multiple sexual partners, and abstinence from sexual activity and intravenous drug use are the most effective means of preventing HIV/AIDS. This information shall provide statistics based on current medical information regarding the success and failure rates of condoms and other contraceptives in preventing sexually transmitted HIV, as well as methods that reduce HIV transmission from intravenous drug use.

(4) Public health issues associated with HIV/AIDS

(5) Local resources for HIV testing and medical care

(6) Effective refusal and decision-making skill instruction to assist students in overcoming peer pressure and avoiding high-risk activities;

(7) Emphasis on compassion for persons living with HIV/AIDS and discussions about societal views, stereotypes, and myths regarding HIV/AIDS and persons with HIV/AIDS.

(Introduced as Senate Bill 71 (SB 71), 2003.)

California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act - (4) In-Service Training

Law Section #: EC51935 - EC51936

51935. Instructor Training.

A school district shall work with the teachers of the district who provide HIV/AIDS prevention education and with the SBE to cooperatively plan and conduct in-service training for all school district personnel who provide HIV/AIDS prevention education. Periodic in-service training shall be offered to enable school district personnel to stay current on new scientific developments regarding HIV/AIDS. Training shall be voluntary for school district personnel who have demonstrated expertise or received in-service training from the SBE or Centers for Disease Control. A school district may expand HIV/AIDS in-service training to cover comprehensive sexual health education, so that instructors providing this health education can learn new developments in the scientific understanding of sexual health.

51936. Outside Consultants.

School districts may contract with outside consultants with expertise in comprehensive sexual health education or HIV/AIDS prevention education to deliver the instruction or to provide training for school district personnel.

(Introduced as Senate Bill 71 (SB 71), 2003.)
California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act - (5) Parent Notification and Excuse of Pupils
Law Section #: EC51937 - EC51939


The legislature recognizes that parents and guardians have the ultimate responsibility for imparting values and supervising their children's education regarding human sexuality; and encourages students to communicate with their parents or guardians about human sexuality and HIV/AIDS. As a result, parents and guardians may review materials and evaluation tools related to comprehensive sexual health education and HIV/AIDS prevention education, and, if they wish, to excuse their children from participation in all or part of that instruction or evaluation.


A parent or guardian of a pupil has the right to excuse their child from all or part of comprehensive sexual health education, HIV/AIDS prevention education, and related assessments. At the beginning of each school year, or at the time of a student's enrollment, each school district shall notify parents or guardians about instruction in comprehensive sexual health education and HIV/AIDS prevention education and any research on student health behaviors and risks planned for the coming year. The notice shall:

1. Advise the parent or guardian that all written and audiovisual educational materials are available for inspection
2. Advise the parent or guardian whether the instruction will be taught by school district personnel or by outside consultants
3. Explain the parent's or guardian's right to request a copy of this legislation
4. Inform the parent or guardian that they may request in writing that his or her child not participate in comprehensive sexual health education or HIV/AIDS prevention education; and
5. Provide information that anonymous, voluntary, and confidential research measuring students' health behaviors and risks, and age-appropriate sex-related attitudes or practices of students in grades seven to twelve may be administered. Parents or guardians must be notified in writing about the administration of this evaluation, and be given the opportunity to (a) review the materials and (b) request in writing that his or her child not participate.

51939. Excuse of Pupils from Participating in Comprehensive Sexual Health Education or HIV/AIDS Prevention Education.

Upon receipt of a parent’s written request excusing the student from participation, a student may not be subject to disciplinary action, attend any class in comprehensive
sexual health education or HIV/AIDS prevention education, or participate in any evaluation measures of student health behaviors and risks. For non-participating students an alternative educational activity shall be made available.

(Introduced as Senate Bill 71 (SB 71), 2003.)
APPENDIX E

Comprehensive Sexual Health Education Curriculum
Comprehensive Sexual Health Education Curriculum

Middle School and High School

Sacramento, California

Created by Danielle Crowley

May 2010

The enclosed material includes a comprehensive sexual health education designed for both middle school and high school students. This following curriculum meets all of the requirements of the state of California according to the Comprehensive Health Education Act, Educational Code sections 51890-51912. The curriculum also includes information meeting all of the requirements of the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act 1-5 as well: Act 1-General Provisions and Definitions sections 52930-52932, Act 2-Authorized Comprehensive Sexual Health Instruction section 51933, Act 3-Required HIV/AIDS Prevention Education section 51934, Act 4-Inservice Training sections 51935-51936, and Act 5-Parent Notification and Excuse of Pupils sections 51937-51939. The material is broken up into two sections: Family Life and Human Sexuality and Mental and Emotional Health. The goals and objectives are outlined for each section within the curriculum. The overall goal of the curriculum is to provide students with adequate and medically accurate knowledge to encourage self-understanding, the promotion of overall health and well being, and encourage responsible behavior and healthy decision-making. The curriculum requires the use of tests to evaluate the student’s knowledge and the effectiveness of the program, and the use of group activities, presentations, written papers, and parent participation with assignments and the learning process.
Section 1: Family Life and Human Sexuality

Instructional Outcomes

By the end of the course the students should be able to:

- Define terms related to male and female human anatomy and reproduction
- Define terms related to human sexuality
- Define stereotyping and discuss generalizations regarding sexual identity
- Examine Myths and Misconceptions about Human Sexuality
- Explore how cultural and family values affect relationships and marriage
- Describe the process of pregnancy and birth, recognizing the importance of prenatal care for the mother and fetus
- Discuss the effects of hormonal changes in the body and on behavior throughout the life cycle
- Analyze the influence of peer pressure and other factors on an individual’s decisions regarding sexual behavior
- Analyze consequences of sexual activity
- Discuss the social, emotional, and economic impact of teenage parenting
- Identify abstinence from sexual intercourse as the most effective means of pregnancy, STD, and HIV/AIDS prevention
- Identify various STDs: names, symptoms of each of them, how to contract and transmit them, and how to treat them.
- Identify and describe various methods of prevention of pregnancy, STD, and HIV/AIDS.

Content Outline

Key Terms:

<table>
<thead>
<tr>
<th>term</th>
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<th>term</th>
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</tr>
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<tbody>
<tr>
<td>pituitary</td>
<td>adrenal</td>
<td>seminal vesicles</td>
<td>scrotum</td>
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<tr>
<td>estrogen</td>
<td>androgen</td>
<td>penis</td>
<td>semen</td>
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<td>hormones</td>
<td>gonads</td>
<td>erectile tissue</td>
<td>testes</td>
</tr>
<tr>
<td>puberty</td>
<td>genitals</td>
<td>seminal plasma</td>
<td>urethra</td>
</tr>
<tr>
<td>prostate gland</td>
<td>epididymus</td>
<td>vas deferens</td>
<td>circumcision</td>
</tr>
<tr>
<td>foreskin</td>
<td>Cowper’s</td>
<td>sperm cells</td>
<td>erect, erection</td>
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<tr>
<td>sterility</td>
<td>ejaculate</td>
<td>nocturnal emissions</td>
<td>ovaries</td>
</tr>
<tr>
<td>fallopian tubes</td>
<td>uterus</td>
<td>female sex glands</td>
<td>cervix</td>
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<tr>
<td>menstruation</td>
<td>periods</td>
<td>endometrium</td>
<td>vagina</td>
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<tr>
<td>hymen</td>
<td>labia major</td>
<td>vulva</td>
<td>clitoris</td>
</tr>
<tr>
<td>labia minor</td>
<td>anus</td>
<td>cilia</td>
<td>menarche</td>
</tr>
<tr>
<td>ovulation</td>
<td>menopause</td>
<td>breasts</td>
<td>endometrium</td>
</tr>
<tr>
<td>amniotic sac</td>
<td>placenta</td>
<td>umbilical cord</td>
<td>afterbirth</td>
</tr>
</tbody>
</table>
Key Terms Continued:
fertilization  embryo  miscarriage  contraception
fetus  prenatal care  obstetrician, gynecologist (ob gyn)
HIV  venereal disease  gonorrhea  Herpes I and II
AIDS  STDs  Chlamydia  trichomoniasis
yeast infection  pubic lice  syphilis  scabies
venereal warts  HPV  abortion  homosexuality
questioning  transgender  Plan B  patch
abstinence  birth control  contraceptives  bisexual
cervix  fertilized egg  heterosexual  zygote
condom  female condom  cervical cap  diaphragm
spermicide  Intrauterine methods  sterilization  intersexed
Depo Provera  Norplant  Implanon
oral contraceptive pill  hormonal contraceptives
contraceptive vaginal ring  Emergency contraception

A. Define Terms Related to Male and Female Anatomy and Reproduction
- Male Anatomy
- Female Anatomy
- The Reproduction Process

B. Define Terms Related to Human Sexuality
- Emotional closeness
- Sexual health
- Sexual identity
- Gender identity
- Gender roles
- Sexual orientation

C. Stereotyping and Generalizations Regarding Sexual Identity
- Define stereotyping
- Give examples of stereotyping: gender role, gender identity, sexual orientation
- Factors that influence stereotyping
- Accept Differences

D. Examine Myths and Misconceptions about Human Sexuality
- Myths regarding pregnancy
- Myths regarding sexual orientation
- Other myths
E. Cultural and Family Beliefs that can Affect Relationships and Marriage
- Possible effects of cultural factors
- Possible affects of religious beliefs
- Other factors that may affect relationships

F. Describe the Process of Pregnancy and Birth, Recognizing the Importance of Prenatal Care for the Mother and Fetus
- Human reproduction
- Male and Female anatomy
- Fertilization
- Embryo
- Fetus
- Pregnancy
- Birth

G. Discuss the Effects of Hormonal Changes in the Body and on Behavior Throughout the Life Cycle
- Hormonal changes in the male during puberty
- Hormonal changes in the female during puberty
- Hormonal fluctuations throughout the life cycle

H. Analyze the Influence of Peer Pressure and Other Factors on an Individual’s Decision Regarding Sexual Behavior
- Peer pressure
- Family expectations and values
- Cultural and religious beliefs
- Influences from media
- Decision-making

I. Analyze Consequences of Sexual Activity
- Feelings of others: reputation, change of friends, being accepted
- Pregnancy: affect on life, goals, and finances
- Risk factors associated with different types of sexual activity: oral sex, anal sex, and vaginal sex.
- Sexually Transmitted Diseases: how to contract and transmit them, symptoms, risk factors/consequences, and how to treat them
- Long term relationships and marriage
- Positive consequences
J. Discuss the Social, Emotional, and Economic Impact of Teenage Parenting
- Social: loss of friends and social activities
- Economic: inability to complete educational goals, lack of employment skills, and low paying employment
- Emotional: low self-concept, depression, rushed into adulthood, lost adolescence

K. Abstinence
- Define abstinence
- It is the only 100% effective means of preventing pregnancy
- It is the only 100% effective means of preventing sexually transmitted diseases
- Preservation of self-concept and self-esteem
- Keeping true to personal goals

L. Identify Various STDs: Names, Symptoms of Each of Them, How to Contract and Transmit Them, and How to Treat Them.
- Identify STDs: Chlamydia, gonorrhea, Herpes I and II, Human Papillomavirus (HPV), syphilis, venereal disease, pubic lice, and scabies.
- Identify HIV/AIDS, how it is transmitted and treated, how to live a normal life with HIV/AIDS, how it is safe to be friends with someone who has HIV/AIDS, safety precautions to take with someone with HIV/AIDS
- Identify that some STDs are a-symptomatic
- Identify that getting tested regularly and after every partner will help prevent transmitting diseases to others and preventing any complications if one is to have an STD
- Identify the symptoms of each STD
- Ways of contracting and transmitting STDs
- Identify not all STDs are treatable or curable
- Identify ways of treating or curing each STD

M. Identify and Describe Various Methods of Prevention of Pregnancy, STD, and HIV/AIDS and effective rates.
- Abstinence
- Periodic abstinence
- Withdrawal
- Barrier methods: spermicidal preparations, condom male and female, diaphragm
- Hormonal birth control pills and patches
- Implantable hormone: Norplant and Implanon
- Injectable hormone
- Intra uterine devices (IUD)
- Emergency contraception: Plan B
Surgical methods: vasectomy, tubal ligation
Identify resources such as clinics or other medical centers in the area where students can obtain medical attention when needed for testing or obtaining contraceptives.

Section 2: Mental and Emotional Health

Instructional Outcomes

By the end of the course the student should be able to:

- Explain How One Can Reduce Unpleasant or Unhealthy Situations in Daily Living
- Recognize Decision-Making as a Continuous Healthy Life Skill
- Appraise Goal Setting Strategies and Accept Responsibility for the Outcome of the Decision
- Investigate the Positive Outcomes of Risk-Taking
- Discuss the Relationship Between Liking One’s Self and Taking Care of One’s Self
- Develop Skills to Respond with Confidence when Faced with a Challenge Individually or as a Member of a Group
- Explain How Rejection, Separation, and Loss Affect Relationships with Friends and Family
- Identify Self-Destructive Behaviors that Maybe Life Threatening to Peers, Family, and Self
- Discuss How to Give and Receive Equally in Relationships
- Describe Healthy Ways to Express Affection, Love, Friendship, and Concern

Content Outline

A. Explain How One Can Reduce Unpleasant or Unhealthy Situations in Daily Living
   - Techniques: Talking to others, self-talk, conflict resolution,
   - Avoiding peer pressure
   - Improving self-esteem and self-confidence

B. Recognize Decision-Making as a Continuous Healthy Life Skill
   - Where decisions are made: home, school, job, community, leisure, and in relationships
   - Decision-making is a lifetime skill: follows a logical process, uses accurate information, and if process is not followed then irresponsible behavior is likely to occur.
• Explore weighing positive and negative consequences of every situation before making a decision
• Explore how decision-making plays a role in engaging in sexual activities
• Explore how decision-making plays a role in the relationship between alcohol and other drugs and sexual risky behaviors

C. Appraise Goal Setting Strategies and Accept Responsibility for the Outcome of the Decision
• Define goal setting: short term and long term
• Self-awareness: knowing who you are, strengths and weaknesses, likes and dislikes, wants and needs, personal values and standards
• Develop a vision: What do you want to do in life? Where do you want to go? How do you want to be? What do you want to accomplish?
• Set achievable goals: clear, specific, measurable, have realistic timelines, manageable, emphasize positive rather than negative outcomes, and have them written down
• Devise an action plan, including a back up plan
• Establish a support network
• Set up a reward system

D. Investigate the Positive Outcomes of Risk-Taking
• Risk-taking is learned from parents, peers, and media
• Occurs often
• Personality and risk-taking: degree of risk one is willing to take, emotions that influence one’s estimate of risk, something that is difficult to obtain but may be desirable, being sure that the risk is healthy and appropriate
• Positive risks include: change of any type, college, jobs, moving, relationships and friendships

E. Discuss the Relationship Between Liking One’s Self and Taking Care of One’s Self
• Factors contributing to liking one’s self: sense of belonging, family role, support and affection from others, sexual identity, intellect, physical, spiritual, emotional, cultural
• Taking care of yourself: accept yourself as you are, get the proper amount of rest, sleep, exercise, and have a proper diet and nutrition
• Eliminate addictive and destructive behaviors: alcohol, illegal drugs, and prescription drugs and the risk factors associated with these behaviors.
F. Develop Skills to Respond with Confidence when Faced with a Challenge Individually or as a Member of a Group
- Assertiveness skills: how to make decisions for yourself, how to say “no”
- Sticking by your decisions
- Acknowledging your own and other’s feelings

G. Explain How Rejection, Separation, and Loss Affect Relationships with Friends and Family
- Define and give examples: rejection, separation, and loss
- Common feelings resulting from rejection, separation, and loss: denial, sadness, anger, guilt, insecurity, depression, acceptance
- Techniques for developing a healthy attitude

H. Discuss How to Give and Receive Equally in Relationships
- Personal qualities: dependability, honesty, trustworthiness
- How to develop relationships and share equally: avoid criticism, complaints, and put downs, honest and rewarding feedback, learn about others’ strengths and special talents, talk openly and honestly about feelings and needs, accept individual differences, respect personal values, rights, and needs, and treat others as you would like to be treated
- Descriptions of healthy and unhealthy relationships
- Acknowledge an individual’s right and responsibility to refuse unwanted sexual contact
- Acknowledge an individual’s responsibility to verify that all sexual contact is consensual

I. Describe Healthy Ways to Express Affection, Love, Friendship, and Concern
- Personal boundaries
- Age appropriate ways to express love and affection
- Explain situations that could lead to pressures for sex
- Laws in regards to sexual behaviors
- Consequence of risky behaviors
- Explain why individuals have the right to refuse sexual contact
- Recognize techniques that are used to coerce or pressure someone to have sex

Materials that may be used for the course:

Books/supplementary materials:

State adopted textbook
*It happened to Nancy* by an anonymous teenager edited by Beatrice Sparks PhD.
The Health Teacher’s Book of Lists published by Rizzo-Toner & Milliken
Puberty and Reproduction- Comprehensive Health for the Middle Grades published by ETR Associates
Positive Prevention: HIV/STD Prevention Education for California Youth, published by the American Red Cross
A.D.A.M Essentials High School Suite The perfect anatomy and physiology tools for grades 9-12 (interactive tools for the computer)

Videos:
The New Improved Me: Understanding Body Changes
Fetal Development: A Nine-Month Journey
Period Piece: A Film about Menstruation
This Ain’t No Dress Rehearsal: Abstinence and Teens
Update: Sexually Transmitted Diseases
What Teens Want to Know About Sex
AIDS: One Teenager’s Story
Miracle of Life
Intimate Universe: Raging Teens

Websites:

Diagrams for human anatomy and reproductive system:


<http://kidshealth.org/teen/your_body/body basics/female repro.html>

<http://kidshealth.org/teen/sexual_health/guys/male repro.html>

<http://training.seer.cancer.gov/anatomy/reproductive/male/>

<http://training.seer.cancer.gov/anatomy/reproductive/female/>

Centers for Disease Control and Prevention, Division of Adolescent and School Health
<http://www.cdc.gov/nccdphp/dash>

California Department of Education, Safe and Healthy Kids Program Office
<http://www.cde.ca.gov/healthykids>

California Department of Health Services
<http://www.dhs.ca.gov/HealthNet.gov>
California Department of Mental Health
<http://www.dmh.ahw.net.gov>

California Healthy Kids Resource Center
<http://www.hkresources.org>

The following agencies offer guidance and resources relevant to school health programs:

Healthy Start and After-School Partnerships Program Office
California Department of Education
1430 N Street, Suite 6408
Sacramento, CA 95814
(916) 319-0923; FAX (916) 319-0221

Safe and Healthy Kids Program Office
California Department of Education
1430 N Street, Suite 6408
Sacramento, CA 95814
(916) 319-0920; FAX (916) 319-0218

School Health Connections Office
California Department of Education
1430 N Street, Suite 6408
Sacramento, CA 95814
(916) 319-0914 FAX (916) 445-7367

Youth Education and Partnerships Office
California Department of Education
1430 N Street, Suite 6408
Sacramento, CA 95814
(916) 319-0917; FAX (916) 319-0219
REFERENCES


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National Campaign to Prevent Teen Pregnancy (2001). *Emerging answers: research findings on programs to reduce teen pregnancy*. Washington D.C: Kirby, D.


