Human Growth & Development

A Resource Guide to Assist School Districts in
Policy and Program Development and Implementation

Wisconsin Department of Public Instruction

Human Growth and Development: A Resource Guide to Assist School Districts in Policy, Program Development, and Implementation

5th Edition

Prepared by:
Lori Stern, MA Ed
Wisconsin Department of Public Instruction
Student Services/Prevention and Wellness Team

Wisconsin Department of Public Instruction
Tony Evers, State Superintendent
Madison, Wisconsin

This publication is available from:
Student Services/Prevention and Wellness Team
Wisconsin Department of Public Instruction
125 South Webster Street
P.O. Box 7841
(608) 266-8960
(800) 441-4563
www.dpi.wi.gov/sspw/hgd.html

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The following HGD workgroup members and other staff from the Department of Public Instruction were instrumental in the update of this document:

Emily Holder, Coordinated School Health Consultant

Adam Farrell-Wortman, Office Operations Associate

Lori Stern, HIV and Safe and Supportive Schools Consultant

We appreciate the highly dedicated and talented Wisconsin teachers, administrators, and pupil services staff and national youth-serving organizations that continue to address human growth and development with students. We hope you will find this resource guide helpful whether you are forming your Human Growth and Development Committee based on the 2012 HGD Statute, reviewing your district curriculum, or looking for effective ways to teach.

Disclaimer

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Table of Contents

Acknowledgments iii

Disclaimer iv

Acronyms ix

Chapter 1 Background 1
Purpose of the Resource Guide 1
Rationale for HGD Instruction 2
Approaches to Sexuality Education 3
Status of HGD Instruction in Wisconsin Schools 4
Scope of HGD Instruction 5
HGD Program Planning 6
Web-Based Resources 7
Organization of the HGD Resource Guide 8
Resources
Resource 1.1: DPI Statement on K–12 HGD Instruction 9
Resource 1.2: HGD Program Planning Logic Model 11

Chapter 2 State Statutes 13
Overview 13
Statutes 13
Guidelines for Opt-Out Policies 14
Resources
Resource 2.1: Statute 115.35 Health problems education program 15
Resource 2.2: Statute 118.01 Educational goals and expectations 16
Resource 2.3: Statute 118.019 Human growth and development instruction 18

Chapter 3 Profile of Wisconsin Youth 21
Overview 21
What We Know: Child Development 23
What We Know: Attitudes 25
What We Know: Behaviors 26
What We Know: Health Outcomes 27
What We Know: Youth Development 28
What We Know: Special Populations 28
Children and Youth with Disabilities 29
Children and Youth Who are Homeless 31
Sources for Local Data 33
Resources
Resource 3.1: Wisconsin Youth Sexual Behavior and Outcomes Report 35
Resource 3.2: Surveys of Adolescent Sexual Attitudes and Behaviors 37
Resource 3.3: Youth Development Measures 39
Resource 3.4: Adolescent Sexual Risk Behavior Prevention Needs and Assets Assessment 41
Resource 3.5: Youth Profile for Our Community Worksheet 49

Chapter 4.0 Human Growth and Development Advisory Committee 53
Purpose 53
Creating the HGD Advisory Committee 53
Recruitment 54
Group Process 55
Getting Down to Work 56
Short-Term Outcomes and Longer Term Impacts 60
Resources
Resource 4.1: HGD Advisory Committee: Oconomowoc 61
Resource 4.2: HGD Advisory Committee Ground Rules: Eau Claire Area School District 63
Resource 4.3: Example of HGD Advisory Committee Purpose and Meeting Schedule: Stoughton Area School District 65
Resource 4.4: HGD Advisory Committee: 10 Tips for Meeting Facilitation 67
Resource 4.5: Managing Controversy in Pressure Cooker Situations 69
Resource 4.6: Envisioning the Future of Sex Education—A Toolkit 73
Resource 4.7: Milwaukee Public Schools HGD Implementation Guidelines 83
Resource 4.8: MPS Parent Survey about Scope and Sequence of HGD Topics 87

Chapter 5 Parental Communication 91
Communicating with Parents about the HGD Program 91
Opt-Out Option 92
Involving Parents in the HGD Program Planning 92
Supporting Parents as the Primary Sexuality Educators of their Children 93
Resource
Resource 5.1: Sample Agenda: HGD Parent Information Meeting 95
Resource 5.2: Sample Opt-Out Request: Whitefish Bay 97
Resource 5.3: Sample Opt-Out Request: Milwaukee Public Schools 99
Resource 5.4: Sample Opt-Out Request: Fort Atkinson 101
Resource 5.5: Are You an Askable Parent? 103
Resource 5.6: Ten Tips for Parents to Help Their Children Avoid Teen Pregnancy 105
Resource 5.7: Talking Back: Ten Things Teens Want Parents To Know About Teen Pregnancy 111
Resource 5.8: Ten Tips for Parents of a Gay, Lesbian, Bisexual, or Transgender Child 113
Resource 5.9: Our Sons and Daughters: Questions & Answers for Parents of Lesbian, Gay, Bisexual and Transgender Youth 115
Resource 5.10: Ten Tips for Talking about Sexuality with Your Child Who Has Developmental Disabilities 117
Resource 5.11: Parents as Advocates for Comprehensive Sex Education in Schools 119
Resource 5.12: Parents as Sexuality Educators Recommended Reading List 121
Resource 5.13: Parental Influence and Teen Pregnancy 133

Chapter 6 **Effective Human Growth and Development Curriculum and Instruction 137**
Overview 137
Needs of Children and Youth 138
Parental Support 138
State Academic Standards 138
Human Growth and Development Connections with the State Standards in Health Education 139
Human Growth and Development Connections with the State Standards in Family and Consumer Education 139
National Sexuality Education Standards 140
Effectiveness of the Curriculum 140
Acceptability 141
Cultural Competence 142
Implementation 144
References and Resources on Effective HGD Curriculum and Instruction 147
Resources
Resource 6.1: Wisconsin Standards for Health Education: Critical Questions 149
Resource 6.2: National Standards for Family and Consumer Sciences Education—Human Development Comprehensive Standard 157
Resource 6.3: National Sexuality Education Standards: Core Content and Skills, K–12 159
Resource 6.4: The Association Between Sex Education and Youth's Engagement in Sexual Intercourse 203
Resource 6.5: Resources on Preventing Teen Pregnancy, STDs, and HIV 211
Resource 6.6: Kirby's Characteristics of Effective Curriculum-Based Programs to Reduce Teen Pregnancy 213
Resource 6.7: Lessons That Matter: LGBTQ Inclusivity and School Safety 217
Resource 6.8: Human Growth and Development (HGD): Cultural Responsiveness to Diverse Classrooms 225
Resource 6.9: Adolescent Sexual Health and the Dynamics of Oppression: A Call for Cultural Competency 231
Resource 6.10: Vulnerable Youth: A Closer Look at Reproductive Health Outcomes 235
Resource 6.11: Effective Teaching Methods for Sexuality Education 241
Resource 6.12: Answering Difficult Sexual Education Questions in the Classroom 247

Chapter 7 **Assessing and Reviewing Your Human Growth and Development Curriculum 255**
Overview 255
Scope and Sequence 255
Review Instruments 255
Resources
Resource 7.1: Tools to Assess the Characteristics of Effective Sex and STD/HIV Education Programs 257
Resource 7.2: Health Education Curriculum Assessment Tool—HECAT Revised 329
Resource 7.3: Wisconsin Standards for Health Education Curriculum Checklist 363

Resource 7.4: Human Growth and Development Instructional Materials Review Form 393
Resource 7.5: Human Growth and Development in Wisconsin Schools 118.019..... 397

Chapter 8 Resources 401
State Agencies 401
Federal Agencies 402
Selected National Organizations 402

Acronyms Used in This Resource Guide

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centers for Disease Control and Prevention
CESA	Cooperative Educational Service Agency
DCF	Wisconsin Department of Children and Families
DHS	Wisconsin Department of Health and Services
DPI	Wisconsin Department of Public Instruction
FCE	Family and Consumer Education
GLSEN	Gay, Lesbian and Straight Education Network
HGD	Human Growth and Development
HIV	Human Immunodeficiency Virus
LGBT	Lesbian, Gay, Bisexual, and Transgender
SIECUS	Sexuality Information and Education Council of the United States
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
YRBS	Youth Risk Behavior Survey

Chapter 1
Background

Background

1

Purpose of the Resource Guide

Sexuality, and expression of one's sexuality, is an important part of each person's identity. Achieving healthy sexuality and learning about this aspect of ourselves begins at birth and continues throughout our lives. This important and multidimensional concept involves anatomy, physiology, and growth and development, including self-esteem, body image, self-care, communication, values, an understanding of satisfying and healthy relationships, decision-making, sexual intimacy, responsibilities of parenthood, and a host of other relevant topics. Although parents are the primary sexuality educators of their children, children also receive messages about various aspects of sexuality from many other sources, including family members, friends, peers, schools, media, faith communities, and other institutions. Schools can be important partners with parents to provide children and adolescents with accurate and developmentallyappropriate sexuality education or human growth and development (HGD) instruction. Evaluations of comprehensive sexuality education programs show that many of these programs can help youth delay onset of sexual activity, reduce the number of sexual partners, and increase condom and contraceptive use (*The Future of Sex Education Initiative*, 2011). Ideally, this instruction will enhance communication between parents or guardians and their children about this important topic.

*The purpose of this **Human Growth and Development Resource Guide** is to provide school districts with information and resources to develop effective HGD programs in their schools that reflect the values and norms of the local community.*

The purpose of this *Human Growth and Development Resource Guide* is to provide school districts with information and resources to develop effective HGD programs in their schools that reflect the values and norms of the local community. This edition builds on the success of earlier editions and provides updated and new materials. It contains information and resources to help teachers, curriculum coordinators, administrators, and HGD advisory committee members with the following:

- Identify desired objectives, goals, and outcomes for a district's HGD program;
- Evaluate existing or new curricula based on criteria of effective curricula;
- Plan for implementation of a HGD curriculum; and
- Educate others about the need, rationale, and approach the district develops to provide HGD instruction for its students.

Rationale for HGD Instruction

There are many reasons Wisconsin schools decide to provide human growth and development instruction:

- **Statutory support**. Wisconsin Statute 118.019 encourages all school boards to provide students in grades Kindergarten to 12 with human growth and development instruction. The purpose is "to promote accurate and comprehensive knowledge in this area and responsible decision making and to support and enhance the efforts of parents to provide moral guidance to their children."
- **Public health plan**. Healthiest Wisconsin 2020: A Partnership Plan to Improve the Health of the Public is the Wisconsin state health plan for the decade 2010–2020. The reduction of high-risk sexual behavior is one of eleven health priorities identified in the plan. More information on the state health plan can be obtained in Chapter 3 of this document and from the Department of Health and Family Services' web site at http://dhfs.wisconsin.gov/statehealthplan/.
- **Youth risk behaviors**. Data documents an unacceptably high number of Wisconsin youth engage in sexual behavior, resulting in negative health outcomes. For example, too many young people experience pregnancy and sexually transmitted infections. The negative health outcomes are particularly striking when U.S. youth, including Wisconsin youth, are compared to their European counterparts. Young people need accurate information, motivation, and skills to avoid or reduce risks and promote their emotional and physical health.
- **Academic standards**. Wisconsin's model standards, especially in health education and family and consumer education, provide guidance about what students should know and be able to do at certain points in time. Human growth and development curriculum and instruction can be used to prepare students to meet these standards.
- **Parents and students want it**. National surveys consistently find parental support for school-based sexuality education. Eighty to eighty-five percent of parents indicate they want their children to receive comprehensive, medically accurate, age-appropriate sex education. Parents see such courses and content as supplementing, not supplanting, their discussions at home, and parents want their children to be taught about the maturity and responsibility required of healthy intimate relationships so that they can delay sexual activity until they are older. Parents also want children to receive information about condoms and contraception so that they have the skills and knowledge they need when they do decide to become sexually active.

The education and guidance provided by parents, in combination with accurate and age-appropriate human growth and development provided in schools, are important factors to promote health and well-being of young people. Decisions about how and when a school provides HGD instruction to meet the needs of youth in the community should be made as part of the HGD program planning process, involving parents, teachers, school administrators, students, health care professionals, members of the clergy, and other residents of the school district.

The education and guidance provided by parents, in combination with accurate and age-appropriate human growth and development provided in schools, are important factors to promote health and well-being of young people.

Approaches to Sexuality Education

Many parents, educators, health professionals, clergy, and others have discussed the type of sexuality education they believe should be provided in the schools. Almost everyone agrees that the goal of school-based HGD instruction is to provide young people with the knowledge and skills to promote their health and well-being as they mature into sexually healthy adults. The question is: What approach should be used to do this?

Comprehensive sexuality education refers to sexuality education on a range of topics that begins in kindergarten and continues through grade 12. It takes an approach much broader than preventing unplanned pregnancies and disease transmission. According to SIECUS (2001), "Comprehensive sexuality education has four main goals:

- To provide accurate information about human sexuality
- To provide an opportunity for young people to develop and understand their values, attitudes, and beliefs about sexuality
- To help young people develop relationships and interpersonal skills, and
- To help young people exercise responsibility regarding sexual relationships, including addressing abstinence, pressures to become prematurely involved in sexual intercourse, and the use of contraception and other sexual health measures."

The term **comprehensive sexuality education** also refers to HIV, sexually transmitted infections (STI), and pregnancy prevention education that not only stresses abstinence, but also includes information on contraceptives and other ways to reduce risks of negative health outcomes. This approach is also called **abstinence-based** or **abstinence-plus** education because it provides an abstinence message, and it provides information about how youth who are sexually active can reduce their risks related to HIV, STI, and unplanned pregnancy. Most of the commercially available abstinence-based curricula are designed for middle school and high school students.

Abstinence education, abstinence-only education, or **abstinence-only-until-marriage education** refers to sexuality education and HIV, STI, and pregnancy prevention education that emphasize abstinence from all sexual behaviors outside of marriage. Typically this approach does not include information about contraceptives other than their failure rates. Following are the eight points highlighted in abstinence education or motivational programs:

- Have as its exclusive purpose to teach the social, psychological, and health gains to be realized by abstaining from sexual activity
- Teach abstinence from sexual activity outside marriage as the expected standard for all school-age children
- Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems
- Teach that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of sexual activity
- Teach that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects
- Teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society
- Teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances
- Teach the importance of attaining self-sufficiency before engaging in sexual activity

Those programs and curricula utilizing an abstinence-only or -centered approach uphold these messages and only talk about contraception in terms of failure rates. Usually the lessons and messages use fear to motivate students to abstain from sexual activity.

Status of HGD Instruction in Wisconsin Schools

At this time, it is not possible to accurately describe human growth and development or sexuality education that is occurring in K-12 classrooms in Wisconsin schools. The Department of Public Instruction (DPI) does not routinely collect data on curricula in any area including those that are being used to teach human growth and development. As such, many questions remain about human growth and development instruction in Wisconsin schools. For example, what HGD curricula are most frequently used? To what extent are the curricula implemented as written? To what extent do students learn, develop skills, and reduce risk behaviors following HGD instruction?

The DPI does have a general picture of the health education topics, including sexuality education, taught in middle and high schools. Results from the 2012 Wisconsin School Health Profile, a survey of principals and lead health teachers developed and supported by the Centers for Disease Control and Prevention (CDC), indicate that the vast majority of required health education courses in grades 6–12 include instruction on HIV (96%), human sexuality (95%), pregnancy prevention (93%), and STI prevention (96%) (Wisconsin DPI, 2012). With the exception of instruction about HIV, the survey does not provide information about the specific content, quantity, or quality of this instruction. With regard to HIV prevention, the survey found that all high school teachers taught abstinence as the most effective method to avoid HIV infection. The survey found that while the majority of schools address a number of topics as part of their HIV instruction, they are less likely to provide instruction on topics considered to be sensitive or controversial, including how to correctly use a condom. The 2012 School Health Profile report can be obtained from http://sspw.dpi.wi.gov/sspw_shepindex.

Each school district will decide which components of sexuality will be addressed as part of its HGD program.

Funding provides another measure of support for sexuality education. In recent decades there has been no funding earmarked for DPI or cooperative educational service agencies (CESAs) to provide technical support to school districts for HGD instruction. DPI has received federal funding from the CDC to provide technical assistance and consultation to school districts on HIV/STI prevention, school health programs, and education.

Wisconsin was also a recipient of funding from the Personal Responsibility Education Program (PREP), which is a component of the Affordable Care Act (ACA). The grant supports programs targeted at youth ages 10 to 19, especially at-risk youth who are homeless, in foster care, live in areas with high teen birth rate, or are living with HIV. Programs will reach out to African American, Hispanic, and Native American youth.

Scope of HGD Instruction

This *Human Growth and Development Resource Guide* addresses sexuality, and sexuality education, as a complex and multi-dimensional topic. Sexuality education can include developmentally appropriate discussion of human development, relationships, personal skills, sexual behavior, sexual health, and the influences of society and culture. Each school district will decide which components of sexuality will be addressed as part of its HGD program. Some districts may decide to provide HGD as a distinct unit of instruction; others may decide to integrate it into health, family and consumer education, developmental guidance, science, social studies, English, or other subjects.

School districts will also decide on the content and messages provided for each HGD topic taught. For example, some districts will decide that HGD instruction at the high school level should provide accurate and reliable information regarding the various methods of contraceptives, including their advantages and limitations, especially in relation to prevention of pregnancy and transmission of

STI. Provision of instruction about contraceptives has historically been a controversial issue within some local communities. Wisconsin Statute 118.019 makes it clear that this decision rests with the local school board, which must be advised by a broad school–community HGD advisory council.

Local partnerships can help create a climate in schools and the community that supports young people who choose to abstain.

School districts will also identify community partners to support the human growth and development program. The Wisconsin DPI supports local partnerships of parents, teachers, school administrators, students, health care professionals, members of the clergy, and other community partners to address youth risk behaviors and provide mutually reinforcing prevention and health promotion messages for children and youth. Young people need to hear messages that refraining from sexual intercourse and alcohol and other drugs is the most effective prevention strategy to prevent unintended pregnancies, STIs, and HIV/AIDS. Local partnerships can help create a climate in schools and the community that supports young people who choose to abstain. Similarly, local partnerships can provide education and resources to help young people reduce their risks if and when they do become sexually active.

HGD Program Planning

Developing and implementing a K–12 HGD curriculum, like any important program, requires careful planning to increase the likelihood that the program will achieve its desired outcomes. Program planning consists of a series of activities that collectively help educators design, develop, and deliver a program for the target audience. Key planning activities for developing a HGD program include the following:

- Involving key stakeholders (parents, teachers, school administrators, curriculum coordinators, students, health care professionals, members of the clergy, etc.) in the planning process.
- Identifying appropriate goals and objectives based on the current situation, assets, problem, or needs in the school and community.
- Determining the curriculum or program with the "best fit" or, alternatively, developing a new program, replicating an existing program, tailoring a program for a new target population, or adapting a program for a new target population.
- Ensuring that human and material resources are in place.
- Ensuring that students are ready to participate in the program.
- Implementing the program.
- Evaluating the program.
- Revising the program for future implementation.

In Wis. Stat. 118.019 under the advisory committee heading it reads "(the advisory committee's role) is to advise the school board on the design and implementation of the human growth and development curriculum and to review the curriculum." The advisory committee does not necessarily write the curriculum (lessons), especially if the school district has a curriculum in place, which is the case for most districts. Feedback, edits, decisions on topics, and timing are all effective ways for a committee to advise the school board on the curriculum design. However, nothing in the law prevents the committee from actually writing and developing lessons or a curriculum, for that matter.

When developing a curriculum it is important to consider the background, skills, and knowledge of those responsible for writing the curriculum. Usually the primary curriculum writers are the content specialists within the district, which would include teachers and curriculum coordinators who have formal professional preparation in curriculum, instruction, and student assessment. The level of involvement in the actual writing of new or revised lessons can vary greatly among advisory committees because the competency level of advisory committees can also vary greatly. In the end, the level of involvement is the school district's decision. For more information on HGD advisory committees see Chapter 4 of this document.

Organizations are using logic models as part of the planning process. A logic model is a concise causal description showing the connections between perceived needs, available resources, program activities, and program goals. In terms of planning a HGD program, a logic model can help clarify the current situation and a district's rationale for the HGD program based on documented health indicators such as rates of teen pregnancy, STI, and self-reported high-risk sexual behaviors. A logic model can also identify necessary resources to implement the program. In the case of HGD, important resources include statutory guidance, a local HGD Advisory Committee, and school staff members who will actually implement the HGD program or curriculum. The logic model also describes the important activities, such as communicating with parents, and of course, actually providing HGD instruction. And finally, a logic model encourages clarity about the short-term outcomes and longer-term goals or impacts of the HGD program. Specifically, the logic model encourages districts to articulate the knowledge, attitudes, and intentions expected from the HGD curriculum and instruction and the desired longer-term impacts. In short, a logic model can articulate how a school or school district's HGD program contributes to the health of young people. See *Resource 1.2: HGD Program Planning Logic Model* for an example of a completed logic model.

Web-based Resources

The UW-Extension Program Development and Evaluation, www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html, and ETR's Resource Center for Adolescent Pregnancy Prevention, http://recapp.etr.org/recapp/documents/BDILOGICMODEL20030924.pdf, have developed resources to assist with the development of logic models.

Organization of the HGD Resource Guide

The HGD Resource Guide includes eight chapters. Each chapter is designed to provide background information and resources for planning HGD programs. Most of the chapters include numerous resources, including background information, worksheets, information handouts, and sources for additional information.

Chapter 1.0 Background

Chapter 2.0 State Statutes

Chapter 3.0 Profile of Wisconsin Youth

Chapter 4.0 Human Growth and Development Advisory Committee

Chapter 5.0 Parental Communication

Chapter 6.0 Effective HGD Curriculum and Instruction

Chapter 7.0 Assessing and Reviewing Your Human Growth and Development Curriculum

Chapter 8.0 Resources

Your commitment to strengthening your school district's HGD instruction is important—not only as it contributes to the knowledge, skills, and attitudes of children and young people in the upcoming months, but also as it contributes to their health and wellness in the years ahead.

References

National Public Radio, Henry J. Kaiser Family Foundation, and Kennedy School of Government. *Sex Education in America*. Washington, DC. (2004).

The Future of Sex Education. *National Sexuality Education Standards: Core Content and Skills, K–12*. New York, NY. (2011).

Wisconsin Department of Public Instruction. *Wisconsin School Health Profile Report (2012)*. http://sspw.dpi.wi.gov/sspw_shepindex.

DPI Statement on K–12 HGD Instruction

Sexuality, and expression of one's sexuality, is an important part of each person's identity. Achieving healthy sexuality and learning about this aspect of ourselves begins at birth and continues throughout our lives. Infants receive important messages about trust, human contact, interactions between individuals, and expressions of affection from their parents and other caregivers. Children continue to absorb messages about these and other aspects of sexuality and develop attitudes about themselves, including their bodies, long before they enter school. Attitudes and expectations about healthy relationships, worthiness of love, expression of respect and care for themselves and others, as well as other important ideas continue to develop through elementary, middle school, and high school years and into adulthood.

Sexuality is an important and multidimensional concept. Someone once said that "sex is about doing, but sexuality is about 'being'." The way human beings are in the world has a great deal to do with sexuality. From messages about being a boy or girl, to feelings and behaviors, schools along with families and communities contribute to a child's self concept. The variety of topics that can be covered under human growth and development (HGD) might include anatomy, physiology, growth and development, self-esteem, body image, self-care, communication, values, and an understanding of satisfying and healthy relationships, decision-making, sexual intimacy, responsibilities of parenthood, and a host of other topics. Parents are the primary sexuality educators of their children. Children also receive messages about various aspects of sexuality from myriad other sources, including other family members, friends, peers, schools, media, faith communities, and other people and institutions.

Schools can be important partners with parents to provide children and adolescents with accurate and developmentally appropriate sexuality education or HGD instruction. The relationship between youth risk taking and academic success is clear. Students who engage in risky behavior, including sexual intercourse, drugs, and violence, are less likely to attend school and graduate. They are more likely to get an STD or have or cause a pregnancy. Schools along with parents have a vested interest not only in the health of young people, but also in providing them with the relevant skills for a productive adulthood beyond graduation.

Decisions about how and when a school provides HGD instruction to meet the needs of youth in the community need to be made as part of the school district's HGD Advisory Council's program planning process, involving parents, teachers, school administrators, students, health care professionals, members of the clergy, and other residents of the school district.

HGD Program Planning Logic Model

Current Situation	**Resources**	**Activities**	**Short-term Outcomes** (knowledge, attitudes, intentions)	**Longer-term Impacts**
What is the health status of children, adolescents, and young adults in our community?	What do state statutes say school districts can and cannot do related to HGD? What is the role of the HGD Advisory Committee? What support do teachers need to provide effective HGD instruction?	How can the school support parents in their role as primary sexuality educators of their children? What HGD curriculum is most likely to be effective and acceptable in our community?	What do our students know and what can they do as a result of HGD instruction? To what extent does youth behavior promote health or reflect health risks?	What is the health status of children, adolescents, and young adults in our community?
See Chapter 3: Profile of WI Youth	See Chapter 2: State Statutes Chapter 4: HGD Advisory Committee Chapter 7: Assessing and Reviewing Your HGD Curriculum	See Chapter 5: Parental Communication Chapter 6: Effective HGD Curriculum and Instruction	See Chapter 6: Effective HGD Curriculum and Instruction	See Chapter 3: Profile of WI Youth

Chapter 2
State Statutes

State Statutes

2

Overview

Wisconsin statutes support human growth and development (HGD) instruction. Relevant statutes include:

Wis. Stat. 115.35	Critical health problems education
Wis. Stat. 118.01	Educational goals and expectations, including instruction in physiology, hygiene, and sexually transmitted diseases
Wis. Stat. 118.019	Human growth and development instruction

The Wisconsin statutes are explained below. Copies of the statutory language can be found in subsequent pages and on the web at **http://legis.wisconsin.gov/lrb/**. Districts are advised to consult with their legal counsel for interpretation and application for local issues.

Wisconsin statutes support human growth and development (HGD) instruction. Relevant statutes include:

Statutes[♣]

Wisconsin Statute 115.35 authorizes the Department of Public Instruction (DPI) to establish a critical health problems education program that includes specific topics such as sexually transmitted diseases, including acquired immunodeficiency syndrome. It gives the DPI authority to establish guidelines to help school districts develop comprehensive health education programs and prohibits the DPI from requiring school boards to use a specific human growth and development curriculum. This statute also states that participation in the human growth and development program is voluntary.

Wisconsin Statute 118.01 identifies educational goals and expectations of public education, and as part of the goal of personal development states that each school board shall provide an instructional program designed to give pupils knowledge of the human body and the means to maintain lifelong health. Section 118.01(2)(d)2c continues that instruction in physiology and hygiene shall include instruction on sexually transmitted diseases and shall be offered in every high school. However, no student may be required to take instruction in these subjects if their parent/guardian files a written objection with the teacher. In such cases, the student cannot be penalized in any way for not taking the instruction but can be required to complete an alternative assignment if the subject is needed for graduation.

[♣] Statute language current as of October 2012.

Wisconsin Statute 118.01(2)(d)8 requires school districts to provide to students in elementary school "knowledge of effective means by which pupils may recognize, avoid, prevent and halt physically or psychologically intrusive or abusive situations which may be harmful to pupils, including child abuse, sexual abuse and child enticement." This statute requires a school district to provide a protective behaviors curriculum at the elementary level.

Wisconsin Statute 118.019 encourages school districts to provide a developmentally appropriate HGD instructional program in grades kindergarten to 12 to promote optimal health and well-being of the pupils. The statute specifically identifies seven instructional topics that include the following: Abstinence as the only reliable way to prevent pregnancy and STDs; medically accurate information about human papilloma virus (HPV), HIV, and AIDS; pregnancy, prenatal development, and childbirth; parental responsibility and the socio-economic benefits of marriage; abstinence as the preferred choice of behavior for non-married students; criminal penalties for engaging in sexual activity involving a child; and sex offender registration requirements.

The statute requires the school board on an annual basis to provide parents of each pupil enrolled in the school district with an outline of the human growth and development curriculum used in the pupil's grade level and information regarding how the parent may inspect the complete curriculum and instructional materials. In addition, the curriculum and instructional materials must be made available for inspection at any time upon request.

Students can be exempted from HGD instruction if the student's parent files a written request with the teacher or school principal.

In addition, this statute requires that any school district that offers a HGD curriculum must appoint an advisory committee composed of parents, teachers, school administrators, pupils, health care professionals, members of the clergy, and other residents of the school district to advise the school board on the design and implementation of the curriculum.

Guidelines for Opt-Out Policies

The state statutes do not require parents to give permission for HGD instruction; however, Wis. Stat. 118.019 allows parents to exempt their child from instruction in human growth and development with a written request to the teacher or principal. This is referred to as an "opt-out" policy. Wisconsin Statute 118.01(2)(d)2c permits pupils to be exempted from instruction on physiology and hygiene, STDs, symptoms of disease and the proper care of the body if his or her parent files a written request with the teacher or school principal. Typically a school will provide parents with an opt-out form when they provide them with the HGD curriculum outline. Wisconsin statutes do not provide, and legislative history does not support, the use of the parent "opt-in" method by local school districts where the "opt-out" method is statutorily specified. The opt-in method would require a parent to notify their child's principal/teacher if they want their child to take instruction in HGD.

State Statutes

Statute 115.35

115.35 Health problems education program. (1) A *critical health problems education program is established in the department* [emphasis added]. The program shall be a systematic and integrated program designed to provide appropriate learning experiences based on scientific knowledge of the human organism as it functions within its environment and designed to favorably influence the health, understanding, attitudes and practices of the individual child which will enable him or her to adapt to changing health problems of our society. The program shall be designed to educate youth with regard to critical health problems and shall include, but not be limited to, the following topics as the basis for comprehensive education curricula in all elementary and secondary schools: controlled substances, as defined in s. 961.01(4); controlled substance analogs, as defined in s. 961.01(4m); alcohol; tobacco; mental health; *sexually transmitted diseases, including acquired immunodeficiency syndrome; human growth and development* [emphasis added]; and related health and safety topics. Participation in the human growth and development topic of the curricula shall be entirely voluntary. The department may not require a school board to use a specific human growth and development curriculum.

(2) In carrying out this section, the state superintendent may, without limitation because of enumeration:

(a) Establish guidelines to help school districts develop comprehensive health education programs.

(b) Establish special inservice programs to provide professional preparation in health education for teachers throughout the state.

(c) Develop cooperative programs between school districts and institutions of higher education whereby the appropriate health personnel of such institutions would be available to guide the continuing professional preparation of teachers and the development of curricula for local programs.

(d) Assist in the development of plans and procedures for the evaluation of health education curricula.

(3) The department may appoint a council consisting of representatives from universities and colleges, law enforcement, the various fields of education, the voluntary health agencies, the department of health and family services, the professional health associations and other groups or agencies it deems appropriate to advise it on the implementation of this section, including teachers, administrators and local school boards.

(4) The department shall cooperate with agencies of the federal government and receive and use federal funds for the purposes of this section.

(5) In each report under s. 15.04(1)(d), the state superintendent shall include information:

(a) As to the scope and nature of programs undertaken under this section.

(b) As to the degree and nature of cooperation being maintained with other state and local agencies.

(c) As to the state superintendent's recommendations to improve such programs and cooperation.

History: 1971 *c.* 219; 1977 c. 196 *s.* 131; 1977 *c.* 418; 1981 c. 291; 1985 a 56; 1989 a.203; 1993.492;1995 a. 27 as. 3873, 9126 (19), 9145 (1); 1995 a. *Mt* 1997 a. 27.

Statute 118.01

118.01 Educational goals and expectations. (1) Purpose. Public education is a fundamental responsibility of the state. The constitution vests in the state superintendent the supervision of public instruction and directs the legislature to provide for the establishment of district schools. The effective operation of the public schools is dependent upon a common understanding of what public schools should be and do. Establishing such goals and expectations is a necessary and proper complement to the state's financial contribution to education. Each school board should provide curriculum, course requirements and instruction consistent with the goals and expectations established under sub. (2). Parents and guardians of pupils enrolled in the school district share with the state and school board the responsibility for pupils meeting the goals and expectations under sub. (2).

(2) EDUCATIONAL GOALS. (a) Academic skills and knowledge. Since the development of academic skills and knowledge is the most important goal for schools, each school board shall provide an instructional program designed to give pupils:

1. Basic skills, including the ability to read, write, spell, perform basic arithmetical calculations, learn by reading and listening and communicate by writing and speaking.

2. Analytical skills, including the ability to think rationally, solve problems, use various learning methods, gather and analyze information, make critical and independent judgments and argue persuasively.

3. A basic body of knowledge that includes information and concepts in literature, fine arts, mathematics, natural sciences, including knowledge of the elements of agriculture and the conservation of natural resources, and social sciences, including knowledge of the rights and responsibilities of the family as a consumer, cooperative marketing and consumers' cooperatives. The skills and attitudes that will further lifelong intellectual activity and learning.

4. Knowledge in computer science, including problem solving, computer applications and the social impact of computers.

(b) Vocational skills. Each school board shall provide an instructional program designed to give pupils:

1. An understanding of the range and nature of available occupations and the required skills and abilities.

2. Preparation to compete for entry level jobs not requiring postsecondary school education.

3. Preparation to enter job-specific vocational training programs.

4. Positive work attitudes and habits.

(c) Citizenship. Each school board shall provide an instructional program designed to give pupils:

1. An understanding of the basic workings of all levels of government, including the duties and responsibilities of citizenship.

2. A commitment to the basic values of our government, including by appropriate instruction and ceremony the proper reverence and respect for and the history and meaning of the American flag, the Declaration of Independence, the U.S. constitution and the constitution and laws of this state.

3. The skills to participate in political life.

4. An understanding of the function of organizations in society.

5. Knowledge of the role and importance of biological and physical resources.

6. Knowledge of state, national and world history.

7. An appreciation and understanding of different value systems and cultures.

8. At all grade levels, an understanding of human relations, particularly with regard to American Indians, Black Americans and Hispanics.

(d) Personal development. Each school board shall provide an instructional program designed to give pupils:

1. The skills needed to cope with social change.

2. Knowledge of the human body and the means to maintain lifelong health, including:

a. Knowledge of the theory and practice of physical education, including the development and maintenance of physical fitness;

b. Knowledge of the true and comparative vitamin content of food and food and health values of dairy products and their importance for the human diet; and

c. *Knowledge of physiology and hygiene* [emphasis added], sanitation, the effects of controlled substances under ch. 961 and alcohol upon the human system, symptoms of disease and the proper care of the body. No pupil may be required to take instruction in these subjects if his or her parent files with the teacher a written objection thereto. If a pupil does not take instruction in these subjects as a result of parental objection, the pupil may not be required to be examined in the subjects and may not be penalized in any way for not taking such instruction, but if the subjects receive credit toward graduation, the school board may require the pupil to complete an alternative assignment that is similar to the subjects in the length of time necessary to complete. *Instruction in physiology and hygiene shall include instruction on sexually transmitted diseases and shall be offered in every high school.* [Emphasis added.]

3. An appreciation of artistic and creative expression and the capacity for self–expression.

4. The ability to construct personal ethics and goals.

5. Knowledge of morality and the individual's responsibility as a social being, including the responsibility and morality of family living and the value of frugality and other basic qualities and principles referred to in article I, section 22, of the constitution insofar as such qualities and principles affect family and consumer education.

6. Knowledge of the prevention of accidents and promotion of safety on the public highways, including instruction on the relationship between highway safety and the use of alcohol and controlled substances under ch. 961.

7. The skills needed to make sound decisions, knowledge of the conditions which may cause and the signs of suicidal tendencies, knowledge of the relationship between youth suicide and the use of alcohol and controlled substances under ch. 961 and knowledge of the available community youth suicide prevention and intervention services. Instruction shall be designed to help prevent suicides by pupils by promoting the positive emotional development of pupils.

8. Knowledge of effective means by which pupils may recognize, avoid, prevent and halt physically or psychologically intrusive or abusive situations which may be harmful to pupils, including child abuse, sexual abuse and child enticement. Instruction shall be designed to help pupils develop positive psychological, emotional and problem–solving responses to such situations and avoid relying on negative, fearful or solely reactive methods of dealing with such situations. Instruction shall include information on available school and community prevention and intervention assistance or services and shall be provided to pupils in elementary schools.

History: 1983 a. 412; 1985 a. 29, 213; 1989 a. 31; 1995 a. 27, 229, 448; 1997 a. 27,35.

Statute 118.019

118.019 Human growth and development instruction. (1) PURPOSE. The purpose of this section is to foster a partnership between parents of pupils attending schools in the school district and the schools in the school district to promote the optimal health and well-being of the pupils. The provisions of this section are in addition to, and do not supplant, the requirements under ss. 118.01 (2) (d) 2. c. and 8. and 118.13 (1), which are critical to maintaining the physical and psychological health of each pupil.

(1m) DEFINITIONS. In this section:

(a) "Age-appropriate" means suitable to a particular age group o pupils based on their developing cognitive and emotional capacity and consistent with adolescent development and community standards.

(b) "Medically accurate information" means information that is scientifically-based and published, where appropriate, in peer-reviewed journals and textbooks.

(2) SUBJECTS. A school board may provide an instructional program in human growth and development in grades kindergarten to 12. If the school board elects to provide an instructional program under this section, when the school board establishes the curriculum for the instructional program, the school board shall make determinations as to whether and, if so, for what subjects covered in the curriculum the pupils shall be separated by gender. If an instructional program is provided, the following instructional program is recommended:

(a) Present medically accurate information to pupils and, when age-appropriate, address the following topics:

1. The importance of communication about sexuality between the pupil and the pupil's parents or guardians.

2. Reproductive and sexual anatomy and physiology, including biological, psychosocial, emotional, and intellectual changes that accompany maturation.

5. The benefits of and reasons for abstaining from sexual activity. Instruction under this subdivision shall stress the value of abstinence as the only reliable way to prevent pregnancy and sexually transmitted infections, and shall identify the skills necessary to remain abstinent.

7. Methods for developing healthy life skills, including setting goals, making responsible decisions, communicating, and managing stress.

8. How alcohol and drug use affect responsible decision making.

9. The impact of media and one's peers on thoughts, feelings, and behaviors related to sexuality.

10. Adoption resources, prenatal care, and postnatal supports.

11. The nature and treatment of sexually transmitted infections.

(c) Address self-esteem and personal responsibility, positive interpersonal skills, and healthy relationships.

(d) Identify counseling, medical, and legal resources for survivors of sexual abuse and assault, including resources for escaping violent relationships.

(e) Address the positive connection between marriage and parenting.

(f) Present information about avoiding stereotyping and bullying, including how to refrain from making inappropriate remarks, avoiding engaging in inappropriate physical or sexual behaviors, and how to recognize, rebuff, and report any unwanted or inappropriate remarks or physical or sexual behaviors.

(2d) NONDISCRIMINATION. An instructional program under this section shall use instructional methods and materials that, consistent with s. 118.13 (1), do not discriminate against a pupil based upon the pupil's race, gender, religion, sexual orientation, or ethnic or cultural background or against sexually active pupils or children with disabilities. Nothing in this subsection shall be construed to prohibit a school board from approving an instructional program under this section that includes instruction on abstinence from sexual activity or that is abstinence-centered.

(2m) REQUIRED SUBJECTS. If a school board provides instruction in any of the areas under sub. (2) (a), the school board shall ensure that instruction conforms to s. 118.13 (1) and that the following is provided, when age appropriate, in the same course and during the same year:

(c) Presents abstinence from sexual activity as the preferred choice of behavior for unmarried pupils.

(d) Emphasizes that abstinence from sexual activity before marriage is the only reliable way to prevent pregnancy and sexually transmitted diseases, including human immunodeficiency

virus and acquired immunodeficiency syndrome.

(e) Provides instruction in parental responsibility and the socioeconomic benefits of marriage for adults and their children.

(f) Explains pregnancy, prenatal development, and childbirth.

(g) Explains the criminal penalties under ch. 948 for engaging in sexual activities involving a child.

(h) Explains the sex offender registration requirements under s. 301.45. Instruction under this paragraph shall include who is required to report under s. 301.45, what information must be reported, who has access to the information reported, and the implications of being registered under s. 301.45.

(i) Provides medically accurate information about the human papilloma virus and the human immunodeficiency virus and acquired immunodeficiency syndrome.

(2s) PROVISION OF INSTRUCTION. Subject to s. 120.13 (37m), nothing in this section prohibits a school district from providing instruction under this section, in whole or in part, to pupils while the pupils are separated from members of the opposite sex.

(3) DISTRIBUTION OF CURRICULUM TO PARENTS; NOTICE. Each school board that provides an instructional program in human growth and development shall annually provide the parents or guardians of each pupil enrolled in the school district with an outline of the human growth and development curriculum used in the pupil's grade level, information regarding how the parent or guardian may inspect the complete curriculum and instructional materials, an explanation of the exemption under sub. (4), and a statement that pupils exempted from instruction under this section will still receive instruction in the subjects under s. 118.01(2)(d)2. c., unless exempted, and s. 118.01(2)(d)8. The school board shall make the complete human growth and development curriculum and all instructional materials available for inspection by a parent or guardian upon his or her request at any time, including prior to their use in the classroom.

(4) EXEMPTION FOR INDIVIDUAL PUPILS. No pupil may be required to take instruction in human growth and development or in the specific subjects under subs. (2) and (2m) if the pupil's parent or guardian files with the teacher or school principal a written request that the pupil be exempted.

(5) ADVISORY COMMITTEE. In any school district that offers a human growth and development curriculum, the school board shall appoint an ad hoc advisory committee whose role is to advise the school board on the design and implementation of the human growth and development curriculum and to review the curriculum. Parents, teachers, school administrators, pupils, health care professionals, members of the clergy, and other residents of the school district shall comprise the committee. No one category of member shall constitute more than one-fifth of the membership of the committee, except that parents may comprise more than one-fifth of the membership of the committee. No more than one-quarter of the members of the committee may be made up of employees of the school district or their spouses or members of the school board or their spouses.

History: 1985 a. 56; 1987 a. 399; 1989 a. 203; 1995 a. 27; 1997 a. 27; 2001 a. 16; 2005 a. 341, 445; 2009 a. 134; 2011 a. 216.

Chapter 3

Profile of Wisconsin Youth

Profile of Wisconsin Youth

3

Overview

Information about the attitudes, behaviors, and health outcomes of young people provides an important foundation for parents, school personnel, and other youth advocates to use to determine developmentally appropriate and timely messages, skills, and services to support young people's healthy development and well-being. Acquiring an accurate profile of young people in a community can be difficult. There is limited scientific data on adolescent sexual behavior, and most of what does exist is available at the national or state level. Each community will need to identify which measures of attitudes, behaviors, and health outcomes will be most important to consider, in part based on what is available or can be acquired. It is not necessary to obtain a lengthy list of measures of youth attitudes, behavior, and health outcomes. What should be priority measures are those that are critical to the goals of the human growth and development (HGD) program. Local school districts usually use state or national data as a beginning point, and then supplement these data with local data that better describe the local situation. The better the understanding of the attitudes, sexual behaviors, and sexual health outcomes of youth in the community, the more likely it is that a HGD program can be developed to meet their needs.

School districts must determine what data is accessible, what is realistic to collect, and what may be sufficient for their needs.

Data is useful for a number of reasons. Perhaps most important, it can help school districts identify adolescent behaviors in need for attention and priority. Data can then serve as benchmarks from which school districts and communities can measure progress in addressing these aspects of adolescent health. The state health plan suggests goals to address individual adolescent behavior change. It also sets goals related to the social environment that enhance healthy adolescent development, including adoption of healthy behaviors. In addition to measures of risk behaviors, school districts are increasingly using youth development indicators as broader measures of adolescent health and well-being. Such measures focus on assets, resiliencies, and strengths of young people. They recognize the importance of family, school, and community factors to provide a supportive environment in which young people develop.

Many districts find that quantitative data does not exist for all behaviors, environmental factors, and youth development indicators for which measures would be helpful. School districts must determine what data is accessible, what is realistic to collect, and what may be sufficient for their needs. When local data is not available, there may be national or state data that can be used. There also may be qualitative data, such as results from focus groups or interviews, which can be useful in developing a profile of youth in the community.

Development is a complex process that involves physical development, psychosocial development, and cognitive development.

Knowledge and Attitudes—Teachers use various strategies to assess student learning. A district may consider using selected learning assessments over time to measure trends in what students know and learn to assess the effectiveness of the HGD instructional program.

Behaviors—The following indicators are commonly used to describe prevalence of behaviors in a population:

- percentage of youth not sexually active
- age of first intercourse
- percentage of youth who are sexually active
- number of sexual partners
- alcohol and drug use before last sexual intercourse
- condom use at last sexual contact
- juvenile arrests/crime

Health Outcomes—This type of data measures the longer-term goals of HGD programs. Because there are many factors that contribute to these outcomes within a community, it is seldom possible to attribute a school-based HGD program for changes in these indicators, but an effective HGD program can contribute to positive health outcomes. Commonly used measures of health outcomes include the following:

- pregnancy rate,
- birth rate,
- STD rate,
- family planning visits, and
- cases of HIV

Youth Development—These indicators attempt to measure youth characteristics, assets, and competencies, as well as the environmental factors that contribute to youth development. Some of the commonly used indicators are as follows:

- aspects of identity (feelings of confidence, well-being, connections and commitment to others),
- areas of ability (behaviors that enhance physical and mental health, employment, civic and social engagement),
- supportive relationships with caring adults (family, school, community), and
- opportunities for personal development and meaningful involvement.

This chapter briefly reviews key aspects of typical child development, and then reviews what is known from state and national data about the attitudes and sexual behavior of youth. It also provides suggestions for acquiring local data to describe the status of young people in a particular community.

What We Know: Child Development

Development is a complex process that involves physical development, psychosocial development, and cognitive development. During a child's school years some physical changes will occur slowly, while at other times children will experience rapid physical growth spurts and physiological changes. The psychosocial development process is influenced by family, peer, school, and other factors. It is a process of exploration and experimentation through which children develop competence, the ability to manage emotions, a sense of autonomy and identity, meaningful relationships, and integrity reflecting their personal and family values. Although there are general characteristics that describe children at various developmental stages, it is important to remember that each child will develop physically, psychosocially, and cognitively at his or her own rate. These developments are based on numerous factors, including his or her personality, family, culture, and community.

Early Elementary—The preschool and kindergarten years are characterized as the "play age" and "years of magic" as children move about, develop social skills, and express curiosity about their world. Children ages 5–8 years of age continue to be curious about many things, including their own bodies. Children become more aware of similarities and differences, and may express their curiosity by asking questions. Many are also curious about pregnancy and birth.

In terms of social development, children are learning about being a friend. Children have more opportunities to select their friends. Most children this age prefer to play with children of the same gender. Children are becoming aware of socially defined roles, especially related to gender. Children are also becoming more aware of what their peers think, especially as friendships become increasingly important. It is also a period during which children begin to develop empathy and understand the feelings of others. As children are taught numerous skills related to social interactions, it is important to include instruction on gender diversity, protective behaviors, or child sexual abuse prevention. Children this age are concrete learners, and school provides a setting to teach developmentally appropriate content and skills through which children begin to gain a sense of competence.

Upper Elementary and Middle School—Children in upper elementary school and middle school experience the most rapid physical, social, and emotional development since the growth spurt they experienced as infants and toddlers. Puberty, the stage during which a person becomes capable of sexual reproduction, may begin as early as 8 or 9 years of age or as late as 15 or 16. Puberty usually takes four or five years to complete. At this stage children are more aware of changes in their bodies and frequently wonder, "Am I normal?" It may be helpful for teachers and parents to reinforce the following important messages about puberty for all children (Haffner, 1999):

- Puberty begins and ends at different ages for different people.
- Everyone's body changes at its own pace.
- Most changes in puberty are similar for boys and girls.
- Girls often begin pubertal changes before boys.
- Preadolescents may feel uncomfortable, clumsy, and/or self-conscious because of the rapid changes in their bodies.
- The sexual and reproductive systems mature during puberty. Girls begin to ovulate and menstruate, and boys begin to produce sperm and ejaculate.
- Emotional changes also occur during puberty. Young people may begin to develop romantic and sexual feelings.

In addition to noticeable changes in physical development, children experience significant changes in their social and emotional development. Young people may increasingly identify with and spend time with their peer groups, and begin to separate from their families. Peer pressure may become more apparent. Some early adolescents become interested in dating and may experience intense emotions as part of these relationships. Young people this age are targeted by, and susceptible to, media messages, including messages about gender roles, expression of sexual intimacy, and body image. Because young adolescents are developing abstract thinking, school-based HGD instruction can provide important content information and opportunities for young people to develop skills to successfully manage and negotiate potential challenging situations.

Adolescence—Adolescence, the period between puberty and adulthood, is a period of changes, challenges, and new experiences. By this time most young people have completed most of the physical changes associated with puberty and their major growth spurt. Recent research shows that neurological development is an important aspect of adolescent development. Some parts of this brain development aren't completed until young people are in their mid-20s (Weinberger et al., 2005). This is particularly significant as a factor in understanding adolescent sexual behavior. For example, the prefrontal cortex, the region associated with impulse control, planning, and decision-making functions, is one of the last areas of the brain to fully mature. Given the numerous changes, challenges, and new experiences that take place during this stage of development, adolescence is a period during which a young person

- Adjusts to a new self-image based on a physically mature body;
- Develops a personal identity, including their gender identity and sexual orientation;
- Develops a personal identity based on personal values, ethics, and behavior;

- Increases independence, including a redefinition of relationships and communication patterns with parents/guardians, siblings, and peers;
- Establishes intimate relationships involving emotional and physical attraction and intimacy; and
- Increasingly develops skills to set priorities, make decisions, organize plans, form strategies, and control impulses.

It is a period during which young people continue to develop a sense of self as they develop answers to, "Who am I?" and "What am I capable of doing?" Sexual topics (including dating, relationships, sexual behavior, abstinence, contraception, safer sex, etc.) are of interest to many adolescents. Youth are bombarded with conflicting messages about sexuality from the media, music, parents/guardians, teachers, and other influential adults. For a significant number of young people it is a time of sexual debut, or first intercourse, although the percentage of high school students who report being sexually active continues to decline.

At this stage of development some young people continue to believe they are invincible in the face of risk behaviors, or that potential negative health outcomes will not happen to them. For most adolescents the capacity for abstract thinking continues to develop. By late adolescence, roughly ages 16–18, young people have developed more independence from their parents, and a set of values, morals, and ethics from which they are able to specify general life goals and career plans.

References

Haffner, DW. *From Diapers to Dating: A Parent's Guide to Raising Sexually Healthy Children*. New York: Newmarket Press (1999).

Sexuality Education Within Comprehensive School Health Education. 2nd edition. Kent, Ohio: American School Health Association (2003).

Weinberger, DR, Elvevag, B, Giedd, JN. *The Adolescent Brain: A Work in Progress*. The National Campaign to Prevent Teen Pregnancy. Washington, D.C. (2005). Available at www.teenpregnancy.org/resources/reading/pdf/BRAIN.pdf.

What We Know: Attitudes

Surveys of attitudes of youth, as well as assessments of public opinion, provide useful supplements to the behavioral data discussed below. In recent years the National Campaign to Prevent Teen Pregnancy has conducted *With One Voice: America's Adults and Teens Sound Off About Teen Pregnancy,* an annual national survey of adults (aged 20 and older) and teens (aged 12–19) about teen

pregnancy and related issues. The results from this national survey underscore the importance of parents as powerful influences in their children's lives. The survey results indicate the following:

- Parents continue to underestimate their influence on their teenagers' decisions about sex.
- Support for providing young people with a strong abstinence message is overwhelming.
- Support is also strong for giving young people information about contraception.
- Few teens feel that they are getting enough information about both abstinence and contraception.
- The clear majority of adults and teens believe that teens should not be sexually active, but teens that are should have access to contraception.
- Teens continue to express more cautious attitudes toward sex than is perhaps generally believed.
- Teens overestimate the percentage of their peers who have had sex.
- Adults mistakenly believe that rates of teen sexual activity and pregnancy have been increasing over the past several years.

The authors of the report conclude, "the majority of adults and teens in this country continue to hold a practical, moderate view about teen sexual behavior and pregnancy prevention."

What We Know: Behaviors
Youth Risk Behavior Survey (State Level Data)

The Wisconsin Youth Risk Behavior Survey (YRBS) is conducted as part of a national effort by the U.S. Centers for Disease Control and Prevention (CDC) to monitor health-risk behaviors of the nation's high school students. In Wisconsin, the survey has been administered every two years beginning in 1993, and as such it provides valuable longitudinal data. These and other findings from the Wisconsin Youth Risk Behavior Survey are available at http://sspw.dpi.wi.gov/sspw_yrbsindx.

See Resource 3.1 **Wisconsin Youth Sexual Behavior and Outcomes Report**

See Resource 3.2 **Surveys of Adolescent Sexual Attitudes and Behaviors**

Youth Risk Behavior Survey (Local Level Data)

The Wisconsin Department of Public Instruction offers a free confidential online student survey system to assist school districts in gathering data that will yield results that can be used in grant applications, to monitor and plan risk behavior prevention programs aimed at school-aged youth, and to meet evaluation requirements for funders. School districts, at no-charge, can administer the Youth Risk Behavior (YRBS) Survey to middle school and high school students on an annual or semi-annual basis. School districts are responsible for coordinating survey process and administering the survey. Districts that administer the YRBS will receive a slide presentation file (PowerPoint™) providing aggregate frequency tables and graphs, and a dataset that can be used for further analysis and interpretation. For more information on the Online YRBS go to http://sspw.dpi.wi.gov/sspw_oyrbsindex

Also see: DPI's A Guide to Conducting the Wisconsin Online Youth Risk Behavior Survey (2010) available at http://sspw.dpi.wi.gov/files/sspw/pdf/oyrbsguide.pdf

What We Know: Health Outcomes State Health Plan Objectives

Healthiest Wisconsin 2020: Everyone Living Better Longer was designed to articulate a vision of public health and state goals and objectives for the next 10 years to achieve the vision of healthy people in healthy communities in Wisconsin. The plan is available at: http://www.dhs.wisconsin.gov/hw2020/index.htm. Based on statewide rates, Wisconsin tends to have lower rates of risky sexual behaviors and negative health outcomes than the national averages. Nevertheless, some rates are unacceptably high. High-risk sexual behavior, including high-risk sexual behavior of adolescents, is one of the 11 health priorities identified by Wisconsin's state health plan. The objectives related to adolescents and sexuality are as follows:

Objective 1: Adolescent Sexual Behavior—Percentage of sexually active high school students who report that they or their partner used a condom during last sexual intercourse.

Objective 2: Health Policies that Improve Equity in Sexual Health-Comprehensive sexuality education taught in schools.

Objective 3: Reduce Disparities in Reproductive and Sexual Health—Reduce the racial and ethnic disparities in teen birth rates. Reduce incidence rates of HIV in sexual minority populations, particularly young men who have sex with men. Reduce disparities in education as they relate to sexual behaviors.

Because of the public attention and public health commitment to these objectives, school districts have public health partners in their communities who are also interested in implementing effective programs to reduce the number of young people engaging in high-risk sexual behaviors.

Data Available on these Objectives

Teen Pregnancies/Birth Rates
http://www.dhs.wisconsin.gov/births/

Sexually Transmitted Infections
http://www.dhs.wisconsin.gov/communicable/STD/Statistics/WisconsinAdolescents.htm

HIV/AIDS
HIV Among Youth—National Data
http://www.cdc.gov/hiv/youth/index.htm

Joint Data Report: Youth Risk Related to HIV, Pregnancy and STDs
http://www.dhs.wisconsin.gov/aids-hiv/Stats/09YouthSexBehaviorUpdate.pdf

See Resource 3.2 Surveys of Adolescent Sexual Attitudes and Behaviors

What We Know: Youth Development

In addition to health behaviors and health outcomes, it is useful to assess the extent to which young people develop assets and competencies that help them avoid problem behaviors. According to increasing youth development literature, youth develop competencies, resiliencies, and assets when they have sufficient support and opportunities from families, other caring adults, schools, and communities. A number of instruments to measure youth development indicators are listed in the Youth Development Measures resource included at the end of this chapter.

See Resource 3.3 Youth Development Measures

What We Know: Special Populations
Sexual Minority Youth

Limited data exist about the experience of lesbian, gay, and bisexual (LGB) youth, including their knowledge, attitudes, perceived support, risk behaviors, and health outcomes. Many people are unaware of ways in which school and community environments affect LGB youth, including lower self-esteem related to harassment. In 2011 extensive analysis on LGB youth was done utilizing state level Youth Risk Behavior Data. The report and findings can be found at http://www.dhs.wisconsin.gov/lgbthealth/HealthReports/index.htm

Health Outcomes

Many LGB youth face environments in which they experience verbal and physical abuse related to real or perceived sexual orientation. Some LGB youth

are at particularly high risk for negative health outcomes, including substance abuse, suicide, teen pregnancy, and other negative health outcomes. Fortunately, some evidence shows that when environmental and social supports are provided, differences in rates of negative health outcomes between LGB youth and their heterosexual peers diminish or disappear (Safren and Heimberg, 1999).

Young gay men, or men who have sex with other men, are at particularly high risk for HIV transmission. This health disparity is particularly noticeable and unacceptable among young men of color who have sex with men.

Inclusive school-based HGD programs provide an opportunity to reach all youth, including young gay men, and other special populations that experience disparities in sexual health outcomes before risky behaviors are initiated or established.

References

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Children and Youth with Disabilities

All children, including children with emotional/behavioral, physical, cognitive, communication, or learning disabilities, need accurate information to learn about their developing sexuality. In addition to learning about physical changes they will experience, children and youth will benefit from opportunities and support to develop social skills, respectful and meaningful relationships with other people, and other relevant life skills related to sexuality. The type and onset of the disability may affect the way in which information is most effectively presented as well as the type of information presented. For example, children and youth with learning or cognitive disabilities may need information presented in small amounts, and in concrete ways. A child with a physical disability may need specific information about how the physical disability affects his or her expression of sexuality.

Numerous challenges may influence the process of learning about sexuality and the sexual development of children and youth with disabilities. Cole (2001) explains:

> In many situations, chronological age of the child will not be consistent with the maturational or emotional age. Many factors can influence this delay—mobility limitations which require a great deal of physical assistance in all or many activities, lack of privacy, including the area of personal hygiene, and other daily living experiences which can interfere with spontaneous learning about sexuality. …A congenitally disabled child can experience a great lack of privacy due to excessive personal care

> needs and perhaps unrealistic assistance or protection from family who wish to protect the child from emotional injury by an insensitive society. The child may experience isolation from peers because interaction takes organization, planning, effort, and assistance. Mobility limitations and lack of privacy are significant factors in alerting or limiting natural sexual development, education, and values. [p. 6]

There are a number of reasons why sexuality education for students with disabilities has been neglected. Some reasons may include the belief that these students do not need to know about sexuality because they will not have sex, the belief that these students will not understand the information, and the myths that people with disabilities are not interested in sex or cannot experience intimacy. In addition, some parents may be more protective of a child with a disability than a child without a disability. This may result in the parent inadvertently or intentionally providing fewer opportunities for their child to develop and practice social skills related to relationships and sexual situations, potentially leading the child to misinformation on developing healthy relationships. Schools have an important role in developing and delivering HGD instruction to meet the needs of their students with disabilities.

The research literature provides parents with recommendations on how to talk with their children with developmental disabilities This information is also useful for school staff members. One researcher advises (McLaughlin, 2003) the following:

- You may have to initiate the conversation.
- Give age-appropriate (based on the child's biological age) information in a way that the child will understand.
- Take advantage of "teachable moments."
- Simplify your responses and add more information as the child continues to be interested.
- Be patient and provide multiple opportunities to reinforce concepts and skills.
- Find ways to be concrete when teaching the topic.
- Try not to overreact to shocking questions or inappropriate behaviors.
- Provide for practice in a safe setting.
- There's nothing wrong with being embarrassed, and there's nothing wrong with telling the child that you're embarrassed.
- You don't need to know the answer to every question because together you can research the answer.

- If you're thrown by a question, you have the right to answer it later.
- You have the right to pass on personal questions.
- Make sure your words and body language provide a consistent message.
- Ask the child for their opinion.

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Children and Youth who are Homeless

Homeless children and youth have been defined as individuals who lack a fixed, regular, and adequate nighttime residence. This includes children and youth who are away from home at least one night without the permission of parents, guardians, or custodial authorities; young people who move from one friend's home to another ("couch surfers"); children and youth who have been told or forced to leave home or deserted by parents or guardians ("throwaways"); children and youth who have run away from home ("runaways"); youth who manage to live for an extended time on the streets ("unaccompanied youth"); and children and youth whose families are homeless.

Violence affects the lives of many young children experiencing homelessness. There are serious emotional effects for children experiencing violence. These

children tend to be more aggressive, antisocial, fearful, and have higher levels of depression and anxiety compared to children who have not experienced violence. Children exposed to violence also have a greater acceptance of using violence as a means for resolving conflict (4). Exposure to violence has an impact on the sexual attitudes of children from homeless households.

The primary causes of homelessness among youth are physical or sexual abuse by a parent or guardian, neglect, parental substance abuse, and family conflict. Sexual abuse is common, with estimates ranging from 20 percent to 50 percent of homeless youth experiencing this form of maltreatment and 40 percent to 60 percent report being physically abused (3). Other reasons include parental disapproval of pregnancy, parenting status, sexual orientation, gender identity, school problems, and drug or alcohol use (5).

Youth who live on the street are at high risk for numerous negative physical and emotional health outcomes. These include malnutrition, sexually transmitted infections, HIV infection, unwanted pregnancies, drug and alcohol abuse, robbery, and sexual and physical assault. They are also at high risk for psychological disorders, including depression, conduct disorder, and post-traumatic stress. Meeting the basic survival needs of these young people is the highest priority.

Schools can provide support services and may be the only source of stability in the life of a child or young person who is homeless. The McKinney-Vento Homeless Education Assistance Act requires each public school district to designate a homeless liaison to help identify and assist homeless families, children, and youth. It can be challenging for children and teens that are homeless to get to school, and succeed once they are there. Flexibility in school policies and procedures, provision of emotional support, and linkages to community resources are all important factors that contribute to the possibility of children and youth who are homeless remaining in school and graduating. Schools may consider providing these students with specific HGD and prevention messages tailored to their survival needs, including information about community resources.

For additional information and resources about youth who are homeless in Wisconsin, see the Wisconsin Association for Homeless and Runaway Services at www.wahrs.org

For data on homeless youth and sexual risk taking and other health risks, go to http://www.nn4youth.org/system/files/FactSheet_Unacompanied_Youth_0.pdf

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Sources for Local Data

There may organizations in or near your community that have collected local data on youth attitudes, behaviors, health outcomes, and youth development. These include the University of Wisconsin-Extension, CESAs, local public health, community-based organizations, United Way, and others. Sometimes local data is based on a convenience sample, and so caution should be used in generalizing from these studies or reports. Anecdotal evidence and qualitative data, such as summaries of youth perceptions collected through focus groups, can be important and useful supplements to quantitative data. In interpreting this data keep in mind it should not be generalized to represent all young people in the community. Nevertheless, this data can provide a valuable part of the general profile of young people in the community.

See Resource 3.4 **Adolescent Sexual Risk Behavior Prevention Needs and Assets Assessment: What Is Needs and Assets Assessments and What Are the Key Data Sources?**

See Resource 3.5 **Youth Profile for Our Community Worksheet**

Wisconsin Youth Sexual Behavior and Outcomes Report

Historically programs that address adolescent sexual health have been segmented into the consequences of risky sexual behavior, such as STDs, teen pregnancy, HIV, and the interaction of substance abuse and risk-taking behavior. However, adolescent sexual risk-taking behavior cuts across all of these areas and outcomes. Risky behaviors include early sexual debut, multiple partners, not using condoms/contraception, and drug and alcohol use prior to sexual activity.

Every two years the Department of Public Instruction (DPI) and programs at the state Department of Health Services collaborate to provide a broad perspective on the state of adolescent sexual health. This data project is unique in its examination of multiple indicators of adolescent sexual health. The report sections include data on the following:

- Sexual behaviors
- Sexually transmitted diseases
- HIV infection
- Births to teens

Information and data is compiled from multiple sources, including the state Youth Risk Behavior Survey, the Wisconsin Sexually Transmitted Diseases Surveillance System, Division of Public Health, Office of Health Informatics, Division of Public Health, Wisconsin AIDS/HIV Program, HIV surveillance system Annie E. Casey Foundation, Kids Count Data Center, and the Center for Urban Population Health. Analysis of the data addresses gender, race/ethnicity, sexual orientation, geography within Wisconsin, and comparisons to other jurisdictions in the United States. The richness of these various data systems and compiling them into one report highlights health disparities, geographic areas with higher rates, and a multifaceted approach to addressing all of these risks to adolescent sexual health.

The report also includes trend analysis and charts and graphs. Over the years of this collaboration, communities across Wisconsin have downloaded the report to utilize with citizens, school boards, parents, and students. It is available at http://www.dhs.wisconsin.gov/aids-hiv/stats/index.htm in both PowerPoint™ and PDF. The report also includes speaker notes to enable easy presentations. DPI encourages community members and health teachers alike to utilize this report to address adolescent sexual health and any specific issues that may be impacting their communities.

Surveys of Adolescent Sexual Attitudes and Behaviors

Youth Risk Behavior Survey (YRBS)—This survey is conducted every two years by the Centers for Disease Control and Prevention to assess risk behaviors of students in grades 9–12.
http://www.cdc.gov/HealthyYouth/yrbs/index.htm
http://sspw.dpi.wi.gov/files/sspw/pdf/yrbs13hsques.pdf

Wisconsin Online Youth Risk Behavior Survey (OYRBS)—This survey can be tailored to meet the needs of local schools and communities. Questions are available from the national YRBS in addition to users having the opportunity to choose different questions or submit suggestions for questions to be added to the system.
http://sspw.dpi.wi.gov/sspw_oyrbsindex

National Longitudinal Study on Adolescent Health (Add Health)—This is a national survey that examines adolescent health behaviors and other factors that influence their health. The recent survey interviewed 12,118 young people in grades 7 through 12. The recent survey can be found at
http://www.cpc.unc.edu/projects/addhealth/data

National Campaign to Prevent Teen Pregnancy's Fourteen and Younger: The Sexual Behavior of Young Adolescents—This report (2003) is based on three national and three local sets of data to provide important information about younger teens.
http://www.thenationalcampaign.org/resources/pdf/pubs/14summary.pdf

Kaiser Family Foundation's National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes, and Experiences—This is a nationally representative survey (2003) of more than 1,800 young people in three age groups: young adolescents ages 13–14, adolescents ages 15–17, and young adults ages 18–24. The survey assessed knowledge and attitudes about sexuality and sexual experience (asked only of participants 15 and older).
http://www.kff.org/entpartnerships/upload/Sex-Smarts-Birth-Control-and-Protection-Bruchure.pdf

Human Rights Campaign's Growing Up LGBT in America—HRC's report, Growing Up LGBT in America 2012, is a groundbreaking survey of more than 10,000 LGBT-identified youth ages 13–17. It provides a stark picture of the difficulties they face.
http://www.hrc.org/youth

Youth Development Measures

Youth Development Approach Researchers, Name of Instrument, Website	Features of Instrument
Communities That Care (CTC)	
• J.D. Hawkins, R. Catalano • The Youth Survey • http://depts.washington.edu/sdrg • (Social Development Research Group, University of Washington, Seattle)	• focus on adolescents' negative outcomes and their antecedents • measures have high predictive value • appropriate for culturally & socio-economically diverse populations • requires high reading level • must purchase
Resilience	
• B. Bernard et al. • Healthy Kids Resilience Module • https://www.wested.org/chks/pdf/rydm_presentation.pdf	• most rigorously tested instrument focusing on resiliency • relatively short, can be used with younger children • appropriate for culturally & socio-economically diverse populations
Search Institute	
• P. Scales, D. Blythe • Profiles of Student Life: Attitudes & Behaviors • http://www.search-institute.org/research-and-publications	• pioneering study, leading first efforts to measure external and internal assets • no published reports of psychometric properties • must purchase

Adapted from Cagampang et al. (2001).

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA (2004).

Adolescent Sexual Risk Behavior Prevention Needs and Assets Assessment: What is Needs and Assets Assessment and What Are the Key Data Sources?[1]

Introduction

Needs and assets assessment can be defined as the process of collecting and assessing data that describe the nature and magnitude of both a community's needs, as well as its resources or assets (e.g., financial, organizational, intellectual, institutional, and human), in order to facilitate program planning.

The information collected through needs and assets assessment should describe the following:

- the extent, magnitude, and scope of the problem in the community;
- current efforts to address the problem;
- gaps in existing services;
- local residents' perceptions of the problem, what causes it, and how it might be prevented; and
- current (science-based) knowledge about "what works" to prevent youths' sexual risk-taking, pregnancy, and STI/HIV infection.

Needs and assets assessment is an important first step in your program planning process because it will point toward appropriate (that is, relevant and realistic) goals and objectives for your programming efforts. In addition, depending on the methods used, it can help to inform and interest community members in your prevention or intervention program. It can also provide baseline (pre-program) data that can be used to evaluate your program's progress later on. Finally, needs and assets data are extremely useful as you develop funding proposals and seek to justify to funders why you need the resources that you are requesting.

Sources of Data

I. Data already available

- census data; city, county, and state vital statistics
- survey data on community-wide youth behaviors and experiences (e.g., Youth Risk Behavior Survey)
- research studies (reports or journal articles) on the prevalence, antecedents, and consequences of youth sexual risk-taking, pregnancy, and STI/HIV prevention *nationwide*
- research articles describing science-based best practices in preventing youth sexual risk-taking behavior, pregnancy, and STI/HIV infection *nationwide*

[1] The information in this sheet is adapted from: J. J. Card, C. Brindis, J. L. Peterson, & S. Niego. *Guidebook: Evaluating Teen Pregnancy Prevention Programs, 2nd ed.* Sociometrics Corporation Los Altos, CA:. 2001, Chapter 4.

II. Additional data and information that may already be available

- local needs assessment reports produced by other organizations in your community (e.g., nonprofits, government agencies, universities, foundations, private research organizations, or practitioner networks)
- research studies (reports or journal articles) on the prevalence, antecedents, and consequences of youth sexual risk-taking, pregnancy, and STI/HIV prevention *in your local community*
- evaluation reports on youth-focused interventions that have been conducted *locally*

III. New Data Sources that You May Wish to Tap (with Suggested Methods for Data Collection)

- opinions of key informants or experts from local public and private youth-serving organizations (key informant interviews, focus groups, surveys, community forum events)
- opinions of parents or families of adolescents (focus groups, surveys, community forum events)
- opinions of youth (focus groups, surveys, community forum events)

Part 1

What Should I Collect Information About?

The following information categories should guide your needs and assets assessment data collection efforts. The specific information that you collect should reflect the particular youth reproductive health issue(s) you would like to address, the population(s) you seek to work with, the values of your organization, and the broad prevention approach(es) that you will take (or are considering taking).

I. Youth Profile

A. General demographic and socioeconomic profile of youth and families in your target community (e.g., gender, ethnicity, age, sexual orientation, income, households below poverty, educational attainment, etc.).

_____

_____

_____

B. Statistics on sexual risk-taking behavior, pregnancies, births, STI, and HIV infection among youth in your community.

_____

_____

_____

C. Statistics on related youth and community issues (e.g., school drop-out rates, alcohol/drug use, gang violence, dating violence, single-parent households, etc.).

_____

_____

_____

D. Youth assets (e.g., positive youth values, interests, and talents).

_____

_____

_____

II. Available Community Resources Serving Youth

A. Comprehensive health and social services resources (public and private).

_____

_____

_____

B. Family planning services (public and private).

_____

_____

_____

C. School systems resources (e.g., funds to support school-based programs, district coordinator).

D. Youth development efforts (e.g., opportunities for youth to participate in sports, arts, career development activities, tutoring, mentoring, community service, etc.).

E. Concurrent teen pregnancy and youth STI/HIV prevention efforts (local, state, national).

III. Community Environment and Norms

A. Community attitudes and perceptions regarding youth sexual risk-taking behavior, pregnancy, childbearing, STI, and HIV.

B. Formal and informal policies (in schools, clinics, other organizations, and the media) that create a positive (supportive) or negative (damaging) environment for youth.

C. Funding options and possibilities (including potential sources of money, in-kind contributions, donations of equipment or materials, and volunteers) for your programming efforts.

Part 2

What Should I Do with My Needs and Assets Data?

It is helpful to use your needs and assets data to develop a brief *problem statement* that offers a succinct summary of the issues, problems, and needs facing a community. The problem statement provides the perspective needed for subsequent program planning activities.

To develop your problem statement, use your needs and assets data as well as your (and your colleagues') prior knowledge about your community to answer the following questions

1. What is your vision for your community? *Describe your vision or values stance*.
   (*Example:* "Our vision is that all youth are entitled to a healthy adolescence—free of pregnancy, STI, and HIV—as well as hope for a bright and productive future.")

   _____

   _____

   _____

   _____

2. What is the affected population that you seek to address? *Describe your target population.*
   (*Example:* "We seek to target 100 boys and girls per year, ages 14-18, who attend Southside High School in New City. This population is 60% African-American, 30% Latino, and 10% other ethnicities, mainly White.")

   _____

   _____

   _____

   _____

3. How significant is the problem? What are the consequences for teens and community members? *Provide evidence for the scope of the problem.*
   (*Example:* "In our community, 30% of young women experience a pregnancy by age 18. Among pregnant and parenting teens, the high school dropout rate is four times that of youth who do not become pregnant or parents during their teen years. Teen parents are three times more likely to live below the poverty line households than teens who are not parents.")

   _____

   _____

   _____

   _____

4. What causes the problem? *Indicate what key precursors are contributing to the problem based on reliable sources of information (e.g., youth behavior surveys, research studies), and what the gaps are between available and needed services.*
   (*Example:* "In our community, teens lack knowledge about the risks of unprotected sex and ways to protect themselves from pregnancy, STI, and HIV. In addition, they lack the communication and negotiation skills needed to decline unwanted sexual advances and to insist upon condom use if they are sexually active. They also do not have strong motivation to avoid teen pregnancy, due to a desire for 'unconditional love' from a child and a perceived lack of other options for the future. Our high school currently lacks in-school or after-school activities that address these gaps in knowledge, skills, and motivation.")

   _____

   _____

   _____

   _____

5. How should the problem be addressed? *Summarize potential solutions to the problem, based on scientific research[2] and community perspectives. Include reference to solutions that you will seek to implement.*
   (*Example:* "We seek to address the problem through a school-based program that offers teens after-school activities that build the knowledge, skills, and motivation that they need to avoid engaging in sexual risk-taking behavior. This program will include sex education and youth development approaches, and will incorporate characteristics identified in the scientific literature to be common to effective sex education and youth development programs. We will use parent/family outreach and forum activities to build support among parents/families so that they will encourage their youth to attend.)

6. How will we know the problem has been solved? *List one or two key indicators that will provide evidence of program success.*
   (*Example:* "Within three years, we will have delayed the average onset of sexual intercourse by one year and achieved a statistically significant increase in use of contraception among program participants.")

   _____

   _____

   _____

   _____

[2] Do not worry about incorporating science-based information on best practices during your initial use of this worksheet if you do not have that information readily at hand. Subsequent Institute activities will help you to further address this aspect of program planning.

Using your responses to items (1–6) above, develop a succinct, two-paragraph *problem statement* that summarizes the issue to be addressed in the community.

Youth Profile for Our Community Worksheet

Indicator	State Data	Local Data	Local Data Source
Knowledge, Attitudes, and Behaviors			
Believe it is important to delay having sexual intercourse			
High school students who have had sexual intercourse			
High school students who are currently (past three months) sexually active			
Sexually active students who use reliable form of birth control			
Sexually active students who use condoms			
Number of sexual partners among high school students			
Alcohol or other drug use among youth			
High school students who identify as gay, lesbian, bisexual			
High school students who identify as transgender			

Indicator	State Data	Local Data	Local Data Source
Health Outcomes			
Pregnancy rate among teens under age 13–14			
Pregnancy rate among teens age 15–19			
Birth rate			
Abortion rate			
Cases of STIs among youth			
Chlamydia			
Gonorrhea			
Herpes			
Cases of HIV among youth			

Indicator	State Data	Local Data Source	Local Data
Youth Development			
Supportive family			
Supportive adults			
School climate			
Other community supports			
Other youth competencies and assets:			
Internal Assets			
External Assets			

Chapter 4
Advisory Committee

Human Growth and Development Advisory Committee

4

Purpose

Wisconsin Statute 118.019 states that school districts that offer human growth and development (HGD) must have an advisory committee appointed by the school board and composed of parents, teachers, school administrators, pupils, health care professionals, members of the clergy and other residents of the school district to advise the school board on the design and implementation of the human growth and development curriculum and to review the curriculum. No one category of member shall constitute more than one-fifth of the membership of this committee, except that parents may comprise more than one-fifth, but no more than one quarter of the members may be made up of employees of the school district.

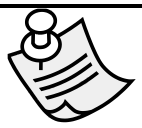
... to keep the Human Growth and Development curriculum current, a regular review of the curriculum is recommended at least every three years.

Although not included in the current statute, to keep the Human Growth and Development curriculum current, a regular review of the curriculum is recommended at least every three years. The term "develop" above can be interpreted in the broad sense of ongoing development and evolution, or it can be interpreted as designing and writing selected lessons or the entire curriculum. In some districts the advisory committee provides leadership in a significant planning process, including conducting a needs assessment of young people, developing detailed educational HGD objectives for K–12 instruction, designing and writing the curricula, presenting the curricula for recommendation to the board of education, and evaluating implementation and outcomes associated with use of the curriculum. In some districts, the advisory committee does not write the curriculum lessons, especially if the school district has a curriculum in place, which is the case for most districts. Feedback, edits, decisions on topics, and timing are all effective ways for a committee to work and develop a curriculum. In other districts, the HGD advisory committee delegates to school staff much of the developmental work, and then reviews curricula, selects curricula with the "best fit," and recommends the curricula to the board of education. In all cases, the HGD advisory committee is a critically important link between the school and the broader community.

Creating the HGD Advisory Committee

Wisconsin Statute 118.019 requires that a school district offering a human growth and development curriculum appoint an advisory committee composed of parents, teachers, school administrators, pupils, health care professionals, members of the clergy, and other residents of the school district. Remember that this committee representing a cross section of values and opinions from the

community and including individuals willing to use a consensus decision-making model should increase the likelihood that the resulting recommendations to the school board will be accepted without controversy.



Also see: *DPI's Tools for Comprehensive School Health Programs: Starting a School-Community Health and Safety Council* (2001) available at **http://sspw.dpi.wi.gov/files/sspw/pdf/health&safety.pdf** and *Running An Effective Meeting* (2001) available at **http://sspw.dpi.wi.gov/files/sspw/pdf/effectivemeeting.pdf**.

Recruitment

There are a variety of ways to recruit members for the HGD advisory committee. Regardless of whether the approach includes informal or formal invitations to apply for membership or school board invitations to serve, it is important that prospective members understand the charge to the committee and the time commitment expected of committee members. Some form of written application is useful as it provides documentation of prospective committee members' expertise or perspective. Members of the HGD advisory committee should include parents with children currently attending the district's schools, teachers, school administrators, pupils, health care professionals, members of the clergy, and other residents reflecting the community's racial and ethnic composition. The HGD advisory committee could include both a male and female student, and the students' parents/guardians will need to approve of the student's participation. Selection of advisory committee members and the committee's role and responsibilities needs to be made by the school board.

Suggested requirements for HGD advisory committee membership include the following:

- Willingness to serve and the ability to make the time commitment (ideally for at least two years).
- Effective communication skills, including listening well, and speaking in an understandable manner, especially at public meetings when emotions run high.
- The ability to be objective and open to others' ideas when making decisions and recommendations.
- The ability to control one's emotions, even when holding strong opinions about sexuality education.
- Being viewed as a respected representative of the community.
- A commitment to young people and the school's educational mission.

An example of how HGD advisory committee recruitment can occur is included in this guide.

See Resource 4.1 HGD Advisory Committee: Oconomowoc

Group Process

The HGD advisory committee chairperson should be a skillful group facilitator who is respected by members of the advisory committee and the community. This individual will be expected to conduct effective meetings of the HGD advisory committee, facilitate public meetings, make presentations to the school board, and possibly interact with the press.

Best practices suggest it is helpful for HGD advisory committee members to establish ground rules to guide their meetings. The combination of guidelines should help to create a meeting environment in which ideas are shared, individuals are respected, there is a commitment to consensus, and there is a group norm for effective use of meeting time.

Another initial task of the HGD advisory committee is to develop a policy and approach to address potentially controversial issues.

See Resource 4.2 **HGD Advisory Committee Ground Rules: Eau Claire Area School District**

An agenda distributed before the meeting is useful to encourage preparation for the meeting and to help facilitate focused discussion and decisions. Meeting frequency varies and is a function of the magnitude of the tasks at hand and the time frame in which recommendations must be made. In general, momentum diminishes when too much time passes between meetings, but sufficient time is needed between meetings to accomplish the "leg work" and other tasks needed to move the planning process along.

Stoughton Area School District's HGD advisory committee sent a letter to all committee members detailing the group's purpose and the meeting schedule to complete the review of the HGD curriculum.

See Resource 4.3 **Example of HGD Advisory Committee Purpose and Meeting Schedule: Stoughton Area School District**

See Resource 4.4 **HGD Advisory Committee: 10 Tips for Meeting Facilitation**

It is important to develop and distribute meeting notes. The degree of detail will vary, but, in general, the record of the meeting should include attendance, key discussion points, and, most important, a record of decisions made by the committee.

Another initial task of the HGD advisory committee is to develop a policy and approach to address potentially controversial issues. Advocates for Youth provide guidance for this. Anticipating potential controversy, being prepared with clear policies, and opportunities for communication are keys to working with challenging issues.

See Resource 4.5 **Managing Controversy in Pressure Cooker Situations**

Getting Down to Work

Best practices also suggest it is helpful for HGD advisory committee members to identify the steps and processes necessary to accomplish its charge. In general this includes understanding the current situation (e.g., risk behaviors, assets) and desired short-term and longer-term impacts, identifying resources, planning and developing activities, and documenting outcomes or goals. The logic model provided below illustrates as a linear flow chart the rationale for a HGD program and the program planning process. It is important to remember that in practice the planning process steps may not be as discrete or linear as presented here.

HGD Program Planning Logic Model

Current Situation ⇨	**Resources** ⇨	**Activities** ⇨	**Short-term outcomes** *knowledge, attitudes, intentions* ⇨	**Longer-term impacts**
What is the health status of children, adolescents, and young adults in our community?	What do state statutes say school districts can and cannot do related to HGD? What is the role and what are the responsibilities of the HGD advisory committee? What support do teachers need to provide effective HGD instruction?	How can the school support parents in their role as primary sexuality educators of their children? What HGD curriculum is most likely to be effective and acceptable in our community? What HGD curriculum is most likely to promote healthy behaviors and prevent risky behaviors?	What do our students know and what can they do as a result of HGD instruction? To what extent does youth behavior promote health or reflect health risks?	What is the health status of children, adolescents, and young adults in our community?

1. **Describe Current Situation and Identify Desired Short-term Outcomes and Longer-term Impacts**

   Describing the current context in which young people are developing, and articulating the desired knowledge, behaviors, and health outcomes of young people provides a foundation for HGD program development. This stage includes developing or reviewing background information about young people in the state and district, including trends in sexual risk behaviors such as information included in the Profile of Wisconsin Youth section of this resource packet.

2. **Identify Available Resources and Statutory Guidance**

   Identify available school district and community resources, as well as HGD statutes (see Chapter 2) that are integral for developing a HGD program. What support will HGD teachers need to provide effective instruction?

   See Resource 4.6: Envisioning the Future of Sex Education—A Toolkit

3. **Plan HGD Program Activities**

   There are many components to this important step in the planning process.

   a. **Develop Position Statement.** As a foundation for the actual curriculum development and planning, it is useful for the HGD advisory committee to develop a position statement or belief statement about sexuality education in the district. Two examples are provided below.

   Sample Belief Statement (American School Health Association, 2003, p. 10)

   - Parents are the primary teachers of sexuality education, and the best place for discussion to provide the values and religious preferences of the family is in the home. Schools need to instruct curriculum in a manner that encourages communication between students and parents.
   - Every decision has positive or negative outcomes, some of which can result in serious consequences. For students to make responsible decisions regarding sexuality, they need accurate information, respect for others, and a framework of values.
   - Abstinence prior to marriage is the healthiest choice for physical, emotional, social, and spiritual well-being.
   - Sexuality is a natural and healthy part of living.
   - Sexual relationships should never be coercive or exploitative.
   - Sexuality education is a lifelong process that begins in the home and family.
   - Sexuality education includes formal education programs as well as the informal learning that comes from the influence of peer groups, cultural heritage, messages of the media, advertising, religious teachings, and daily exposure to custom and changing technologies.

Sample HGD Mission Statement (Grades K–12): Stoughton Area School District (2005)

> Human Growth and Development is one part of the district's health curriculum.
>
> Stoughton's human growth and development curriculum is based on abstinence* and is designed to help students
>
> 1) Understand their growth, development, and sexuality
>
> 2) Develop a positive self-concept
>
> 3) Acquire factual knowledge, skills, attitudes, and values that result in behavior that contributes to the well-being of the individual in connection with their family as they develop strategies for responsible decision-making.
>
> *A human growth and development curriculum based on abstinence emphasizes the value of abstinence but also includes information on contraceptives at specified grade levels.

b. **Develop Statement of Implementation Guidelines.** A related document is a Statement of Implementation Guidelines to identify and describe decisions and approaches upon which the HGD program is based. This written document serves as a summary statement about the HGD program for administrators, school staff involved in HGD instruction, and other interested parents and community members.

See Resource 4.7 Milwaukee Public Schools HGD Implementation Guidelines

c. **Identify Topics for Inclusion in Curriculum.** As the HGD advisory committee begins the process of determining what topics should be addressed at what grade level in their particular district, they may wish to survey or hold focus groups with parents and/or students. Both formal and informal surveys can provide guidance on ways in which parents would like the school to support them in their role as primary sexuality educators of their children.

Hearing parental reactions, support, and concerns provides an informal way in which an on-going needs assessment can be conducted.

See Resource 4.8: MPS Parent Survey about Scope and Sequence of HGD Topics

d. **Adopt Curriculum Review Criteria**. Before the HGD advisory committee begins the process of reviewing curricula, it is helpful for committee members to adopt curriculum review criteria to guide discussion and decisions about curricula to be used in the district. Suggested curriculum review criteria are provided in the Effective HGD Curriculum and Instruction chapter. Some school districts include HGD instruction as part of comprehensive school health education, and others

address HGD as a discrete unit of instruction. In either case, the HGD advisory committee may be reviewing packaged curriculum, curriculum developed locally, or some combination. More guidance and resources for this critical step are included in Chapter 6 of this resource packet.

e. **Review curriculum or develop curriculum.** When developing a curriculum it is important to consider the background, skills, and knowledge of those responsible for writing the curriculum. Usually the primary curriculum writers are the content specialists within the district, which would include teachers and curriculum coordinators who have formal professional preparation in curriculum, instruction, and student assessment. The level of involvement in the actual writing of new or revised lessons can vary greatly among advisory committees because the professional expertise of advisory committees can also vary greatly. Delegation of the writing responsibilities is a decision to be made by the school district.

f. **Obtain additional feedback.** The HGD advisory committee may present the proposed recommendation to the community and parents for additional feedback prior to making its recommendation to the school board for approval. Community support is a critical component for sexuality education in the schools, and the time and energy required to develop and maintain positive public relations is a sound investment.

g. **Make recommendation.** The HGD advisory committee recommends adoption of a HGD curriculum to the school board, which has ultimate responsibility for curriculum adoption. Usually the HGD advisory committee chairperson makes a verbal and written presentation to the school board, and members of the advisory committee respond to questions.

h. **Continue communication about the HGD program.** Throughout the process (as well as after a decision to adopt a particular HGD curriculum has been made) it is important to communicate with parents and to keep the school board apprised of progress. Even after decisions have been made about the curriculum, HGD advisory committee members may continue to be involved in fostering communication about the curriculum. For example, members of the HGD committee could participate in the process by which parents have the opportunity to review the instructional materials. Hearing parental reactions, support, and concerns provides an informal way in which an on-going needs assessment can be conducted. Sometimes parental objections to the curriculum may occur because parents have not had an opportunity to thoroughly review and discuss the curriculum. A respectful exchange where parents are comfortable sharing their concerns and the local school district has an opportunity to explain why they think this is an important curricular area and the basis for decisions about curricular content will enhance the likelihood of parent acceptance of the curriculum. There are

numerous ways to foster communication with parents, and specific strategies are discussed in Chapter 5 of this resource packet.

i. **Support staff development.** Following selection of a curriculum, it will be important to provide staff development opportunities for teachers who will be involved in teaching human sexuality.

Short-Term Outcomes and Longer-Term Impacts

The HGD advisory committee can recommend that data be collected about the knowledge, attitudes, and skills students develop as a result of the HGD curriculum. In addition to monitoring these short-term outcomes, the advisory committee can update the profile of the health status of children and youth in the community to ensure that the HGD curriculum is addressing the needs of youth. In this way, there is not only information about the effectiveness of the HGD curriculum and instruction, but also an on-going needs assessment to guide future review and revision of the HGD curriculum for the district.

Also see DPI's Health Literacy Performance Assessments CD: 2004–2005 Edition. Included on the CD are performance assessments for Alcohol & Other Drug Use Prevention, Character Education, Community Health, Consumer Health, Driver Impairment, Environmental Health, Food Safety, HIV/AIDS Prevention, Mental & Emotional Health, Nutrition & Dietary Behavior, Personal Health, Physical Activity Promotion, Sexuality & Family Living, Suicide Prevention, Sample Unit on Suicide Prevention, Tobacco Use Prevention, Unintentional & Intentional Injury Prevention, Appendix. The CD is available from the DPI Student Services/Prevention & Wellness team and can be ordered by calling 608-266-8960 or send an email request to sspw@dpi.wi.gov.

References

Future of Sexuality Education (2010). Envisioning the Future of Sex Education: A Tool Kit for States and Local Communities http://165165www.futureofsexed.org/component/content/article/1663-fose-toolkit

American School Health Association (2003)

HGD Advisory Committee: Oconomowoc

Human Growth and Development Committee Background Information from the Oconomowoc School District

According to state statute, our school board appointed a 22-member community advisory committee to develop a human growth and development curriculum. In order to follow state statutes and to ensure that our community is well represented on the committee, the school district health coordinator:

1. Contacted the PTO/PTA organizations at each of the district's schools and asked them to provide committee members from their school who would report back to those parents.
2. Contacted the Ministerial Association and asked them to provide a committee member from the clergy.
3. Sent notices out to all elementary teachers to ask for representatives from each grade level.
4. Requested that the health teachers from middle and high school participate on the committee.
5. Contacted district student services and asked that at least one guidance counselor participate on the committee.
6. Contacted district administrative council and requested representation.
7. Requested that the district nurse be on the committee.
8. Contacted the local medical association and asked them to provide a health care professional for the committee.
9. Contacted the high school student services and asked them to provide a list of students (juniors or seniors) who would be candidates for committee membership. Those students were then contacted for committee membership.
10. Contacted local papers to "notice" the formation of this committee and to ask anyone interested to contact the superintendent for committee membership.

This committee developed the objectives for the curriculum and the grade levels at which the objectives should be covered. The meetings were publicly noticed and time was allotted at each meeting for public input.

The school board adopted the curriculum as presented and directed the health coordinator to implement the objectives. Local teachers from each grade level met and developed the actual lessons and materials needed for each grade.

HGD Advisory Committee Ground Rules

Eau Claire Area School District

1. One speaker at a time.
2. Confidentiality.
3. Silence equals consent.
4. Address the issue not the person.
5. Respect/honor others' opinions.
6. Disagree without being disagreeable.
7. Members who leave the committee can be replaced.
8. Time limits are set for meetings (two hours maximum).

Example of HGD Advisory Committee Purpose and Meeting Schedule

Stoughton Area School District

Committee Purpose

(1) Review the present human growth and development grade level objectives and make recommendations for changes. Grade level objectives address (a) issues surrounding sexuality to include physical/emotional changes, sexual intercourse, birth control, pregnancy, and childbirth, (b) communicable diseases including sexually transmitted diseases, and (c) protective behaviors including prevention of sexual abuse.

(2) Review parent notification procedures and make recommendations for changes.

(3) Draft recommendations to be presented to the School Board.

Meeting Schedule

Tuesday, May 18, 4:00 – 5:30 pm

- Time for public comment
- Time for questions/discussion regarding prior material distributed
- Review, discuss, reach consensus
  - Mission statement
  - Partnerships with parents/guardians
  - K–3 guidelines
  - 4–12 guidelines
- If time permits, begin grade level objective review

Thursday, June 3, 4:00 – 5:30 pm

- Time for public comment
- Review, discuss, reach consensus on K–12 grade level objectives (Work in 4 groups: K–3, 4–6, 7–8, high school—consensus will be reached first in small groups, and the K–12 discussion will occur and consensus will again be reached.)

Tuesday, June 15, 4:00 – 6:00 pm

- Time for public comment
- Review, discuss, consensus on parent exemption from Human Growth & Development
- Plan for Board presentation

Tuesday, June 29, 4:30 – 6:00 p.m.
Remaining business

HGD Advisory Committee: 10 Tips for Meeting Facilitation

1. Be clear about the purpose of the meeting, and set an agenda based on the purpose.
   - To inform—to get or give information.
   - To form—to make a decision or to solve a problem.
   - To perform—to complete a task.
   - To conform—to maintain a routine.
2. Be prepared.
3. Start and end meeting on time.
4. Establish group guidelines or working agreements for how the meeting will function.
5. Assign procedural tasks (e.g., recorder, timekeeper).
6. Facilitate discussion, and as the facilitator, maintain neutrality.
7. Make decisions, recommendations, and/or assign tasks.
8. Refer tasks to committees when appropriate.
9. Bring closure to the meeting.
   - Summarize without introducing new ideas.
   - Schedule next meeting.
10. Follow-up with substantive and procedural tasks (e.g., distribution of minutes via mail or email).

Adapted From

Anderson K. *The Busy Manager's Guide to Successful Meetings*.
GLSEN. *The GLSEN Jump-Start. A How-to Guide for New and Established GSAs*

Managing Controversy
in Pressure Cooker Situations

STRATEGIES FOR ORGANIZATIONAL SUCCESS

Rights. Respect. Responsibility.

INTRODUCTION

Most teen pregnancy prevention organizations, sex education teachers, and reproductive health advocates face controversy and conflict at some point in time. During such controversy, we and our organizations may be closely scrutinized and questioned, put on the defensive, challenged, or attacked. To address conflict effectively, we need to anticipate and strategize. This handout identifies some common 'pressure cooker situations' and offers suggestions from the field on how to aproach them.

PRESSURE COOKER #1: THE PUBLIC HEARING

Our community coalition is trying to get an evaluated sex education curriculum approved for use with tenth graders in local public high schools. We have tried to avoid a public hearing because we know that such meetings are usually unproductive. They tend to draw people on the extremes, heighten emotions, and end in deadlock.

Despite our attempts to keep a low profile by working 'under the radar' with the curriculum committee, a small and vocal group of parents actively opposes our efforts. We now realize that a public hearing is inevitable. What steps can we take to ensure that the school board and community members hear our position? We can:

- Meet with representatives of the school board prior to the hearing and ask that the school board take the following measures to ensure an effective meeting:
  - Schedule a 90 minute hearing (Otherwise, the debate could go on for days!);
  - Have security available;
  - Ask speakers to sign a roster;
  - Allow only persons to speak who live in the county and/or who have children in the public school system;
  - Give each speaker a maximum of two to three minutes, a time limit established before the hearing;
  - Allow each speaker only one opportunity to speak;
  - Keep a stop watch and stick to the designated time.
- Ask influential, supportive people in the community (such as physicians, ministers, and PTA officers) to speak on behalf of the issue;
- Encourage supporters to arrive early and to fill the front rows;
- Ask articulate young people to speak about students' needs;
- Prepare press kits and develop sound bytes for the media.

PRESSURE COOKER #2: REQUESTS TO CONSIDER ALTERNATIVE MATERIAL

A health teacher in a local public high school recently contacted us for help. He explained that he is responsible for teaching family life education for 10th and 12th grade students. He teaches a science-based, evaluated curriculum that was approved several years ago after a lengthy review process. Recently, a group of parents sent him a new curriculum, with a letter firmly requesting that he introduce the material in the upcoming semester. The curriculum has not yet been evaluated. To help him respond in an effective manner, we give him the following advice:

- Accept the materials graciously. Contact the parents to let them know that you will review the materials over the next two weeks. Then, they can follow up with you during a specified period of time.
- Describe why the current curriculum was selected and explain the school's process for accepting new material. Explain that new material must meet specific criteria and competencies and must be approved by an advisory committee.
- If the group continues to press, ask one representative to meet with you in person. Explore with that person the parts of the curriculum that are acceptable. Then talk about unacceptable or questionable material.
- If the group still continues to press, take the request to the curriculum advisory committee along with your own research and findings regarding it.

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Build support among your allies on the board. Don't go out on a limb by yourself.

PRESSURE COOKER #3: THE DIFFICULT BOARD MEMBER

Most members of the board of our teen pregnancy prevention organizations clearly support the organization's governance, philosophy, mission, fund-raising efforts, and strategic direction. However, one member consistently challenges decisions and frequently undermines the work of individuals and committees. As the new president of the board, I learned from other board members that this member threatened in the past to 'go public' with his concerns. I realize that I have inherited a 'pressure cooker' situation that I must address. What can I do?

- Establish rules for the board and its committee. Rules should spell out:
  - Who can speak on behalf of the group;
  - How members should offer input and participate in dialogue;
  - The use of the democratic process and majority vote;
  - The use of anonymous voting procedures when the group is deadlocked.
- Establish operating policies for rotation and replacement of members.
- Screen new candidates for the board to ensure they will: be representative of the community; participate in constructive dialogue; and respect the democratic process.
- On controversial issues, talk with members individually to make sure you have the votes you need before you call the question. Build support among your allies on the board. Be sure that you don't go out on a limb by yourself

PRESSURE COOKER #4: THE MEDIA

Our community coalition is making a concerted effort to build public support for science-based prevention efforts in the community. We have seen professional colleagues sometimes misrepresented and misquoted in local television interviews and newspaper articles. Rather than simply reacting to community controversy when it arises, we know that we are more likely to be successful if we are proactive. We decide to develop a public relations plan and approach the media strategically. Where do we start? We:

- Anticipate when reporters will call by monitoring their interests, beats, and concerns.
- Train spokespersons and decide who will best handle the media in a given situation.
- Avoid putting teachers in the position of having to speak on behalf of a curriculum.
- Prepare to address various controversial topics. We develop a set of note cards with sound bytes. We practice our response.
- Ask supporters to be visible and vocal at public hearings.
- Develop good working relationships with local media representatives. We talk with them often, not only for interviews but to offer background and assistance with research.
- Respect reporters' deadlines and are careful to give them accurate quotes and verifiable facts.
- Use various strategies to educate the media about our key issues. We provide press packets, hold press events, and request individual interviews, as appropriate.
- We talk to reporters when we have not been asked to respond to misrepresentations by the opposition. At the same time, we honor reporters' responsibility to cover both sides of the issue.

PRESSURE COOKER #5: THE POWERFUL POLICY MAKER

Our community teen pregnancy prevention coalition focuses primarily on consumer education, professional training, and program development rather than on advocacy and policy work. Yet, we know that elected officials play a powerful role in supporting or opposing state and local teen pregnancy prevention efforts. We have seen politicians change laws regarding young people's access to health services. We have seen them enact new laws that undermine minors' rights. We have watched our school board vote for a so-called 'family life education' curriculum that provides inaccurate information and uses fear to discourage sexual risk behaviors. We have watched our governor slash prevention funding and/or veto a bill that would fund integrated programs.

Now, we realize that we will be more effective if we combine our current efforts with advocacy. We are ready to be vocal advocates for young people. How can we work within the political process to make a difference? We can:

- Determine what types of policies will help reduce teen pregnancy in our state and community. For example, what types of laws, policies, and regulations are needed to ensure that teens have complete and accurate information about their sexual health? Have access to confidential and affordable reproductive health services? Have the opportunity to participate in youth development opportunities from tutoring, to after-school programs, to job training?

- Determine which decision-making bodies or elected officials are responsible for these policies.
- Mount a carefully constructed campaign to educate policy makers, media and the public about the importance of comprehensive sex education and unrestricted access to health care. Educating elected officials *before* there is controversy is the best way to ensure their support when controversy arises.
- Identify knowledgeable people who are committed to science-based programs, including comprehensive sex education. Encourage them to run for the school board, county or city commission, and state legislature.
- Recruit people to our coalition who have access to these elected officials.
- Get involved as private citizens in campaigns by making contributions; working actively in the campaigns; and speaking out on the priority issues.

PRESSURE COOKER #6: GROUPS OPPOSED TO SCIENCE BASED APPROACHES AND PROGRAMS AND TO COMPREHENSIVE SEX EDUCATION

In recent years, a small, yet vocal group of advocates has grown to be a significant force in our community. This group opposes comprehensive sex education in schools. It also opposes confidential reproductive health services for teens. The group is often visible in the media and often misrepresents our positions and goals. We must address the group and the controversy head on. Where do we start? We can:

- Learn about the opposition.
    - Get on the group's mailing list so we can monitor its activities and claims.
    - Attend the group's meetings so we will know who participates and what issues they represent.
    - Develop a working relationship with at least one leader from the group.
- Do our homework.
    - Offer accurate information and valid points when rebutting opposition arguments, whether in print or at public meetings.
    - Present credible research and data on youth's risk behaviors; community polls and surveys; and program evaluations.
- Have a strategy plan to help us deal with potential controversy.
    - Develop and maintain a readily available group of spokespeople and supporters.
    - Create a telephone tree so we can mobilize our supporters quickly.
    - Have a small committee that can troubleshoot in crisis situations and respond on behalf of our supporters.
- Avoid public confrontations.
- Work together to support our issues.
    - Insist on negotiating and identifying common interests. Reach decisions that the majority supports.
    - Develop a strategy that helps us to handle personal attacks and to support the one attacked.

Preparation is key to managing controversy. By anticipating our own 'pressure cooker' scenarios and developing our own strategic responses, we can be effective in handling these difficult situations!

Written by Barbara Huberman,RN, Med; Tom Klaus, MS; and Tanya Gonzalez, MPH; © 2008 Advocates for Youth

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Talk with local media representatives often, not only for interviews but to offer background and assistance with research.

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MISSION

Established in 1980 as the Center for Population Options, Advocates for Youth champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health. Advocates believes it can best serve the field by boldly advocating for a more positive and realistic approach to adolescent sexual health.

OUR VISION: THE 3RS

Advocates for Youth envisions a society that views sexuality as normal and healthy and treats young people as a valuable resource.

The core values of Rights. Respect. Responsibility.® (3Rs) animate this vision:

RIGHTS: Youth have the right to accurate and complete sexual health information, confidential reproductive and sexual health services, and a secure stake in the future.

RESPECT: Youth deserve respect. Valuing young people means involving them in the design, implementation and evaluation of programs and policies that affect their health and well-being.

RESPONSIBILITY: Society has the responsibility to provide young people with the tools they need to safeguard their sexual health, and young people have the responsibility to protect themselves from too-early childbearing and sexually transmitted infections (STIs), including HIV.

SOME RELATED PUBLICATIONS FROM ADVOCATES FOR YOUTH

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Envisioning the Future of Sex Education

A Tool Kit for States and Local Communities

FoSE
Future of Sex Education
www.FutureofSexEd.org

Prepared by Danene Sorace, MPP, Consultant to Future of Sex Education Project, led by Advocates for Youth, Answer and the Sexuality Information and Education Council of the U.S. (SIECUS) | March 2010

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answer
sex ed, honestly

SIECUS
Sexuality Information and Education Council of the United States

Contents

Overview	5
Background	5
Getting Started	6
Sample Invitation	7
Conducting the Meeting	8
Sample Agenda	9
After the Meeting	11

Overview

This tool kit outlines a strategic planning process designed to assist state and local advocates interested in advancing comprehensive sexuality education in America's public schools. The process outlined in this tool kit is based on a two-day strategic planning meeting that was held in December 2008 as part of the Future of Sex Education (FoSE) Project and created in response to inquiries from sexuality educators and advocates to implement something similar in their state/community.

The Future of Sex Education Project began in July 2007 when staff from Advocates for Youth, Answer and SIECUS first met to discuss the future of sex education in this country. At the time, each organization was looking ahead to the possibility of a future without federal abstinence-only-until-marriage funding and simultaneously found themselves exploring the question of how best to advance comprehensive sex education in schools.

In May of 2008, Advocates, Answer and SIECUS formalized these discussions with funding from the Ford, George Gund and Grove Foundations, and the FoSE Project was launched. It was decided then that the purpose of the project would be to create a national dialogue about the future of sex education and to promote the institutionalization of comprehensive sexuality education in public schools. Public schools were specifically chosen because they represent venues at which most young people can be reached.

Subsequently, *The Future of Sex Education in America's Public Schools* report was released. This report represents the culmination of interviews and/or written comments from over 75 individuals in response to a draft document of the same name and a two-day planning meeting held in December 2008. That meeting, attended by 40 individuals from a variety of organizations and funding institutions, resulted in the foundation of a strategic framework for implementing effective sexuality education programming in public schools nationwide.

Currently, there is a lot of exciting work happening around the country in support of sex education – even in the midst of significant economic challenges. Recognizing that work at the state and local level is absolutely essential in affecting change in individual classrooms, this tool kit is aimed at helping states and local/regional organizations initiate their own strategic planning process. The process described in this tool kit can be helpful in:

1. Identifying key stakeholders (i.e., public education, public health, youth development, funding communities) and building a broader coalition of sexuality education supporters.
2. Cultivating a shared understanding and knowledge by bringing these key stakeholders together.
3. Moving efforts forward regardless of what stage a state or community is in – taking action on the heels of a policy victory, seeking to advance implementation efforts already underway or preparing to initiate sex education in their state or community for the first time.

BACKGROUND

Sexuality education encompasses a broad umbrella of topic areas and activities for different age groups, audiences (i.e., parents, young people) and settings (i.e. churches, community-based organizations, schools). For the purposes of this tool kit, the focus is limited to Pre-K through Grade 12 public school students and all of the adults involved in providing sexuality education in this setting: school administrators, teachers, educators, parents, and others.

As such, the underlying goal on which this document is based is for every young person in public schools to have developmentally, culturally and age-appropriate comprehensive sexuality education in Pre-K through Grade 12.

It also assumes the following definition of comprehensive sexuality education:

> A planned, sequential, Pre-K – 12 curriculum that is part of a comprehensive school health approach which addresses age-appropriate physical, mental, emotional and social dimensions of human sexuality. It should allow students to develop and demonstrate developmentally appropriate sexual health-related knowledge, attitudes, skills and practices. The curriculum should be designed to motivate and assist students to maintain and improve their sexual health by delaying sexual initiation, preventing disease and too-early pregnancy and reducing sexual health-related risk behaviors. The comprehensive sexuality education curriculum should include a variety of topics, including anatomy, physiology, families, personal safety, health relationships, abstinence, pregnancy and birth, sexually transmitted diseases (including HIV), contraceptives, sexual orientation, pregnancy options, medical literacy and more. It should be medically accurate, and provided by qualified, trained teachers.

Getting Started

To begin a strategic planning process, it is helpful to consider the current environment, how you are going to plan and implement this process to ensure maximum participation and learning, as well as the logistics of the actual strategic planning meeting and follow-up. Here are some questions to reflect on to help get started:

1. What is the current status of sexuality education in your state, community, and/or school district? What are the existing policies and practices? Are these policies and practices in alignment with one another?
2. How committed is your state or community to improving the status of comprehensive sex education in your public schools? What are the current political, economic and educational climates? What are the opportunities for/barriers to moving forward?
3. With this information in mind, what do you hope to accomplish by conducting a strategic planning session on the future of sex education in your state/community? Your answer to this question becomes the goal of your strategic planning process. For example, it could be to develop a strategic direction that will advance implementation of school-based comprehensive sexuality education in a particular school, district, region or state. It could be limited to creating a specific policy priority or to building an infrastructure to support schools and their implementation efforts. You could decide that the goal of the planning process is to increase understanding among school administrators and staff about the existing state policy and how to build their school's capacity to meet the sex education requirements.
4. Whatever the goal, be sure to be clear in advance, include the stated goal on the meeting invitation and facilitate any meetings with that goal always in mind.

Because this should be a planning effort done in coalition with other organizations, consider the following:

1. Who are the key partners that should be involved in organizing this effort? Generally, you are likely to begin with the obvious partners for whom comprehensive sexuality education is already a priority. This may include local school staff (i.e., teachers, nurses and counselors), youth-serving organizations, local or state teen pregnancy organizations or coalitions, Planned Parenthood affiliates and/or other family planning organizations, local health departments, ACLU affiliates, AIDS service organizations or other community-based organizations. This group does not have to be more than 5-7 people.
2. Who will be serving as the convener of the planning effort? Typically one or two individuals take on this responsibility. You will need to discuss who will prepare agendas, organize meetings, take and disseminate notes, etc.
3. How will the planning group work together? Again, because this is done best when it is a coalition of groups, think about how you will make decisions. Will you vote or work toward consensus on things like the agenda and invitation list? With whom should the final decision rest should there be disagreement?
4. If you already have a coalition, how can this effort be incorporated into the existing work of that group? Should a separate coalition or working group be established in order to bring in additional partners? Can a strategic planning effort about advancing sex education in public schools be connected with an existing conference or other convening?
5. What are you going to call this effort? It could be the "Future of Sex Education in ____(fill in locale)". Perhaps it is something along the lines of "envisioning healthier students" or "promoting coordinated school health for every student." Whatever you call it, the name should reflect your goals, the current climate in your state and/or community, and what you believe will ensure maximum involvement and participation.
6. What is the scope of your efforts to advance comprehensive sex education? Will you be working at a local, regional or state-wide level? Will the plan be focused on policy/advocacy efforts or in-school implementation strategies? Knowing the answer to this will impact who should be invited to the actual strategic planning meeting.
7. Who should be invited? Given that the focus is on implementing comprehensive sexuality education in school-based settings, consider inviting the following:
   a. Relevant staff at state governmental agencies including departments of education and health and/or human services. Even if your effort is a local one, staff working at the state level can provide important networks within the state and nation-wide. For example, your state department of education's HIV/AIDS Coordinator, Curriculum Director and/or Coordinated School Health Program Manager can serve as

important connectors between the state's school districts, the department of education and Centers for Disease Control and Prevention's Division of Adolescent School Health;

b. Relevant staff at county or city health and human service departments who may be working in public schools;

c. Superintendents, principals, curriculum supervisors, teachers, school nurses and school counselors;

d. Representatives from other state or local public education related institutions. For example, your state's board of education, association of school administrators, Parent Teacher Association, state education association, or at the local level, representative(s) from the local school board;

e. Parents;

f. Students (currently enrolled in school as well as those who have recently graduated);

g. Religious/faith-based leaders;

h. Community-based organizations working to advance adolescent sexual health (i.e., a local family planning provider, Planned Parenthood or other service organization). Here are two other organizations that may or may not be relevant depending on your state/community:

   i. American Cancer Society which is working to advance school health through their National School Health Education Standards

   ii. HIV Prevention Community Planning Groups which are charged with developing a community driven plan to address HIV prevention;

i. Advocacy organizations working to advance adolescent sexual health (i.e., ACLU);

j. Community- and state-focused funders who are committed to improving public education and health outcomes for young people;

k. Researchers familiar with your state and local area (i.e., epidemiologists from the state health department, faculty at a local university, etc.).

Remember that the more people you invite to participate in the strategic planning meeting, the more challenging it may be to manage the agenda. Twenty to thirty participants is ideal.

Also, a special note about having funders participate: It is important to be clear from the beginning—to both funders and other participants—that funders are being invited to participate and not to evaluate current or potential grantees. In addition, non-funder participants should be discouraged from advancing their own organizational agendas. The goal is to create an environment in which all individuals can freely share their thoughts and ideas recognizing that the whole of the effort is greater than any one organizational agenda.

8. Revisit your stated goal from question #2. Next, determine the objectives of the meeting. At the end of the day, what do you want to have accomplished?

9. What is the agenda? A sample agenda for a one-day meeting follows. If you have more time, you can always increase the amount of time for the small groups to more fully flesh out their work.

10. Who can manage logistics? Space, invitations, registration, name tags, note taking during the event, and dissemination of notes afterwards are just a few of the logistical tasks that will need to be managed.

11. How will you cover the costs of the meeting? There are three items that may be costly—space, food and a meeting facilitator. You'll need to discuss whether any or all of these items can be donated as an in-kind contribution. If not, you'll need to prepare a budget and devise a plan to raise the necessary funds to cover these expenses.

SAMPLE INVITATION:

Envisioning the Future of Sex Ed in_____

DATE, TIME, PLACE

It is our pleasure to invite you to a strategic planning session for the future of sex education in _____ (or other name). (Names of convening organizations here) have been working together to plan this meeting which will include representatives from (select or add to list that follows): state departments of education, teachers, school administrators, policy makers, youth, funders, sexuality educators, researchers, AIDS organizations, and state coalition leaders. (See attached list of invited participants.)

The purpose of this meeting is to_____. We will address (select or add to list that follows) policy, advocacy, research, teacher preparedness and training and classroom resources. This meeting is by invitation only (no substitutes) and we hope you will join us. Should you have any questions, please contact ____ at ____.

Sincerely,

(Names of conveners here)

(Attach via email or mail a copy of the agenda, list of invited participants, registration information (form, email, number to call) and directions to the meeting facility.)

Conducting the Meeting

This sample agenda is very full. To move through the agenda in the time allotted, it is very helpful to have a facilitator. The facilitator's job is to guide the process and conversations toward the defined goal and objectives, to ensure participation, to build and maintain rapport among participants, to encourage the open expression of diverse points of view and to keep to the allotted time.

One of the most notorious ways for an agenda to get derailed is to spend too much time on introductions. It seems like a small thing, but without clear guidance from the facilitator, introductions can take up a lot of time. Ask people to simply state their name and affiliation. If you anticipate having many new people together in the room, consider sending out the list of attendees in advance so that people will at least be familiar with names and organizational affiliations. You should also make this list available to each participant as they register. You can also facilitate introductions and build rapport by inviting people to come early for a meet-and-greet over a continental breakfast, by encouraging them to network during lunch, by asking them to reintroduce themselves (quickly) when they get into their small groups, and by having everyone state their name/organizational affiliation each time they address the large group.

Registration can be "self check-in," meaning participants can pick up their name tag and materials for the day. Again, materials should include a list of participants, as well as the agenda and any speaker handouts.

The meeting space should allow for large group discussion as well as areas for break-out groups. Groups will need plenty of flip chart paper, markers, and masking tape. Having extra pens and notepads is also a good idea.

At the end of the meeting, allow a few minutes for participants to complete an evaluation form. Here are some sample sentence stems you can have participants complete on your evaluation:

- The most valuable part of this meeting to me was…
- I wish that…
- I still have questions/concerns about…
- Beyond the report of today's meeting, I'd like the next step in this process to be…
- Something I'd like the meeting conveners to know is…

SAMPLE AGENDA (ONE DAY MEETING)

45 minutes Welcome, Introductions and Focusing or Ice Breaker Activity

15 minutes Goal, Objectives and Agenda for the Day

1 hour Current Environment around Sexuality Education

This portion of the agenda is important for laying the foundation for the remainder of the day. Depending on the scope of your efforts, you may decide to ask some of the participants to share their perspectives as part of a panel format. Here is one example of how you might organize this section of the agenda:

Speaker 1: National – What is happening at the national level? Consider inviting a representative from Advocates for Youth, Answer or SIECUS to provide an overview.

Speaker 2: State – What is happening at the state level? This should, at a minimum, include an overview of any state law or mandate (or pending legislation) pertaining to sex education, content standards for health and/or sexuality education, teacher certification and/or professional development requirements, etc. From an implementation perspective, it should include any information you have about what school districts presently are teaching in sex education, including the age at which specific topics are being taught, and the background of the professionals who are teaching those topics.

Speaker 3: Local – What is the curriculum or what are the materials being taught in your local schools? Who are the key supporters of sex education? What local data do you have?

Speaker 4: Opportunities for and barriers to for moving forward. In terms of opportunities, are there key partnerships in place, frameworks for advancing implementation (i.e., existing curriculum, training mechanism, etc.)? Barriers should address the funding climate, public support (real and perceived), opposition groups/individuals that may become mobilized, etc.

30-45 minutes Small Group Set-Up

Decide how you want to break into smaller groups and what the task of each small group will be. Here are three suggestions for how to accomplish this:

1. Building from the discussion about opportunities and barriers, prioritize and rank the opportunities and barriers to determine the topics to be discussed in small groups. For example, an opportunity could be an existing policy in support of sex education. A small group could begin deliberating about how to build on this opportunity and strengthen it. A barrier may be lack of school administration support. Another small group could come up with some realistic strategies for overcoming this barrier. Keep in mind that it is okay if a priority is identified for which the group needs more information. In this case, the job of the small group will be to come up with the relevant questions, a process for answering them and a procedure for how they will report back to the group.

2. Divide the group into smaller groups by "essential elements" including:

    a. Advocacy, including administrative (i.e., pushing for implementation of existing laws/regulations), grassroots community mobilization and legislative

b. Implementation, including teacher training, curriculum and resource development, and capacity-building

c. Funding, including public and private sources of support

3. Divide into smaller groups by first identifying possible interventions. These could include introducing legislation, expanding standards to include sexuality education, building a cadre of trainers to build capacity of teachers to deliver sexuality education effectively, and so on. After making a list of possible interventions, assign each small group one intervention. If there is a longer list of interventions, charge the group with prioritizing them and divide into smaller groups accordingly.

Regardless of how you organize the small groups, there should be no more than four or five small group discussion topics/goals. Also, small groups should comprise a mix of participants. It would be easy, for example, for the educators to migrate toward the school-based implementation group. Including a teacher, however, in a discussion about advocacy could benefit those who are more familiar with advocacy than with implementation. To do this effectively, consider assigning people to groups in advance denoting (with a number on their name tag, for instance) whether they represent an advocacy group, implementer, funder, researcher, etc. When it comes time to break into small groups, it will be easier to make sure that these groups have a diverse representation of viewpoints and experiences.

LUNCH (30 minutes)

1 hour Small Group Discussions and Information Synthesis

It helps to provide some guidance to each group about what they will need to report on at the conclusion of their time together. These reports could include things like key objectives for the short-, mid- and long-term, issues that need further investigation, indicators and measures of success, potential partners, etc.

1+ hour Small Group Report Outs

It is important to be clear in advance what you want the small groups to report on. For example, you may consider asking each small group for their top five prioritized actions or recommendations.

30 minutes Next Steps & Closure

It is essential to leave this meeting with a clear sense of next steps, the identification of who is responsible for completing those next steps, how you will communicate with one another (i.e., via a listserv), when you will convene again, etc.

After the Meeting

As soon as possible after the meeting, send out a summary of the day. You do not need to worry as much about documenting each part of the day, but you should be able to provide a meaningful summary of the morning presentations, the reports from each of the small groups and the next steps. We encourage you to send a copy of your meeting summary to one of the FoSE partner organizations as a way to know whether the tool kit is being used, the results it produced, etc.

To maintain momentum, the next steps should be as concrete as possible. When will the group reconvene? Where? Who is in charge of the next phase of work? What is the timeline? Many of the same questions about how the group will work together to plan the meeting in the first place are relevant here.

These meetings can take some work, but they can yield invaluable results to your community, schools, and state. If you have any questions about this process, please don't hesitate to contact any of the FoSE national partner organizations:

Advocates for Youth	info@advocatesforyouth.org
Answer	answered@rci.rutgers.edu
SIECUS	siecus@siecus.org

Milwaukee Public Schools HGD Implementation Guidelines

Principals should be aware that:

- The person responsible for the program in each school is the principal.
- It is the responsibility of the principal to provide coordination for the program to ensure vertical and horizontal articulation as well as appropriate planning, implementation, and evaluation of the program within his or her school.
- The teachers of the program must be regular teachers in the schools.
- An integral part of the kindergarten through grade 12 Human Growth and Development program is teacher inservice education. The inservice education program should instruct teachers in the scope and sequence of the K–12 program. This will provide a logical continuity of sequencing on which more advanced concepts can be taught at higher grade levels. Encourage teachers to participate in this inservice.
- It is expected that all teachers will be provided the necessary preparation to implement the program in their classrooms. However, when for good reason, a teacher is unwilling or unable to teach the content, the principal has the responsibility to make appropriate adjustments.
- The parents play the most important role in this educational process. The parents are to be invited to attend meetings to have the curriculum explained. Initial implementation meetings for elementary schools, middle schools, and high schools are to be held on separate dates (in either the day or the evening) in case a parent has children in more than one school. Background material in the introductory section of this curriculum can be shared with parents to assist them in their primary role of sexuality educator for their children.

Teachers and principals should be aware that:

- A student may be excused from the Human Growth and Development program upon written parental request to the classroom teacher or principal.
- The classroom teacher/s will be responsible for coordinating the Human Growth and Development unit. The classroom teacher/s may utilize the strengths of other teachers and resource persons available to the school in a team-teaching approach.
- Teachers of Human Growth and Development should possess:
  - A willingness to learn as well as to teach.
  - A readiness to admit ignorance or discomfort.

- Sensitivity to individual differences and comfort levels.
- A commitment to freedom of speech and diversity of values.
- A belief that one of the important goals of education is to help people think clearly.
- A good dose of natural humor.

- Teachers shall follow the accepted scope and sequence to ensure that basic attitudes and concepts are reinforced and developed further at advanced levels of instruction. This also provides parents with the expectations and concepts to be taught at the respective grade levels.
- The curriculum may be modified as necessary for the exceptional education student. Such modifications may utilize programs already in existence as guidelines in writing curriculum.
- Teachers are expected to select methods of teaching that are appropriate to the developmental levels of their students and to the content areas being studied.
- Certain topics (self-control, self-respect, self-esteem, chastity, celibacy, abstinence, sexual intercourse, birth control, homosexuality, masturbation, abortion) are to be addressed in the programs in a factual manner, allowing parents to teach in the home their personal, moral, ethical, and religious convictions on these subjects. Parents and community will be informed regarding which grade levels the topics will be taught.
- Whereas actions involving sexual intercourse, birth control, abortion, abuse, sexual assault, and alternative lifestyles have become issues of legislative and judicial procedure, the current legal implications will be taught at appropriate grade level.
- When students come to teachers with personal problems regarding sex, the teachers answer the questions factually as far as their training qualifies them to do and give such guidance as seems appropriate for understanding the wholesome decision making on the part of the students. At all times, teachers refer students to their parents as the first source of guidance.
- All resources brought from outside the school need to be reviewed by appropriate staff/committee before utilizing the resources in a classroom presentation.
- The classroom teacher/s shall have the cooperation of the health and physical education specialist, staff members of the supportive services, and other persons interested in the unit to assist them with specific lessons and/or units in the Human Growth and Development curriculum.
- In addition to meetings, parents will be made aware of the curriculum by one or more of the following:
  - MPS INFO (parent information bulletin).
  - A single brochure and/or mailing.
  - An announcement made by principals of schools.
  - An invitation by school principals for parents to come to school and review curriculum.
  - Parent involved school organizations.

Teachers may wish to consider the following suggestions when implementing this curriculum:

- Teachers have the primary responsibility for developing an appropriate atmosphere or emotional climate in the classroom.
- Become familiar enough with materials to be comfortable with them.
- Establish rules—the right to be heard and the importance of respecting each other's opinions and feelings.
- Avoid separating males and females except for specifically recommended areas. They need practice talking together. Avoid separating, except to fill gaps in their knowledge about their own sex that they don't want to discuss with the opposite sex.
- Do not assume knowledge or understanding of words (street or scientific language).
- Use correct terminology and correct spelling. When street language comes up use it as an opportunity for learning correct terms. This might mean that students also have to learn meaning of the word *slang* to help differentiate between the two categories of words.
- The role of the teacher is to present information, stimulate discussion, to correct misconceptions, and answer relevant and appropriate questions others can't answer.
- Answer students' questions simply and factually. If you don't know an answer, say so and tell students you will look it up and tell them next time—and then do that. Encourage students also to look up and seek answers to such questions.
- Rephrase a question to a level of mutual comfort for all members present.
- Do not assume anyone knows everything. It is difficult for people to admit that they don't know everything about themselves and issues related to sexuality. For example, saying "you probably already know this, but…"
- Avoid answering individual questions for which all pertinent information is not available. For example, if an individual student asks "If I have a catheter can I still father children?" tell him this is something to discuss with his own doctor because of medical information about his own condition that is necessary to provide an exact response.
- Start where the group is. Have the participants, to some extent, select their own discussion topics. Distribute cards and ask students to write questions on topics they want to discuss. Discussion should not center on specific personal problems unless almost everyone in the group shares the same problem.
- Refer certain types of parent requests to the administrator in charge. This individual is in a better position to be aware of the entire situation—such things as previewing materials and visiting classes require preparation on the part of the school to meet needs of parents most effectively.
- Because limited knowledge is often one characteristic of individuals making unhealthy decisions, it is often necessary to teach about topics a teacher does not necessarily wish students to participate in immediately. The teacher should take care that students are made aware of appropriate/healthy and inappropriate/unhealthy behaviors and situations in their environments.

MPS Parent Survey about Scope and Sequence of HGD Topics

Dear Human Growth and Development Advisory Board Members,

Please work with 5–10 parents who have children in the MPS schools. Do not simply hand this to them. We would like you to talk with them about the survey. Listen to their concerns and questions. Make note of them. Tell them about this process of revising the curriculum and our desire to listen to their ideas and concerns. Let them know that we will be looking at our children in Milwaukee. We will consider what kids and families need. We will look at the information about what sexual behavior our kids are choosing and what seems to be working to help kids make wise choices for their health.

This fall there will be an opportunity for them to review what this committee has done prior to it being offered to the students. If they would like direct notice of this opportunity, please get their address. Otherwise, this can remain an anonymous survey.

To complete the survey, use only the page titled Scope and Sequence. Ask the parent to put an "I" in the box of the grade level that they feel would be best to introduce the concept to children. The definitions page is to help you explain some of the categories and the range of information that the topic covers. Explain that even though a topic is introduced, it is not thoroughly covered at that grade and will be built upon as the students mature and progress through the following grades. They can put any comments in the comment line to clarify what they would like to see taught. (Don't be surprised if there are not many in the K-1 column.)

This is not meant to be an exact science. We mostly want to engage you and parents from MPS in dialogue that will help us to do our work in the context of the community we are serving.

Please FAX the responses to XXX or mail to XXX.

Thank you for this important input to the advisory board.

Scope and Sequence for Human Growth and Development K-12

	K-1	2-3	4	5	6	7-8	H.S.	Never	Comments
Human Development Reproductive anatomy and physiology									
Reproduction									
Puberty									
Body image									
Sexual identity and orientation									
Other									
Relationships Families									
Friendship									
Dating									
Marriage and lifetime commitments									
Adoption									
Raising children									
Other									
Personal Skills Values									
Decision-making									
Communication									
Assertiveness									
Negotiation									
Looking for help									
Other									
Sexual behavior Sexuality throughout life									
Masturbation									
Shared sexual behavior									
Abstinence									
Human sexual response									
Sexual dysfunction									
Other									
Sexual Health Contraception									
Pregnancy options									
Sexually transmitted diseases, HIV Infection									
Sexual abuse									
Reproductive health									
Other									
Society and Culture Gender roles									
Sexuality and the law									
Sexuality and religion									
Cultural diversity									
Sexuality and the media									
Other									

I = introduce concept

Some Helpful Clarifications

Human Development

- Reproductive anatomy and physiology—from parts "covered by swimsuit" to specific organs/functions in later years
- Reproduction—from "all life reproduces" to human intercourse in later years
- Puberty—changes adolescents go through
- Body image—how students feel about their bodies and the impact of this on health behaviors
- Sexual identity and orientation—variety in expression of maleness and femaleness to sexual orientation in later years
- Other

Relationships

- Families
- Friendship
- Dating
- Marriage and lifetime commitments
- Adoption
- Raising children
- Other

Personal Skills

- Values
- Decision-making
- Communication
- Assertiveness
- Negotiation
- Looking for help
- Other

Sexual behavior

- Sexuality throughout life—how sexuality is intertwined throughout a person's life
- Masturbation—self pleasing to safe sex alternative
- Shared sexual behavior—range of behavior for consensual activity along with the potential health risks
- Abstinence
- Human sexual response—natural urges and responses to stimulus
- Sexual dysfunction—natural—fluctuations during lifetime to physical conditions that limit function
- Other

Sexual Health

- Contraception—various options with risks and benefits
- Unwanted pregnancy options—adoption, abortion
- Sexually transmitted diseases, HIV Infection
- Sexual abuse
- Reproductive health—routine health exams during and beyond puberty
- Other

Society and Culture

- Gender roles—stereotypes to current roles in families
- Sexuality and the law—what is unlawful sexual behavior (adult-child, teen-teen, etc.)
- Sexuality and religion
- Cultural diversity—understanding different attitudes around sexuality
- Sexuality and the media—how sex is portrayed in the media and how media influences sexual attitudes and conduct

Chapter 5
Parental Communication

Parental Communication

5

Parents are the first and primary sexuality educators of their children.

Parents are the first and primary sexuality educators of their children. Communication is critical for parents/guardians and school staff to complement each others' efforts in providing high quality and developmentally appropriate human growth and development (HGD) instruction for children and youth. Schools can support parents by providing opportunities and resources to increase parents' knowledge, skills, and confidence in their important role as sexuality educators of their children and, clearly, the experts in sharing their family's values. Schools can use a variety of strategies as noted below to increase parents' familiarity with the school-based HGD curriculum and instruction.

Communicating with Parents about the HGD Program

Invite parents to a HGD information meeting. Provide at least two convenient opportunities for parents and guardians to meet the HGD teachers, preview HGD curricular materials, and have their questions about the instruction answered. It is helpful for one of these meetings to be scheduled in the morning or early afternoon to accommodate parents who work in the evenings. It may also be helpful to hold one of the meetings out of the school and in a community setting where some parents may be more likely to attend. Send invitations in languages family members can read. Publicize the meeting in community newspapers. Phone or e-mail parents to remind them of the meeting. Provide food and beverages for the parent meeting. Arrange for childcare to be available. Provide transportation for parents/guardians to attend the meeting.

See Resource 5.1 Sample Agenda: HGD Parent Information Meeting

- Distribute a handbook to inform parents about the district's HGD unit of instruction.
- Disseminate a grade-level brochure describing available HGD library materials.
- Provide written information about the HGD program in languages used by students' parents (e.g., Spanish, Hmong).
- Provide information about the HGD program on the local access cable channel, and distribute a letter to parents making them aware of this viewing opportunity.
- Distribute newsletters with information about the HGD program.

Opt-Out Option

In general, few parents do not want their children to participate in HGD instruction.

State law requires that parents have the option to exempt their children from HGD instruction. This is called the "opt-out" option. Wisconsin statutes do not provide, and legislative history does not support, the use of the parental "opt in" method by local school districts in which parents give consent for their children to participate. The opt-in method would require a parent to notify their child's principal/teacher if they want their child to take instruction in HGD.

In general, few parents do not want their children to participate in HGD instruction. Parental objections may occur because parents have not had an opportunity to thoroughly review and discuss the curriculum. A respectful exchange where parents are comfortable sharing their concerns and the local school district has an opportunity to explain why they think this is an important curricular area will enhance the likelihood of parent acceptance of the curriculum. Frequently when parents are given the opportunity to learn more about the HGD curriculum, review the materials, and have their questions answered, their reservations and concerns are alleviated.

In a situation where a parent continues to object to their child participating in instruction on physiology and hygiene, AIDS/HIV/Sexually Transmitted Infections (STI), or other aspects of HGD, they retain the right to exempt their child from this instruction by filing a written request with the teacher or principal.

See Resource 5.2 **Sample HGD Unit Opt-Out Request: Whitefish Bay**

See Resource 5.3 **Sample Opt-Out Request: Milwaukee Public Schools**

See Resource 5.4 **Sample Opt-Out Request: Fort Atkinson**

Involving Parents in the HGD Program Planning

- Invite parents to serve on the HGD advisory committee or to be involved in related subcommittees or workgroups.
- Involve parents in planning a HGD information meeting for other parents.
- As discussed in Chapter 4, conduct a survey of current district parents to assess topics they think should be included in the HGD program and the appropriate grade levels for teaching these topics.
- Conduct a survey or informal focus groups to assess satisfaction with the HGD curriculum. What are they hearing from their children? What seems to be working well? Where can improvements be made?

Supporting Parents as the Primary Sexuality Educators of their Children

Provide workshops to help families talk about family values and other aspects of human sexuality. The following web resources may be of particular interest to parents:

The National Campaign for Teen Pregnancy Prevention
http://www.thenationalcampaign.org

Parents and Friends of Lesbians and Gays
www.pflag.org

Advocates for Youth
www.advocatesforyouth.org

Search Institute: Parent Further Initiative
http://www.search-institute.org/families

American Academy of Child and Adolescent Psychiatry
Talking to Your Kids About Sex
www.aacap.org

Sample Agenda

HGD Parent Information Meeting

Welcome and Introductions (5 minutes)

Principal

HGD advisory committee member

Staff teaching HGD curriculum

Meeting Ground Rules

Rationale for Teaching HGD at this Grade Level (5 minutes)

Questions Parents/Guardians Have About the Curriculum (5 minutes)

(post on newsprint)

Overview of the Curriculum (30 minutes)

- Goals and objectives
- Description of selected activities
- Review of teaching materials
- District's approach to answering students' questions
- Approaches to communicate with parents about HGD instruction

Answer Remaining Questions (15 minutes)

Closure and Adjourn to Examine Instructional Materials

Sample Opt-Out Request

WHITEFISH BAY MIDDLE SCHOOL

1144 E. Henry Clay Street
Whitefish Bay WI, 53217

414/963-6800 414/963-6808 fax

Lisa Gies
Principal
Lisa.Gies@wfbschools.com

Charles Orvold
Associate Principal
Chuck.Orvold@wfbschools.com

Dear Parents/Guardians:

The School District of Whitefish Bay believes that the family plays a crucial role in students' human growth and development education. The schools support both parents/guardians and children in their efforts to develop an understanding of human sexuality and the family.

A Human Growth and Development Curriculum has been in place since 1983 as an integral part of the Health Education program for the School District of Whitefish Bay. With input from students, parents, teachers, administrators and local clergy, we have developed an excellent curriculum that allows your child to participate in age-appropriate subject matter and classroom activities.

On the District Website you will find a copy of the **Whitefish Bay Middle School Human Growth and Development Curriculum** as well as statements concerning our district philosophy, goals and stance on sensitive issues.

Parents who wish to exclude their child from portions or all of the human growth and development unit must place their wishes in writing. Please address this letter to Dr. Gies and send it back to school with your child or mail it to the school office no later than September 2, 2011. Excluded students will be furnished with and required to complete alternative assignments on health-related issues.

If you have any questions, comments, or concerns, please contact me at 963-6800 ext. 4226. I will be happy to talk with you.

Sincerely,
Roberta Stadler
Middle School Health Educator

I would like my child _____ to be pulled out of the following class sessions of the human growth and development curriculum (See curriculum on district website):

_____

_____

Thank You,

First and Last Name *Please Print*	Signature ➢	Date Signed *Mo./Day/Yr.*

Sample Opt-Out Request

Milwaukee Public Schools

(beginning of the year)

Dear Parent,

We are going to be learning about our bodies and how to keep them safe and healthy throughout the school year. Some of the instruction will include information about the reproductive system and human sexuality. The lessons we will be using have been reviewed by a community advisory board including parents, health experts and religious leaders. We welcome you to review the lessons by calling the school and setting up an appointment to come in to talk with your child's teacher or the principal. At times your son or daughter will be asked to talk with you to better understand your beliefs and values around these issues. We want to support your role as the main educator of your child about human sexuality.

Attached you will find an outline of the lessons to be taught this year. If you would like to have your child sit out during any of these lessons, please indicate which lessons on the form below and send it back to school with your child or mail it to the school office.

We look forward to working with you this year.

Sincerely,
(Names of teachers and Principal)

I would like my child _____to be pulled out of the following class sessions of the human growth and development curriculum (See curriculum on district website):

_____

_____

Thank You,

First and Last Name *Please Print*	Signature ➢	Date Signed *Mo./Day/Yr.*

Sample Opt-Out Request

Fort Atkinson
Human Growth and Development
Grades 4 and 5

Fourth and fifth grade students at Rockwell, Barrie, Luther, and Purdy Schools will be learning about Human Growth and Development during the school year. The information will be integrated into the existing curriculum during appropriate discussions and activities. Students will discuss the feelings that they have about rapid physical changes, will be able to recognize and discuss gender stereotyping, and will *understand the physical changes that occur during puberty (the males and females will be separated for this discussion).* In fifth grade, they will discuss the structure and function of the human reproductive system, and will explain the physical, emotional, and social changes that occur during the onset of puberty. This discussion will include personal hygiene, responsibility, open communication with parents, and a section on what AIDS is and how it is spread. The males and females will meet in separate groups to discuss their unique physical changes.

If you wish to preview the materials to be used, please contact your school principal. Printed and video materials and the lesson objectives will be available for review.

If you **do not** want your child to participate in part or all of the discussions, please fill out the bottom of this page and return it to your child's homeroom teacher. If no form is returned, your child will participate in the lessons.

NOTE: Your child may have questions for you throughout the year. Please see reverse side for guidelines regarding talking to your child about this important subject.

Refusal Form

Human Growth and Development Program - Grades 4 and 5

School Your Student Attends	Teacher *First and Last Name*	Grade

I **do not** want my son/daughter, _____, to participate in the Human Growth and Development Curriculum at school.

Signature	Date Signed *Mo./Day/Yr.*
➢	

I do not want my son/daughter, _____, to participate in this/these part(s) of the Human Growth and Development Curriculum at school: _____

_____

_____

Signature	Date Signed *Mo./Day/Yr.*
➢	

GUIDELINES FOR PARENTS

1. Remember, facts are easy; but values and attitudes are critical. When a child comes to you with a question, he or she wants facts, but also wants to know how you *feel*.
2. Do not use fable, vagueness, or untruths when talking about contraception or birth.
3. Do not talk about animals when your child wants to know about people. It is confusing and evasive.
4. Be patient. Expect the same questions to resurface ten or more times before the idea is securely absorbed.
5. Be a good listener. When children approach you with a question, find out what he or she is thinking first, before you answer.
6. Keep your terms simple and accurate.
7. Be honest and consistent.
8. Give children the vocabulary he or she needs to continue asking more questions.
9. Leave children with a feeling that you are available for other questions as well.
10. If you are not comfortable with the subject, direct your child to a reliable source who is comfortable to discuss the topic.

Advocates For Youth
Rights. Respect. Responsibility.®

From Research to Practice

Are You an Askable Parent?

As a parents or caregiver, it is very important for you to be *askable*. What does that mean? How do adults become *askable*?

To be *askable* means that young people see you as approachable and open to questions. Being *askable* about sexuality is something that most parents and caregivers want but that many find very difficult. Adults may have received little or no information about sex when they were children. Sex may not have been discussed in their childhood home, whether from fear or out of embarrassment. Or, adults may worry about:

- Not knowing the *right* words or the *right* answers;
- Being *out of it* in the eyes of their young people;
- Giving too much or too little information; or
- Giving information at the wrong time.

Being *askable* is important. Research shows that youth with the least accurate information about sexuality and sexual risk behaviors may experiment more and at earlier ages compared to youth who have more information.[1,2,3,4,5] Research also shows that, when teens are able to talk with a parent or other significant adult about sex and about protection, they are less likely to engage in early and/or unprotected sexual intercourse than are teens who haven't talked with a trusted adult.[6,7,8,9] Finally, youth often say that they want to discuss sex, relationships, and sexual health with their parents—parents are their preferred source of information on these subjects.[10,11]

Because being *askable* is so important and because so many adults have difficulty initiating discussions about sex with their children, adults may need to learn new skills and become more confident about their ability to discuss sexuality. Here are some tips from experts in the field of sex education.

Talking with Young People about Sexuality

1. **Acquire a broad foundation of factual information from reliable sources.** Remember that sexuality is a much larger topic than sexual intercourse. It includes biology and gender, of course, but it also includes emotions, intimacy, caring, sharing, and loving, attitudes, flirtation, and sexual orientation as well as reproduction and sexual intercourse.
2. **Learn and use the correct terms for body parts and functions**. If you have difficulty saying some words without embarrassment, practice saying these words, in private and with a mirror, until you are as comfortable with them as with non-sexual words. For example, you want to be able to say "penis" as easily as you say "elbow."
3. **Think through your own feelings and values about love and sex**. Include your childhood memories, your first infatuation, your values, and how you feel about current sex-related issues, such as contraceptives, reproductive rights, and equality with regard to sex, gender, and sexual orientation. You must be aware of how you feel before you can effectively talk with youth.
4. **Talk *with* your child**. Listen more than you speak. Make sure you and your child have open, *two-way* communication—as it forms the basis for a positive relationship between you and your child. Only by listening to each other can you understand one another, especially regarding love and sexuality, for adults and youth often perceive these things differently.
5. **Don't worry about**—
   - Being "with it." Youth have that with their peers. From you, they want to know what you believe, who you are, and how you feel.
   - Being embarrassed. Your kids will feel embarrassed, too. That's okay, because love and many aspects of sexuality, including sexual intercourse, are highly personal. Young people understand this.

- Deciding which parent should have this talk. Any loving parent or caregiver can be an effective sex educator for his/her children.
- Missing some of the answers. It's fine to say that you don't know. Just follow up by offering to find the answer or to work with your child to find the answer. Then do so.

Talking with Young Children

1. **Remember that if someone is old enough to ask, she/he is old enough to hear the correct answer and to learn the correct word(s).**
2. **Be sure you understand what a young child is asking.** Check back. For example, you might say, "I'm not certain that I understand exactly what you are asking. Are you asking if it's okay to do this or why people do this?" What you don't want is to launch into a long explanation that doesn't answer the child's question.
3. **Answer the question when it is asked.** It is usually better to risk embarrassing a few adults (at the supermarket, for example) than to embarrass your child or to waste a teachable moment. Besides, your child would usually prefer it if you answer right then and softly. If you cannot answer at the time, assure the child that you are glad he/she asked and set a time when you will answer fully. "I'm glad you asked that. Let's talk about it on the way home."
4. **Answer *slightly* above the level you think your child will understand**, both because you may be underestimating him/her and because it will create an opening for future questions. But, don't forget that you are talking with a young child. For example, when asked about the differences between boys and girls, don't get out a textbook and show drawings of the reproductive organs. A young child wants to know what is on the *outside*. So, simply say, "A boy has a penis, and a girl has a vulva."
5. **Remember that, even with young children, you must set limits.** You can refuse to answer personal questions. "What happens between your father and me is personal, and I don't talk about it with anyone else." Also, make sure your child understands the difference between values and standards relating to his/her question. For example, if a child asks whether it is bad to masturbate, you could say, "Masturbation is not bad; however, we never masturbate in public. It is a *private* behavior." [values *versus* standards] You should also warn your child that other adults may have different *values* about this subject while they will hold to the same *standard*; that is, they may believe it is wrong and a private behavior.

Talking with Teens

1. **Recall how you felt when you were a teen.** Remember that adolescence is a difficult time. One moment, a teen is striving for separate identity and independence, and the next moment urgently needs an adult's support.
2. **Remember that teens want mutually respectful conversations.** Avoid dictating. Share your feelings, values, and attitudes *and* listen to and learn about theirs. Remember that you cannot dictate anyone else's feelings, attitudes, or values.
3. **Don't assume that a teen is sexually experienced or inexperienced, knowledgeable or naive.** Listen carefully to what your teen is saying and/or asking. Respond to the teen's actual or tacit question, not to your own fears or worries.
4. **Don't underestimate your teen's ability to weigh the advantages and disadvantages of various options.** Teens have values, and they are capable of making mature, responsible decisions, especially when they have all the needed facts and the opportunity to discuss options with a supportive adult. If you give your teen misinformation she/he may lose trust in you, just as he/she will trust you if you are a consistent source of clear and accurate information. Of course, a teen's decisions may be different from ones you would make; but that goes with the territory.

Being *askable* is a lifelong component of relationships. It opens doors to closer relationships and to family connections. It's never too late to begin!

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Written by Barbara Huberman, RN, MEd, and by Sue Alford, MLS

Advocates For Youth
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2000 M Street NW, Suite 750 • Washington, DC 20036 USA • Phone: 202.419.3420 • Fax: 202.419.1448 • www.advocatesforyouth.org

Ten Tips for Parents to Help Their Children Avoid Teen Pregnancy

The National Campaign to Prevent Teen Pregnancy has reviewed recent research about parental influences on children's sexual behavior and talked to many experts in the field, as well as to teens and parents themselves. From these sources, it is clear that there is much parents and adults can do to reduce the risk of kids becoming pregnant before they've grown up.

Presented here as "ten tips," many of these lessons will seem familiar because they articulate what parents already know from experience—like the importance of maintaining strong, close relationships with children and teens, setting clear expectations for them, and communicating honestly and often with them about important matters. Research supports these common sense lessons: not only are they good ideas generally, but they can also help teens delay becoming sexually active, as well as encourage those who are having sex to use contraception carefully.

Finally, although these tips are for parents, they can be used by adults more generally in their relationships with teenagers. Parents—especially those who are single or working long hours—often turn to other adults for help in raising their children and teens. If all these caring adults are on the same "wavelength" about the issues covered here, young people are given more consistent messages. So, What to Do?

1. **Be clear about your own sexual values and attitudes.**

   Communicating with your children about sex, love, and relationships is often more successful when you are certain in your own mind about these issues. To help clarify your attitudes and values, think about the following kinds of questions:

   - What do you really think about school-aged teenagers being sexually active, perhaps even becoming parents?
   - Who is responsible for setting sexual limits in a relationship, and how is that done, realistically?
   - Were you sexually active as a teenager, and how do you feel about that now? Were you sexually active before you were married? What do such reflections lead you to say to your own children about these issues?
   - What do you think about encouraging teenagers to abstain from sex?
   - What do you think about teenagers using contraception?

2. **Talk with your children early and often about sex, and be specific.**

   Kids have lots of questions about sex, and they often say that the source they'd most like to go to for answers is their parents. Start the conversation, and make sure that it is honest, open, and respectful. If you can't think of how to start the discussion, consider using situations shown on television or in movies as conversation starters. Tell them candidly and confidently what you think and *why* you take

these positions; if you're not sure about some issues, tell them that, too. Be sure to have a two-way conversation, not a one-way lecture. Ask them what *they* think and what they know so you can correct misconceptions. Ask what, if anything, worries them.

Age-appropriate conversations about relationships and intimacy should begin early in a child's life and continue through adolescence. Resist the idea that there should be just one conversation about all this—you know, "the talk." The truth is that parents and kids should be talking about sex and love all along. This applies to *both* sons and daughters and to *both* mothers and fathers, incidentally. All kids need a lot of communication, guidance, and information about these issues, even if they sometimes don't appear to be interested in what you have to say. And if you have regular conversations, you won't worry so much about making a mistake or saying something not quite right, because you'll always be able to talk again.

Many inexpensive books and videos are available to help with any detailed information you might need, but don't let your lack of technical information make you shy. Kids need as much help in understanding the *meaning* of sex as they do in understanding how all the body parts work. Tell them about love and sex, and what the difference is. And remember to talk about the reasons that kids find sex interesting and enticing; discussing only the "downside" of unplanned pregnancy and disease misses many of the issues on teenagers' minds.

Here are the kinds of questions kids say they want to discuss:

- How do I know if I'm in love? Will sex bring me closer to my girlfriend/boyfriend?
- How will I know when I'm ready to have sex? Should I wait until marriage?
- Will having sex make me popular? Will it make me more grown-up and open up more adult activities to me?
- How do I tell my boyfriend that I don't want to have sex without losing him or hurting his feelings?
- How do I manage pressure from my girlfriend to have sex?
- How does contraception work? Are some methods better than others? Are they safe?
- Can you get pregnant the first time?

In addition to being an "askable parent," be a parent with a point of view. Tell your children what you think. Don't be reluctant to say, for example:

- I think kids in high school are too young to have sex, especially given today's risks.
- Whenever you do have sex, always use protection against pregnancy and sexually transmitted diseases until you are ready to have a child.
- Our family's religion says that sex should be an expression of love within marriage.
- Finding yourself in a sexually charged situation is not unusual; you need to think about how you'll handle it *in advance*. Have a plan. Will you say "no"? Will you use contraception? How will you negotiate all this?

- It's okay to think about sex and to feel sexual desire. Everybody does! But it's not okay to get pregnant/get somebody pregnant as a teenager.
- One of the many reasons I'm concerned about teens drinking is that it often leads to unprotected sex.
- (For boys) Having a baby doesn't make you a man. Being able to wait and acting responsibly does.
- (For girls) You don't have to have sex to keep a boyfriend. If sex is the price of a close relationship, find someone else.

By the way, research clearly shows that talking with your children about sex does *not* encourage them to become sexually active. And remember, too, that your own behavior should match your words. The "do as I say, not as I do" approach is bound to lose with children and teenagers, who are careful and constant observers of the adults in their lives.

3. **Supervise and monitor your children and adolescents.**

   Establish rules, curfews, and standards of expected behavior, preferably through an open process of family discussion and respectful communication. If your children get out of school at 3 pm and you don't get home from work until 6 pm, who is responsible for making certain that your children are not only safe during those hours, but also are engaged in useful activities? Where are they when they go out with friends? Are there adults around who are in charge? Supervising and monitoring your kids' whereabouts doesn't make you a nag; it makes you a parent.

4. **Know your children's friends and their families.**

   Friends have a strong influence on each other, so help your children and teenagers become friends with kids whose families share your values. Some parents of teens even arrange to meet with the parents of their children's friends to establish common rules and expectations. It is easier to enforce a curfew that all your child's friends share rather than one that makes him or her different—but even if your views don't match those of other parents, hold fast to your convictions. Welcome your children's friends into your home and talk to them openly.

5. **Discourage early, frequent, and steady dating.**

   Group activities among young people are fine and often fun, but allowing teens to begin steady, one-on-one dating much before age 16 can lead to trouble. Let your child know about your strong feelings about this throughout childhood—don't wait until your young teen proposes a plan that differs from your preferences in this area; otherwise, he or she will think you just don't like the particular person or invitation.

6. **Take a strong stand against your daughter dating a boy significantly older than she is. And don't allow your son to develop an intense relationship with a girl much younger than he is.**

   Older guys can seem glamorous to a young girl—sometimes they even have money and a car to boot! But the risk of matters getting out of hand increases when the guy is much older than the girl. Try setting a limit of no more than a two- (or at most three-) year age difference. The power differences between younger girls and older boys or men can lead girls into risky situations, including unwanted sex and sex with no protection.

7. **Help your teenagers to have options for the future that are more attractive than early pregnancy and parenthood.**

   The chances that your children will delay sex, pregnancy, and parenthood are significantly increased if their futures appear bright. This means helping them set meaningful goals for the future, talking to them about what it takes to make future plans come true, and helping them reach their goals. Tell them, for example, that if they want to be a teacher, they will need to stay in school in order to earn various degrees and pass certain exams. It also means teaching them to use free time in a constructive way, such as setting aside certain times to complete homework assignments. Explain how becoming pregnant—or causing pregnancy—can derail the best of plans; for example, child care expenses can make it almost impossible to afford college. Community service, in particular, not only teaches job skills, but can also put teens in touch with a wide variety of committed and caring adults.

8. **Let your kids know that you value education highly.**

   Encourage your children to take school seriously and set high expectations about their school performance. School failure is often the first sign of trouble that can end in teenage parenthood. Be very attentive to your children's progress in school, and intervene early if things aren't going well. Keep track of your children's grades and discuss them together. Meet with teachers and principals, guidance counselors, and coaches. Limit the number of hours your teenager gives to part-time jobs (20 hours per week should be the maximum) so that there is enough time and energy left to focus on school. Know about homework assignments and support your child in getting them done. Volunteer at the school, if possible. Schools want more parental involvement and will often try to accommodate your work schedule, if asked.

9. **Know what your kids are watching, reading, and listening to.**

   The media (television, radio, movies, music videos, magazines, the Internet) are chock full of material sending the wrong messages. Sex rarely has meaning, unplanned pregnancy seldom happens, and few people having sex ever seem to be married or even especially committed to anyone. Is this consistent with your expectations and values? If not, it is important to talk with your children about what the media portray and what you think about it. If certain programs or movies offend you, say so, and explain why. Be "media literate"—think about what you and your family are watching and reading. Encourage your kids to think critically: ask them what they think about the programs they watch and the music they listen to. You can always turn the TV off, cancel subscriptions, and place certain movies off limits. You will probably not be able to fully control what your children see and hear, but you can certainly make your views known and control your own home environment.

10. **These first nine tips for helping your children avoid teen pregnancy work best when they occur as part of strong, close relationships with your children that are built from an early age.**

    Strive for a relationship that is warm in tone, firm in discipline, and rich in communication, and one that emphasizes mutual trust and respect. There is no single way to create such relationships, but the following habits of the heart can help:

    - Express love and affection clearly and often. Hug your children, and tell them how much they mean to you. Praise specific accomplishments, but remember that expressions of affection should be offered freely, not just for a particular achievement.
    - Listen carefully to what your children say and pay thoughtful attention to what they do.

- Spend time with your children engaged in activities that suit their ages and interests, not just yours. Shared experiences build a "bank account" of affection and trust that forms the basis for future communication with them about specific topics, including sexual behavior.
- Be supportive and be interested in what interests them. Attend their sports events; learn about their hobbies; be enthusiastic about their achievements, even the little ones; ask them questions that show you care and want to know what is going on in their lives.
- Be courteous and respectful to your children and avoid hurtful teasing or ridicule. Don't compare your teenager with other family members (i.e., why can't you be like your older sister?). Show that you expect courtesy and respect from them in return.
- Help them to build self-esteem by mastering skills; remember, self-esteem is earned, not given, and one of the best ways to earn it is by *doing* something well.
- Try to have meals together as a family as often as possible, and use the time for conversation, not confrontation.

A final note: it's never too late to improve a relationship with a child or teenager. Don't underestimate the great need that children feel—at all ages—for a close relationship with their parents and for their parents' guidance, approval, and support.

Source: The National Campaign to Prevent Teen Pregnancy

Talking Back: Ten Things Teens Want Parents to Know About Teen Pregnancy

Introduction

Teens hear advice on all kinds of issues from their parents, teachers, and other adults in their lives. But they don't often get asked to offer it. Over the past year, the National Campaign to Prevent Teen Pregnancy has been asking teens from all over the country a fairly simple question: If you could give your parents and other important adults advice about how to help you and your friends avoid pregnancy, what would it be? The following ten tips represent the major themes we heard from teens.

You may be surprised to learn that young people do want to hear from parents and other adults about sex, love, and relationships. They say they appreciate—even crave—advice, direction, and support from adults who care about them. But sometimes, they suggest, adults need to change *how* they offer their guidance. Simply put, they want real communication, not lectures and not threats.

The National Campaign would like to acknowledge the contributions of the many young people who have offered their suggestions for this publication, including the National Campaign's *Youth Leadership Team*, the readers of *Teen People*, and the teens who participated in our focus groups, answered our polling questions, visited our website, or told us their stories in communities we've visited around the country. We would also like to thank our informal group of adult advisors who reviewed drafts of the brochure.

We hope that *Talking Back: Ten Things Teens Want Parents to Know About Teen Pregnancy* offers parents and other adults comfort that their efforts to help teens do make a difference—as well as gives the kind of practical advice that will make the job a little easier.

Sarah Brown
Director
National Campaign to Prevent Teen Pregnancy
April 1999

Source: National Campaign to Prevent Teen Pregnancy

Ten Things Teens Want Parents to Know About Teen Pregnancy

1. **Show us why teen pregnancy is such a bad idea.** For instance, let us hear directly from teen mothers and fathers about how hard it has been for them. Even though most of us don't want to get pregnant, sometimes we need real-life examples to help motivate us.

2. **Talk to us honestly about love, sex, and relationships.** Just because we're young doesn't mean that we can't fall in love or be deeply interested in sex. These feelings are very real and powerful to us. Help us to handle the feelings in a safe way—without getting hurt or hurting others.

3. **Telling us not to have sex is not enough.** Explain why you feel that way, and ask us what we think. Tell us how you felt as a teen. Listen to us and take our opinions seriously. And no lectures, please.

4. **Whether we're having sex or not, we need to be prepared.** We need to know how to avoid pregnancy and sexually transmitted diseases.

5. **If we ask you about sex or birth control, don't assume we are already having sex.** We may just be curious, or we may just want to talk with someone we trust. And don't think giving us information about sex and birth control will encourage us to have sex.

6. **Pay attention to us before we get into trouble.** Programs for teen moms and teen fathers are great, but we all need encouragement, attention, and support. Reward us for doing the right thing - even when it seems like no big thing. Don't shower us with attention only when there is a baby involved.

7. **Sometimes, all it takes not to have sex is not to have the opportunity.** If you can't be home with us after school, make sure we have something to do that we really like, where there are other kids and some adults who are comfortable with kids our age. Often we have sex because there's not much else to do. Don't leave us alone so much.

8. **We really care what you think, even if we don't always act like it.** When we don't end up doing exactly what you tell us to, don't think that you've failed to reach us.

9. **Show us what good, responsible relationships look like.** We're as influenced by what you do as by what you say. If you demonstrate sharing, communication, and responsibility in your own relationships, we will be more likely to follow your example.

10. **We hate "The Talk" as much as you do.** Instead, start talking with us about sex and responsibility when we're young, and keep the conversation going as we grow older.

Source: National Campaign to Prevent Teen Pregnancy

Ten Tips for Parents* of a Gay, Lesbian, Bisexual, or Transgender Child

1. **Engage with your child.** Your gay, lesbian, bisexual, or transgender (GLBT) child requires and deserves the same level of care, respect, information, and support as non-GLBT children. Ask questions, listen, empathize, share, and just be there for your child.

2. **Go back to school.** Get the facts about sexual orientation and gender identity. Learn new language and the correct terminology to communicate effectively about sexual orientation and gender identity. Challenge yourself to learn and go beyond stereotyped images of GLBT people.

   Here's a quick lesson on two frequently misunderstood terms:

   Sexual orientation—Describes to whom a person feels attraction: people of the opposite gender, the same gender, or both genders.

   Gender identity—A person's inner sense of gender—male, female, some of each, neither. Transgender people have a gender identity that is different from the gender to which they were born or assigned at birth.

   Some people ask, "Isn't transgender just like being gay?" No. Transgender describes a person's internal sense of gender identity. Sexual orientation describes a person's feeling of attraction toward other people. Transgender people have some issues in common with gay, lesbian, and bisexual communities, but gender identity is ***not*** the same as sexual orientation.

3. **Get to know the community.** What resources are available? Find out if there is a Gay/Straight Alliance at school, a community group for GLBT and questioning teens, a bookstore with a selection of books on GLBT issues, or a GLBT community center nearby.

4. **Explore the Internet.** There is a growing amount of excellent information on the World Wide Web that connects people with support and materials on these important topics. Two excellent web sites are Parents, Families & Friends of Lesbians and Gays (www.pflag.org), and Gay, Lesbian and Straight Education Network (www.glsen.org/cgi-bin/iowa/all/about/index.html).

5. **Find out where your local Parents, Families & Friends of Lesbians and Gay (PFLAG) meets.** Many parents say that their connections with other parents of GLBT kids made a world of difference in their progress toward understanding their young people. Finding another person you can trust to share your experience with is invaluable. Many people have gone through similar things, and their support, lessons learned, and empathy can be very valuable.

6. **Don't make it ALL there is…**just because your child has come out as GLBT does not mean that young person's whole world revolves around sexual orientation or gender identity. It will be a big part of who the youth is, especially during the process of figuring it all out, including what it means to be GLBT. Still, being GLBT isn't the sum of life for your child, and it is vital to encourage your child in other aspects of life, such as school, sports, hobbies, friends, and part-time jobs.

7. **ASK your child *before* you "come out" to others on the child's behalf.** Friends and family members might have questions or want to know what's up; but it is most important to be respectful of what your child wants. Don't betray your child's trust!

8. **Praise your GLBT child for coming to you to discuss this issue.** Encourage the youth to continue to keep you "in the know." If your child turns to you to share personal information, you must be doing something right! You are askable. You're sending out consistent verbal and non-verbal cues that say, "Yes, I'll listen. Please talk to me!" Give yourself some credit—your GLBT child chose to come to you. Congratulations!

9. **Find out what kind of support, services, and education are in place at your child's school.** Does the school and/or school district have a non-discrimination policy? Is there a GLBT/straight support group? Do you know any "out" people, or their friends and loved ones, to whom you can turn for information? (Before doing so, again refer to tip number 7, above. *Ask* your child if it's okay for you to "come out" about the child.)

10. **Educate yourself on local, state, and national laws and policies regarding GLBT people.** On the national level, GLBT people are still second-class citizens in regard to some national policies, and their rights are not guaranteed by law. Consider educating yourself about this and finding out what you can do to work toward extending equal rights to GLBT people in the United States.

***Note:** These tips can also be useful for other trusted adults in the GLBT young person's life, explaining how a caring adult can be there for GLBT youth.

Source: Lisa Mauer, MS, CFLE, ACSE, Coordinator, The Center for LGBT Education, Outreach and Services, Ithaca College.

Our Sons and Daughters

Questions & Answers for
Parents of Lesbian, Gay, Bisexual & Transgender Youth

"I think the turning point for me was when I read more about it, and read that most kids who can accept their sexuality say they feel calmer, happier and more confident. And of course, that's what I wanted for my child and I sure didn't want to be what was standing in the way of that." — Father of a gay son

As parents, every day we work to ensure that our children are safe, happy and successful. When they are young, we dream about their future. We encourage them to finish school, find love, get married, and have our grandchildren. When we have a child who is lesbian, gay, bisexual, or transgender (LGBT) it's common to feel that those dreams are ruined. Some are taught that being gay is different, wrong, or sinful.

What is the first thing you can do when you learn that your child is gay? Seek support from others. Families all across the country and in your community have lesbian, gay, bisexual, or transgender people in their immediate or extended families. **You are not alone.** Talking about it to someone can really help. Parents, Families and Friends of Lesbians and Gays (PFLAG) chapters have provided support and education opportunities for families just like yours for over 35 years. Find a chapter near you at www.pflag.org.

It's important for you to understand that coming out can be a difficult process. Regardless of how nurturing you are with your children, your son or daughter felt a real risk of losing your love and support by coming out to you. Every day, young people are kicked out of their home for disclosing their sexuality. In a study conducted by The Gay and Lesbian Task Force, nearly 40% of all homeless youth identify as LGBT and cited "experiencing negative reactions by their parents when they came out." By the time your child has built up the courage to come out to you, he or she has gone through the process of self-acceptance. Telling you is a sign of love, and desire for an open and honest relationship.

Is my child different now? We think we know and understand our children from the day they are born. So when a child announces "I'm gay," and we hadn't a clue – or we knew all along but denied it to ourselves – the reactions are often shock and disorientation.

You have a dream, a vision of what your child will be, should be, can be. It's a dream that is born of your own history, of what you wanted for yourself growing up, and especially of the culture around you. Despite the fact that a significant portion of the population is gay, American society still prepares us only with heterosexual dreams for our children. The shock and disorientation you may feel is a natural part of a type of grieving process. You have lost something – your dream for your child. Of course, when you stop to think about it, this is true for all children, straight or gay. They're always surprising us. They don't marry who we might pick for them; they don't take the job we would have chosen; they don't live where we'd like them to live.

Keep reminding yourself that your child hasn't changed. Your child is the same person that he or she was before you learned about his or her sexuality. It is your dream, your expectations, and your vision that may have to change if you are to really know and understand your gay loved one.

"I have to tell you, there are so many pluses now. You begin to recognize what an incredible child you have to share this with you and to want you to be part of their lives… [Look at] the trust that has been placed in your hands and how much guts it took to do that." – Father of lesbian daughter

To learn more about common questions and answers that parents and family members of lesbian, gay, bisexual and/or transgender people often have check out the full length Our Daughters and Sons resource at www.pflag.org or find a chapter in your area.

Ten Tips for Talking About Sexuality with Your Child Who has Developmental Disabilities

Conversations about sexuality can yield many benefits when you talk with your child who has developmental disabilities. The positive effects for your child include, not only an understanding of sexuality, but also opportunities to learn, grow, and build skills for life. Talking about sexuality sets the stage for talking, without guilt or embarrassment, about body parts and their functions. It sets the stage for your child to articulate life goals. It equips young people to understand behaviors that are inappropriate in public or that are destructive to relationships, trust, and self-esteem. It enables young people to recognize and prevent abuse and exploitation. Many parents also observe their children increasing in self-esteem and self-empowerment as they master key concepts related to sexuality.

Young people who have developmental disabilities deserve accurate, age and developmentally appropriate sexual health information. This can sometimes be challenging for parents and young people if some learning channels are blocked or if commonly used teaching tools (such as diagrams and charts) are less than useful for children who learn in non-traditional ways. Nevertheless, the numerous benefits are worth the effort. Here are some tips and ideas for beginning your conversation:

1. **Use pictures as often as you can**. Photos of family or friends can be a springboard for talking about relationships and social interactions. These give important and immediate context to your discussions, which is key for these children who have success with concrete ideas.

2. **Use repetition in providing small amounts of information over time**. Check that your child understands by asking questions that put the information in a practical context. (What could Cousin Laverna have said?) Use opportunities to repeat key ideas in other settings—for instance, while watching television programs that deal with relationships or sexuality issues.

3. **Draw, copy, or buy a full body drawing or chart**. This is a concrete way to show where body parts are and what they do.

4. **For more involved tasks (such as personal hygiene related to menstruation), try to break down the activity into several steps**. Frequently review the steps with your child and always provide feedback and praise. If you are unsure if your steps are concrete and understandable, write them down and try following them yourself. Did you leave *anything* out? Using a pad or tampon during menstruation or cleaning beneath the foreskin of the penis may seem straightforward, but these activities require several separate steps in a particular order.

5. **Repeat information often, and offer feedback and praise**. Reinforce important concepts frequently.

6. **Practice!** Make sure your child has plenty of opportunities to try out his/her skills.

7. **Use existing resources.** Visit the library and check out books and videos about talking with your kids about sexuality. Also use the World Wide Web.

8. Network with other parents. Share your insights and listen to theirs. Involve others by communicating with teachers, coaches, and caseworkers about the topics you are discussing. Share ways they can reinforce these lessons at school, work, or on the playing field.

9. Recognize and validate your child's feelings. This is a unique opportunity to get to know your child better.

10. Don't be afraid to say, "I don't know the answer to that question." But, be sure to follow up with, "Let's find out together!" Then do so.

There is no single approach that is always best. As a parent, you have the opportunity to investigate and experiment, to be creative and to learn from your successes as well as your missteps!

Recommended Resources

Positive Approaches: A Sexuality Guide for Teaching Developmentally Disabled Persons (1991)

Talking Sex! Practical Approaches and Strategies for Working with People Who Have Developmental Disabilities When the Topic Is Sex (1999)

To purchase these publications, contact Planned Parenthood of Tompkins County's Education Department at 607-273-1526.

Source: Lisa Maurer, MS, CFLE, ACSE, Consultant and Trainer, Planned Parenthood of Tomkins County's Education Department

Advocates For Youth
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Parents' Sex Ed Center

Parents as Advocates for Comprehensive Sex Education in Schools

Parental support for school-based sex education is overwhelmingly positive. Over the past 20 years, in survey after survey, local, state or national, 80 to 85 percent of parents indicate they want their children to receive comprehensive, medically accurate, age-appropriate sex education. Parents see such courses and content as supplementing, not supplanting, their discussions at home. They say that their children need both to be taught about delaying the onset of intimate sexual relationships until they are mature and responsible and also given the information and skills they need to use condoms and contraception when they do choose to become sexually active. It's not either/or, but both.

Parents' involvement in school health education committees, as members of school boards, or as advocates during community controversy is vital to making sure that young people receive accurate information and that answers to their questions are not censored. Many curricula and classroom materials exist to meet children's needs and help them grow up sexually healthy. But there are also "education" materials that are discriminatory, inaccurate, biased, and judgmental, and that use shame, fear, and guilt to scare young people about sexual intimacy.

Sexuality education curricula and programs should be reviewed carefully for the following important components:

- Acknowledging that sexuality is a component of each person's personality, character, and life
- Containing age appropriate information, based on physical, emotional, and social developmental stages
- Containing information that is honest, medically accurate, and based upon verifiable scientific and behavioral theories
- Respecting of differences in family, religious, and social values
- Being nonjudgmental and open to all questions and concerns related to sexuality
- Reflecting cultural, social, and ethnic diversity
- Encouraging children/youth to discuss sexuality issues with their parents and to ask them questions
- Providing parental review of all materials used in the classroom
- Avoiding shame, fear, or guilt
- Promoting gender equality
- Including skills for decision making and resisting pressure
- Acknowledging that sexuality and sexual decisions are influenced by family, media, peers, religion, and personal experiences
- Acknowledging both responsibility and pleasure in intimate sexual relationships
- Giving young people opportunities to role play and to practice effective communication
- Acknowledging the diversity of sexual orientation
- Acknowledging that sexual abuse, coercion, and incest occur and offering referrals for counseling and support for survivors

- Promoting responsibility, respect, and honesty in relationships
- Containing materials evaluated by respected researchers and published in credible sources
- Offering reference lists from scientific, professional, peer-reviewed sources rather than personal opinions, newspaper articles, sermons, speeches, or magazine articles.

Finally, the chosen curriculum should be taught by knowledgeable, comfortable, and well trained sexuality educators.

As a Parent You Can Become an Advocate by:

- Learning what your school offers in sex education
- Acknowledging that sex education is a life long process and that parents are only one of the primary sex educators of young people
- Supporting honest, balanced sex education that is comprehensive and that includes education about abstinence and contraception
- Knowing what training your child's teachers have had in sex education
- Knowing the official school system policies on sex education.

Compiled by Barbara Huberman, RN, MEd, Director of Education and Outreach

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A GUIDE TO RAISING SEXUALLY HEALTHY CHILDREN

PARENTS AS SEXUALITY EDUCATORS RECOMMENDED READING LIST

"Sexual knowledge, like all knowledge, is powerful. Used carefully and deliberately, it is the cornerstone of safe, healthy, moral conduct."

—from *But How'd I Get in There in the First Place?* by Deborah Roffman

for families

All About Sex: A Family Resource on Sex and Sexuality
Ronald Filiberti Moglia, Ed.D. and Jon Knowles, Editors. Three Rivers Press, 1997.
This book, published by the Planned Parenthood Federation of America, provides important information about sex and sexuality in straightforward language that families can understand and use. It is intended to facilitate family communication, establish sexual values, and encourage responsible sexual behaviors.

The Family Guide to Sex and Relationships
Richard Walker, Ph.D. Macmillan Publishing USA, 1996.
Complete with over 300 color photos, illustrations, and diagrams, this book presents comprehensive information on the entire life cycle. Chapters include: "The Reproductive Body," "Baby to Child," "Adolescence," and "The Family and Sexuality."

Five Hundred Questions Kids Ask About Sex and Some of the Answers
Francis Younger, M.A. Charles C. Thomas Publisher, Ltd., 1992.
This book is intended for parents, teachers and young people. Written in question-and-answer format, it provides clear, comprehensive answers to questions young people ask. Chapters include: "Bodily Development and Sexual Maturation," "Conception, Pregnancy, and Childbirth," "Relationships," "Birth Control," "Sexually Transmitted Diseases," and "Heredity."

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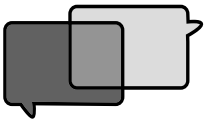

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A GUIDE TO RAISING SEXUALLY HEALTHY CHILDREN

for parents and other caregivers

Always My Child: A Parent's Guide to Understanding Your Gay, Lesbian, Bisexual, Transgendered or Questioning Son or Daughter

Pat Shapiro and Kevin Jennings, Fireside Publishing, 2002.

Using real-life stories, scientific research and practical advice, this book helps others understand the many obstacles GLBTQ youth face and what a family can do to create a safe environment for these teens.

Beyond the Big Talk: Every Parent's Guide to Raising Sexually Healthy Teens

Debra W. Haffner, Newmarket Press, 2001.

A guide for adults about adolescent sexual development, values, influences, parent involvement, and what to say and do.

But How'd I Get in There in the First Place? Talking to Your Young Child about Sex

Deborah Roffman. Perseus Press, 2002.

This book shares thoughtful, thorough guidance for parents' continuous sexuality education of children up to about age six, written by an experienced certified sexuality and family life educator, covering how children assimilate information, what they need to know, and how to recognize and work with one's own inhibitions.

But I Love Him: Protecting Your Teen Daughter from Controlling, Abusive Dating Relationships

Jill Murray, Harper Publishing, 2001.

This book focuses on the different types of relationship abuse (sexual, physical, and emotional), how to spot signs of abuse, and help teens experiencing it break free and heal.

Conversaciones: Relatos Por Padres y Madres de Hijas Lesbianas y Hijos Gay

Mariana Romo-Carmona, Cleis Press, 2001.

Written in Spanish, this book contains a collection of interviews from parents of gay and lesbian teens in Latin America. They share first-hand experiences of everything from discrimination to isolation and ways of coping with these issues.

Everything You Never Wanted Your Kids to Know About Sex (But Were Afraid They'd Ask)

Justin Richardson and Mark Schuster, Three Rivers Press, 2004.

Written by an assistant psychiatry professor at Columbia and Cornell and a UCLA associate professor of pediatrics and public health, Richardson and Schuster team up to provide a positive, straightforward guide for parents on teenage sexuality from the earliest signs of puberty to young adulthood.

Field Guide to the American Teenager: A Parent's Companion

Michael Riera and Joseph Di Prisco. Perseus Publishing, 2000.

Addressing the isolation, fear, and silence parents endure during their child's adolescence, these authors go beyond the stereotypes to expertly guide parents to a better appreciation of their teenager's frustrating if not completely troubling behavior.

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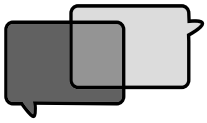
When the question is tough, the answer is ... apparent!



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A GUIDE TO RAISING SEXUALLY HEALTHY CHILDREN

From Diapers to Dating: A Parent's Guide to Raising Sexually Healthy Youth (2nd. Edition)
Debra Haffner. Newmarket Press, 2008.
This book is filled with practical advice and guidelines to help parents feel more comfortable talking to children and early adolescents about sexuality issues. Incorporating values exercise, it encourages parents to examine their own sexual values so that they can share these messages.

How to Talk to Teens About Really Important Things: Specific Questions and Answers and Useful Things to Say
Charles E. Schaefer and Theresa Foy DiGeronimo, Jossey-Bass, 1999.
Schafer and DiGeronimo stress the importance of communication between teens and caregivers in this book. It offers examples of discussions and answers to common questions and issues that adolescents may bring up, such as tattoos, sex, and depression. It also offers further resources for parents needing more specific information.

Sex and Sensibility: The Thinking Parent's Guide to Talking Sense about Sex
Deborah Roffman. Perseus Press, 2001.
This book for parents is intended to inspire honest communication about sexuality between them and their children. Chapters include "Age Appropriateness: Too Much, Too Little, or Just Right?," "Values: Becoming Your Child's Cultural Interpreter," "Sexuality: More Who We Are than What We Do," and Sexual Orientation: Why and How It's Everyone's Business."

Ten Talks Parents Must Have With Their Children About Sex and Character
Pepper Schwartz, Ph.D. and Dominic Cappello. Time Warner Trade Publishing, 2000.
This book is intended for parents of children in grades 4 through 12. Developed to help parents and children talk about sexuality and building character it offers advice to parents on how to begin and what to say. Topics include safety, character, peer pressure, ethics, the Internet, and the media. Each chapter provides ways for parents to clarify their values and family rules about specific sexuality issues, anecdotes to share with children to foster communication, questions to ask your child, opportunity to reflect on responses and identify potential problems, and sample talks.

The Real Truth About Teens and Sex
Sabrina Weill. Perigee Trade, 2005.
This book presents a realistic picture of what today's teens are thinking, feeling, talking about and doing regarding dating and sex. The book contains exclusive results from a nationwide survey conducted by the National Campaign to Prevent Teen Pregnancy.

The Rollercoaster Years
Charlene C. Giannetti and Margaret Sagarese, Broadway, 1997.
A how-to manual for those raising 10-15 year olds, this book addresses issues that are likely to come up in this age-group, how to properly respond to them, and when to seek professional help. With plenty of statistics and humor, this book is clear and effective in helping parents navigate their child's adolescence.

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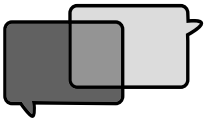

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A GUIDE TO RAISING SEXUALLY HEALTHY CHILDREN

What Every 21st-Century Parent Needs to Know: Facing Today's Challenges with Wisdom and Heart
Debra W. Haffner. Newmarket, 2008.
This book presents parents with facts and statistics about the toughest issues teens face in today's world, including drugs, sex, and drinking, but Haffner interprets them in an optimistic way and focuses on helping parents make realistic and positive parenting choices that will bring out the best in their child.

When Sex is the Subject: Attitudes and Answers for Young Children
Pamela M. Wilson. ETR Associates, 1991.
This insightful handbook was written for teachers and parents, it addresses questions from children 10 years of age and younger. The psychosocial development and learning processes of children are discussed and guidelines are provided for accurate and comfortable responses.

Why Do They Act That Way? A Survival Guide to the Adolescent Brain for You and Your Teen.
David Walsh. Free Press, 2004.
Although this book is not primarily about sexuality, it does cover hormones, impulsivity, sex drive, abuse, sexual activity and education in helpful ways other books omit.

for older children, preteens and teens: GIRLS

American Medical Association Girl's Guide to Becoming a Teen
Kate Gruenwald, Jossey-Bass, 2006.
With information from the American Medical Association, this book teaches girls 9-12 about both the physical (nutrition, exercise, and menstruation) and emotional (feelings and relationships) changes and issues that need to be addressed with the arrival of puberty. This guide does not spend great detail on sex or contraception, encouraging readers to wait.

Are You There, God? It's Me, Margaret
Judy Blum, Yearling, 1986.
Written from a preteen girl's point of view, this novel explores all aspects of female puberty in a relatable way.

Cycle Savvy: The Smart Teen's Guide to the Mysteries of Her Body
Toni Weschler, Harper Publishing, 2006.
Written by a national best-selling women's health author, *Cycle Savvy*; enlighten girls on various phases of their menstrual cycles and gives them the tools to stay physically and emotionally healthy in this area of their lives.

Deal with It! A Whole New Approach to Your Body, Brain, and Life as a gURL
Esther Drill, Heather McDonald, and Rebecca Odes. Simon and Schuster, 1999.
The creators of the gurl.com website offer frank, funny, and factual information about girls' sexuality.

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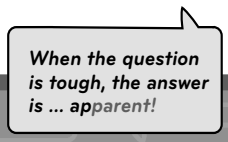

Girl Stuff: A Survival Guide to Growing Up
Margaret Blackstone and Elissa Haden Guest, Harcourt Paperbacks, 2006.
This book gives girls going through puberty helpful tips and lots of straightforward information on everything from stress to menstruation. It also touches on peer pressure and sex and encourages girls to make smart, healthy decisions in all aspects of their lives.

Girltalk: All the Stuff Your Sister Never Told You
Carol Weston, Harper Paperbacks, 2004.
A mixture of advice, facts, and answers to questions from adolescent girls, this book addresses puberty and everything that comes with it in an easily applicable and honest way.

It's A Girl Thing: How to Stay Healthy, Safe, and in Charge
Mavis Jukes. Random House, Inc., 1996.
This book for young women presents general information about puberty, crushes, kissing, intercourse, pregnancy, STDs, birth control, boys and puberty, and health. A list of resources is included.

My Body, My Self for Girls: for Preteens and Teens
Lynda Madaras and Area Madaras, Newmarket Press, 2000.
This journal/activity book for girls eight to 15 years of age is a companion to What's Happening to my Body? Book for Girls. It includes exercises, quizzes, and personal stories to help girls learn about body changes.

Period
LoAnn Loulan and Bonnie Worthen. Book Peddlers, 2001
Illustrated with drawings, this book addresses the changes that girls experience as they mature. Emphasizing that we are all unique and special, it explains physical changes during puberty. Includes a parents' guide. Intended for children ages 8 and older.

Ready, Set, Grow!: A What's Happening to My Body?
Lynda Madaras, Newmarket Press, 2003.
This book focuses on informing and supporting girls 9-12 about the changes they are beginning or about to experience both physically and emotionally and gives tips on staying healthy and positive.

The Period Book: Everything You Don't Want to Ask (But Need to Know)
Karen Gravelle and Jennifer Gravelle with illustrations by Debbie Palen. Walker and Company, 1996.
This is a positive, down-to-earth book illustrated with funny and sympathetic cartoons. It answers the many questions that young women may have about their "period." It will also help guide young women through physical, emotional, and social changes.

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What's Happening to My Body? Book for Girls: A Growing Up Guide for Parents and Daughters
Lynda Madaras with Area Madaras, Newmarket Press, 2000.
Filled with anecdotes, illustrations, diagrams, and honest, sensitive, nonjudgmental information for the young girl, this revised edition also addresses the new scientific facts about when a girl actually begins puberty, advice on "female athletic syndrome," eating disorders, unwanted attention because of early development, and information on eating right, exercise, AIDS, STDs, birth control, and more.

What's with My Body? The Girls' Book of Answers to Growing Up, Looking Good, and Feeling Great
Selene Yeager, Prima Publishing, 2002.
This book contains reassuring, accurate advice for preteen and young teen girls and their parents. Presented in a question-and-answer format, topics include body changes, skin and hair care, menstruation, eating disorders, moods, and sexuality.

Your Body: The Girls' Guide
Janis Brody, Ph.D., St. Martin's Press, 2000.
This book for teens discusses puberty, menstruation, female and male anatomy, sexual intercourse, STDs, birth control, sexual orientation, dating, and crushes as well as eating well, sports, and growing up healthy.

for older children, preteens and teens: BOYS

American Medical Association Boy's Guide to Becoming a Teen
Kate Gruenwald Pfeifer, Jossey-Bass, 2006.
With information from the American Medical Association, this book teaches boys 9-12 about both the physical (nutrition, exercise, and growing bodies) and emotional (feelings and relationships) changes and issues that need to be addressed with the arrival of puberty. This guide does not spend great detail on sex or contraception, encouraging readers to wait.

Changes in You & Me: A Book about Puberty Mostly for Boys
Paulette Bourgeois and Martin Wolfish, M.D., Andrews and McMeel Publishers, 1994.
This is a reference book for boys about the physical changes and feelings that go along with growing up. Topics include anatomy, puberty, birth control, pregnancy, masturbation, what happens to girls, decision making, STDs, sexual abuse, sexual orientation, and where to go for help. The book includes transparent overlays, a glossary, and an index.

Growing up Gay in America: Informative and Practical Advice for Teen Guys Questioning Their Sexuality and Growing Up Gay
Jason Rich. Dimension Publishing. 2002.
Thoughtful, thorough, and expansive exploration of many relevant topics important to male teens who are gay or questioning if they are gay and need information about self-acceptance and fitting in.

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The Guy Book: An Owner's Manual for Teens
Mavis Jukes, Crown Publishing, 2002.
A clever, retro automotive style guide with information for boys on changes that occur in their bodies during puberty and offering advice on sexual topics, nutrition, drugs, girls, and more.

My Body, My Self for Boys: for Preteens and Teens
Lynda Madaras and Area Madaras, Newmarket Press, 2000.
This journal/activity book for boys eight to 15 years of age is a companion to What's Happening to my Body? Book for Boys. It includes exercises, quizzes, and personal stories to help boys learn about the changes that take place in their bodies during puberty.

Our Boys Speak: Adolescent Boys Write about Their Inner Lives
John Nikkah, St. Martin's Griffin, 2000.
This collection of writings by adolescent boys addresses sex and dating, sports, religion, depression, sexual orientation, and family. The author provides commentary and perspective on the question: "What do boys think?"

The Teenage Guy's Survival Guide: The Real Deal on Girls, Growing Up, and Other Guy Stuff
Jeremy Daldry. Little, Brown and Company Children's Books, 1999.
This book for young men discusses basic information about sexuality. Topics include love, dating, sexual orientation, relationships, intimacy, puberty, emotions, confidence, and peer pressure.

What's Going on Down There? Answers to Questions Boys Find Hard to Ask
Karen Graville with Nick and Chava Castro and illustrated by Robert Leighton, Walker and Company, 1998.
Straightforward and entertainingly presented, this book helps boys understand the changes that occur during puberty, what causes these changes, and what to expect. The book addresses sexual orientation, masturbation, intercourse, contraception, STDs and pregnancy.

The What's Happening to My Body? Book For Boys: A Growing Up Guide for Parents and Sons
Lynda Madaras with Area Madaras, Newmarket Press, 2000.
This book discusses the changes that take place in a boy's body during puberty, including information on the body's changing size and shape, the growth spurt, reproductive organs, pubic hair, beards, pimples, voice changes, wet dreams, and puberty in girls.

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for older children, preteens and teens: GIRLS AND BOYS

Changing Bodies, Changing Lives: Expanded Third Edition: A Book for Teens on Sex and Relationships
Ruth Bell, Three Rivers Press, 1998.
Written to address all areas of teenage sexuality, this book includes illustrations, quotes from teenagers themselves, and lots of straight-forward information about sexual health for both boys and girls from eighth grade and older.

GLBTQ: The Survival Guide for Queer and Questioning Teens
Kelly Huegel, Free Spirit Publishing, 2003.
This book is designed to offer practical information on all aspects of life for a teen questioning hihe/sher sexuality. It addresses everything from coming out to religion as well as listing other resources for additional information.

The "Go Ask Alice" Book of Answers: A Guide to Good Physical, Sexual, and Emotional Health
Columbia University's Health Education Program, Owl Books, 1998.
This book provides young people with information and advice on a variety of frequently asked questions from the "Go Ask Alice!" web site at Columbia University. Topics include relationships; sexuality; sexual health; emotional health; fitness and nutrition; alcohol, nicotine, and other drugs; and general health.

Healthy Sexuality
Kristen Kemp, Scholastic, Inc., 2004.
Contributing editor at Girls' Life magazine, Kristen Kemp offers facts, advice, and straight talk about different aspects of sexuality, including gender characteristics, changing emotions during puberty, birth control, and sexually transmitted diseases.

It's Perfectly Normal: Changing Bodies, Sex and Sexual Health
Robie H. Harris and illustrated by Michael Emberly, Candlewick Press, 2004.
In this book accurate information about sexuality is presented in a reader-friendly style that includes age-appropriate illustrations and humor. From conception and puberty to contraception and HIV/AIDS, it covers both the biological and psychological aspects of sexuality.

Love & Sex: Ten Stories of Truth
Edited by Michael Cart, Simon & Schuster, 2001.
This anthology, featuring popular writers for adults and teens, contains stories about love and sexuality in the lives of adolescents.

Puberty's Wild Ride: The Ups and Downs, Ins and Outs, Zigs and Zags of Growing Up
Marta McCave, 2001
This book is intended for young teens and their parents. It is a useful resource for teens to find information. Parents and teen can use it together as a conversation starter or as a reference tool. This book is sure to help teens get through the ups and downs, ins and outs, zigs and zags of growing up.

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STD's: What You Don't Know Can Hurt You
Diane Yancey, Lerner Publishing Group, 2002.
This book explains difference types of sexually transmitted diseases, how they are contracted, their symptoms, and treatment.

The Underground Guide to Teenage Sexuality
Michael Basso, Fairview Press, 2003.
This book for teens on human sexuality covers such subjects as anatomy, sexual intercourse, STDs, contraception, and homosexuality. The author wrote the book to give teens the information they need to protect themselves and accept responsibility for their actions.

Too Old for This, Too Young for That! Your Survival Guide for the Middle-School Years
Harriet S. Mosatche and Karen Unger, Free Spirit Publishing, 2005.
Geared toward preteens ages 9-12, this illustrated book uses humor and examples of situations that may arise to inform about physical and emotional changes, peer pressure, and family life. Survival tips and further resources are listed to give kids more information and confidence as they enter adolescence.

What If Someone I Know Is Gay? Answers to Questions about Gay and Lesbian People
Eric Marcus, Penguin Putnam Incorporated, 2000.
This book for teens provides questions and answers about homosexuality and bisexuality. Topics include coming out, friends and family, religion, sexual behavior, school, activism, and discrimination. The book includes a resource section.

for younger children

Amazing You! Getting Smart About Your Private Parts
Gail Saltz, M.D. and illustrated by Lynne Cravath, Dutton Publishing, 2005.
This book is mostly pictures with anatomically correct illustrations and proper terms for body parts. It's meant for parents and their children, ages 3 to 7, to read together.

A Very Touching Book...for Little People and for Big People
Jan Hindman, Alexandria Assoc, 1983.
This book is designed to teach young children about respecting their bodies and how others should treat them in terms they can understand and includes illustrations to teach proper anatomy.

Bellybuttons Are Navels
Mark Schoen and illustrated by M.J. Quay, Prometheus Books, 1990.
This children's book is intended to create a relaxed environment for the discussion of sexuality. It will help parents initiate and guide matter-of-fact, accurate discussions with their young children about sexual anatomy.

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Did the Sun Shine Before You Were Born?
Sol and Judith Gordon, Prometheus Books, 1992.
Targeted to children three to seven years old, this book focuses on the family and how it grows. It explains everything form conception to birth. Illustrated with charcoal drawings of multicultural images, this book fosters communication between parents and children by the sharing of values and ideas.

Do I Have A Daddy? A Story About A Single- Parent Child
Jeanne Warren Lindsay. Morning Glory Press, 1999.
This book introduces children to single-parent families by following Erik as his Mother explains why he doesn't have a conventional family, but the love she feels for him and the importance of his Uncle and Grandfather in his life.

Emma and Meesha My Boy: A Two Mom Story
Kaitlyn Considine, TWOMOMBOOKS.com, 2005.
This book focuses on the story of Emma learning proper pet care while simultaneously introducing the fact that she has two Moms. While not directly addressing same-sex parenting in-depth, this book allows children to see how different types of families share the same every-day activities.

Happy Birth Day!
Robie H. Harris, Candlewick, 2002.
Designed for children from babies to age 7, this book illustrates a mother describing the first day after birth to her daughter in an affectionate and joyful way.

How Babies and Families Are Made: There Is More Than One Way!
Patricia Schaffer, Tabor Sarah Books, 1988.
This picture book seeks to show children ages 5-9 the journey from conception to birth and alternative circumstances, such as in vitro fertilization, adoption, and premature birth.

How Was I Born?: A Child's Journey Through the Miracle of Birth
Lennart Nilsson and Lena Katarina Swanberg, Dell, 1996.
For children 4-8, this book is told from the point-of-view of Mary, a 5-year-old with a pregnant mother. It includes real photographs of a developing fetus and describes the progression from conception to infancy.

How You Were Born
Joanna Cole, Harper Collins Publishers, 1993.
This book is designed to tell children about birth in simple terms. Using colorful photographs, it can be read to children or pictures can be discussed.

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It's My Body
Lory Freeman, Parenting Press, 1982. Also available in Spanish, ***Mi Cuerpo es Mio***
Simply illustrated, but containing a powerful message, this book aims to explain to young children the difference between "good" and "bad" touch and how to respond appropriately.

It's NOT the Stork! A Book About Girls, Boys, Babies, Bodies, Families, and Friends
Robie Harris and illustrated by Michael Emberley, Candlewick Press, 2005.
This book is for ages four and up to help answer those endless and perfectly normal questions that preschool, kindergarten and early elementary school children ask about how they began and what makes a girl a girl and a boy a boy.

It's So Amazing! : A Book About Eggs, Sperm, Birth, Babies, and Families
Robie Harris and illustrated by Michael Emberley, Candlewick Press, 2002.
Also available in Spanish, ***¡Es Alucinante!***
This book provides a solid combination of appealing cartoon humor and intelligently presented, straightforward information, presented at the middle elementary age level, about many topics kids wonder about: bodily changes, abuse, intercourse, birth control, pregnancy and birth, genetics, love, masturbation, homosexuality, HIV and AIDS.

Molly's Family
Nancy Garden, Farrar, Straus and Giroux Publishing, 2004.
This book depicts to children aged four to eight a story about Molly and her two mothers. While Molly has trouble finding peer acceptance at first, support and understanding grow as all different types of families are explored.

The Family Book
Todd Parr, Little Brown Young Readers, 2003.
Written for children four to eight, this colorful picture book illustrates different types of families, including single, step, and same-sex parents, while highlighting the similarities all families share such as the love to hug and support each other.

What's the Big Secret? Talking About Sex with Girls and Boys
Laurie Krasny Brown and Marc Brown, Little Brown Publishing, 1997.
This inviting children's picture book for children presents information and answers about sexuality. It addresses how boys and girls differ, anatomy, reproduction, pregnancy, and birth. It also discusses feelings, touching, and privacy.

When You Were Inside Mommy
Joanna Cole, HaperCollins, 2001.
Using easily understood language and inviting illustrations, this book describes the fetus growing in the womb through birth to young children.

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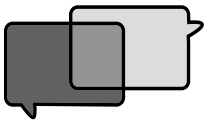


it's that easy!™

A GUIDE TO RAISING SEXUALLY HEALTHY CHILDREN

Where Did I Come From?

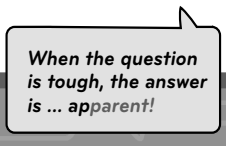
Peter Mayle with illustrations by Arthur Robins, 1997.

Celebrating its twentieth anniversary, this book uses humor and bright illustrations to explain anatomy, intercourse, orgasm, fertilization, pregnancy and birth to children.

Your Body Belongs to You

Cornelia Maude Spelman, Albert Whitman Publishing, 1997.

This book shares positive encouragement for children to use their own judgment to be in charge of who touches their body and how.



PUTTING WHAT WORKS TO work
A Project of the National Campaign to Prevent Teen Pregnancy

SCIENCE Says:

Number 8 February 2004

Parental Influence and Teen Pregnancy

Despite what parents may think, they have an enormous influence on their children's decisions about sex. More than two decades of high quality research, supplemented by recent public opinion polls, point to the same conclusion: the quality of parents' relationships with their teenagers can make a real difference in the decisions that their children make about sex.[1] *This* Science Says *brief makes the case that — even in a culture that bombards young people with conflicting and often-confusing messages about sex and pregnancy — parents remain powerful. This brief compiles much of what is known from research about parental influence and offers parents and others suggestions for how to help children delay sexual activity and avoid teen pregnancy.*

What Research Shows

Relationships matter most. Overall closeness between parents and their children, shared activities, parental presence in the home, and parental caring, support, and concern are all associated with a reduced risk of early sex and teen pregnancy. Teens who feel closely connected to their parents are more likely to abstain from sex, wait until they are older to begin having sex, have fewer sexual partners, and use contraception more consistently.[2]

The importance of attitudes and values. Children whose parents are clear about the value of delaying sex are less likely to have intercourse at an early age. Parents who discuss contraception are also more likely to have children who use contraception when they become sexually active.[3]

The overall strength and closeness of parent/child relationships seems to be the best protection of all.

The importance of parental supervision. Teens whose parents supervise them and monitor their behavior are more likely to be older when they first have sex, to have fewer partners, to use contraception, and to be less at-risk for pregnancy. However, overly strict, authoritarian monitoring is actually associated with a *greater* risk of teen pregnancy,[4] so parents need to strike a balance.

The influence of parents and peers. Teens say that parents influence their decisions about sex more strongly than do friends and other sources. When asked who most influences their sexual decisions, 45 percent of teens say parents. Only 31 percent say friends are most influential, six percent cite teachers and sex educators, seven percent say religious leaders, and four percent say the media most influences their decisions about sex. Meanwhile, adults appear to overestimate the influence of peers and underestimate their own — only 32 percent of adults believe parents most influence teens' decisions about sex, while 48 percent believe friends are most influential.[5]

Family structure. Family structure, income, and where a family lives are also related to the risk of

Teens say parents most influence their decisions about sex. But adults think that teens are most influenced by friends.

The National Campaign to Prevent Teen Pregnancy
www.teenpregnancy.org ■ 202.478.8500 ■ web@teenpregnancy.org

teen pregnancy. Children in single-parent families and teens with older brothers and sisters who are sexually active or who have been pregnant or given birth are more likely to be sexually active at an early age. Those teens living in neighborhoods beset by poverty, unemployment, and high crime rates are more likely to start having sex early, fail to use contraception, and become pregnant or cause a pregnancy.[6] Yet these are not the most significant reasons why teens begin having sex at an early age.[7]

Overall risky behavior. Close parent-child relationships not only help protect young people from early sex and pregnancy, they also help teens avoid other such risky behaviors as violence, substance and alcohol use, and school failure.[8]

Parents are often in the dark. Many parents are not aware that their adolescent children have had sex. Only about a third of parents of sexually experienced 14-year-olds believe that their child has had sex.[9] Half of parents of sexually experienced 8th to 11th graders are aware that their sons and daughters have started having sex.[10]

Most parents of sexually experienced children are unaware that their teenage children have had sex.

Dating and age differences. Research supports what common sense suggests: Two of the most powerful risk factors for early sex and pregnancy are, 1) close romantic attachments, and 2) significant age differences (three years or more) between partners. Young adolescents are particularly vulnerable. Romantic relationships between young teens, and one-on-one dating with an age difference of three years or more, significantly increase the risk of early sexual activity.[11]

Among those aged 12–14:

– 13 percent of same-age relationships include sexual intercourse

– 26 percent of relationships where the partner is two years older include sex

– 33 percent of relationships where the partner is three or more years older include sex[12]

Abuse and neglect. Young people who grow up in abusive families (physical, sexual, and emotional) are more likely to be sexually active and not to use contraception consistently,[13] although there are limitations in the research on this topic.[14] Evidence also suggests that a significant number of teen mothers are in violent, abusive, or coercive relationships just before, during, or after pregnancy.[15]

Abstinence and contraception. Public opinion shows support for both abstinence and contraception for young people. The overwhelming majority of adults and teens believe that young people should be given a very strong message to abstain from sex until they are at least out of high school. At the same time, most adults and teens believe that teens should be given more information about abstinence *and* contraception rather than one or the other.[16]

Stressing abstinence to teens while also providing them with information about contraception is not viewed as a "mixed message." Seven in ten adults and eight in ten teens view such a message as "clear and specific."[17]

Boys and girls. Six out of ten teens (59 percent) believe that teen boys often receive the message that sex and pregnancy are no big deal.[18]

What it all means

The research presented here has clear implications for parents, policymakers, and those working with young people and parents.

Parent/Child relationships matter most of all. Parents who (1) clearly communicate their values and expectations to their children, (2) express their concerns and love for them early and often, and (3) exercise supervision — including their child's selection of friends and role models — raise children who are more likely to avoid early sexual activity, pregnancy, and parenthood than those parents who do not. Research supports the conclusion that the overall strength and

closeness of parent/child relationships seems to be the best protection of all.[19]

Talking is not enough. It is important for parents to discuss sex, love, and relationships directly with their children. Teens make it clear that they want to hear from their parents on these topics, even if they don't always act like it. However, simply talking with their teens about the risks of early sex and pregnancy is not enough. Parents need to become heavily involved in their children's lives in order to delay first sex, increase contraceptive use, or decrease the risk of pregnancy.[20]

Use the media. Many parents say that they want to have discussions with their children about sex, love, values, and relationships but find starting such conversations awkward at best. Parents should consider using television, radio, movies, music videos, and magazines as prompts. In the media, sex often has no meaning, abstinence and contraception are mentioned rarely if at all, unplanned pregnancy seldom happens, and few characters having sex seem to be married or even especially committed to each other. Tell your children what you think about these messages and ask what they think about them. If certain programs or movies offend you, say so, and explain why. Encourage your kids to think critically; ask them what they think about the programs they watch, the magazines they read, and the music they listen to.

Adults support an "abstinence-first" approach. Policymakers and program leaders developing or running programs for youth should note that the majority of American adults support an abstinence-first approach. This approach stresses abstinence as the first — and best — option for teens but also strongly advocates giving young people contraceptive information and services.

Make boys and young men part of the equation. As noted above, a majority of teens believe that boys often receive the message that sex and pregnancy are not a big deal. This suggests that a "double standard" — one that encourages girls to abstain from sex while offering teen boys a wink and a nod — may be alive and well. Those concerned about adolescent pregnancy must expand their efforts to reach boys and young men and parents must be direct with their male children about respect for girls and women, responsibility, and expected standards of behavior.

Recognize the connection between adolescent pregnancy and abuse. Efforts currently underway to inform and educate practitioners and policymakers about the connection between physical, sexual, and emotional abuse and teen pregnancy should be extended and strengthened.

For more information. Much of the information in this research brief is adapted from the National Campaign publication, *Parent Power: What Adults Need to Know and Do to Help Prevent Teen Pregnancy* (available at www.teenpregnancy.org/parent). *Parent Power* is divided into three sections: (1) what research says about parental influence, (2) what teens want parents to know about preventing teen pregnancy, and (3) tips for parents.

About the Putting What Works to Work project

Putting What Works to Work (PWWTW) is a project of the National Campaign to Prevent Teen Pregnancy funded, in part, by the Centers for Disease Control and Prevention. Through PWWTW, the Campaign translates research on teen pregnancy prevention and related issues into user-friendly materials for practitioners, policymakers, and advocates. As part of this initiative, the *Science Says* series summarizes recent research in short, user-friendly briefs

For more information, please visit www.teenpregnancy.org

About the National Campaign

The National Campaign to Prevent Teen Pregnancy is a nonprofit, nonpartisan organization supported largely by private donations. The Campaign's mission is to improve the well-being of children, youth, and families by reducing teen pregnancy. Our goal is to reduce the rate of teen pregnancy by one-third between 1996 and 2005.

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Author information

This research brief was written by Bill Albert, Senior Director of Communications, Publications, and Technology at the National Campaign to Prevent Teen Pregnancy.

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Chapter 6
Curriculum and Instruction

Effective Human Growth and Development Curriculum and Instruction

6

Overview

This section provides information and resources to help districts implement a human growth and development (HGD) curriculum that is likely to result in their students acquiring the knowledge, attitudes, skills, and intentions that will contribute to their health and well-being. It begins with a reminder to consider the specific needs of youth in the community, and then reviews research findings on effective HGD instruction. It discusses what is currently known about the effectiveness of comprehensive and abstinence-only-until-marriage programs.

State academic standards and national guidelines provide a useful framework for program development at the local level.

The selection of a HGD curriculum requires weighing many factors to determine the "best fit" for a particular school or school district. Some of these factors include the:

- Needs of children and youth
- Parental support
- State academic standards
- Scope and sequence for K–12 instruction
- Effectiveness of the curriculum
  - Health outcomes
  - Best practices
- Acceptability in terms of community standards
  - Cultural factors
  - Perspectives on abstinence-only messages
- Implementation issues
  - Ease of replication and adaptability

This section discusses each of these factors and includes resources for districts and advisory committees to use as they review, develop, and implement HGD programs in Wisconsin schools. It also includes references to additional sources for more information on each of the factors.

Needs of Children and Youth

As discussed in Section 3, the particular educational needs of children and youth in the school district should be the primary consideration in development and selection of a HGD curriculum. Seldom is a complete profile of these young people available and so county, state, and even national data can be used to understand behavioral trends and educational needs. For young children little quantifiable data exists, even at the state and national levels, about knowledge and attitudes related to sexuality to guide HGD curricular development. State academic standards and national guidelines provide a useful framework for program development at the local level.

Quality health education programs are needed to increase student knowledge on various age-appropriate contemporary health issues and to apply appropriate skills to take action that promotes or restores health.

Parental Support

The vast majority of Americans agree that sexuality education should be taught in schools. This was the conclusion of the published report, Sex Education in America, based on nationwide telephone survey of the general public and public middle and high schools' principals conducted by National Public Radio, the Kaiser Family Foundation, and Harvard's Kennedy School of Government (NPR et al, 2004). The report is available at www.kff.org.

However, there continues to be significant differences about what kind of sexuality education should be taught. According to Sex Education in America, 15 percent of Americans believe schools should teach only about abstinence from sexual intercourse and should not provide information on how to obtain and use condoms and contraception. Almost half (46%) of Americans believe schools should use an "abstinence-plus" approach that teaches that abstinence is the best approach but also teaches about condoms and contraceptives. The survey also found that parents want sexuality education classes to cover topics that are perceived as controversial by many administrators and teachers. At least 75 percent of parents say sexuality education classes should cover how to use condoms and other forms of birth control, as well as provide information on abortion and sexual orientation.

State Academic Standards

Traditionally, HGD has been taught as part of Health Education and/or Family and Consumer Education. These will continue to be the primary subjects in which HGD instruction is provided, but there are other opportunities to teach and reinforce sexuality education content and skills. Because the topic of sexuality is so broad, sexuality education can be integrated into Science, Language Arts, or Social Studies, as well as other subject areas. It may be useful for teachers in Health Education, Family and Consumer Education, Developmental Guidance, Teenage Parent programs, Science, Language Arts, Social Studies, and other subjects to discuss ways sexuality is addressed in their various curricula so students receive coordinated instruction. School districts are encouraged to plan the HGD curriculum with attention to K–12 sequencing and opportunities to coordinate and integrate HGD with other subjects.

Human Growth and Development Connections with the State Standards in Health Education

Quality health education programs are needed to increase student knowledge on various age-appropriate contemporary health issues and to apply appropriate skills to take action that promotes or restores health. Health education helps youth become health literate people who are critical thinkers, creative problem solvers, self-directed learners, effective communicators, and, ultimately, responsible and productive citizens. Health education programs provide these benefits only if they are carefully planned, implemented, and assessed for outcomes. *Wisconsin Standards for Health Education* www.cal.dpi.wi.gov/files/cal/pdf/health-stds.pdf are based on characteristics of an individual who is health-literate. A health-literate individual is a

- critical thinker and problem solver,
- self-directed learner,
- effective communicator, and
- responsible and productive citizen.

Each of the eight content standards, and related performance standards, contribute to the knowledge and skills of a health-literate person. The health education standards do not specifically mention HGD, HIV, STI, or pregnancy prevention. Taken together, these general standards provide guidance for content priorities.

See Resource 6.1 **Wisconsin Standards for Health Education: Critical Questions**

Human Growth and Development Connections with the State Standards in Family and Consumer Education

Wisconsin academic standards have also been established for Family and Consumer Education (FCE). The academic standards identify expectations of what students know, and can do, and can show how they have met content standards at introductory (by the end of 6th grade), intermediate (by the end of 8th grade), and advanced levels of study (by the end of 12th grade).

Like the Health Education standards, the FCE academic standards serve as guidelines for schools, but decisions about what, how much, and when the core concepts are taught to students reside with local districts. And like the academic standards for Health Education, the academic standards for FCE are designed to support and complement the role of the family (http://fce.dpi.wi.gov/).

See Resource 6.2 **National Standards for Family and Consumer Sciences Education—Human Development Comprehensive Standard**

National Sexuality Education Standards

The goal of the National Sexuality Education Standards is to provide clear guidance on essential content for human growth and development that is developmentally age appropriate. Similar to the National Health Education Standards, the Sexuality Education Standards were developed by a diverse group of experts in the fields of health education, sexuality education, public health, public policy, philanthropy, and advocacy. Recognizing that health education is often given precious little time in the school curriculum, and sexuality education far less time, these standards can guide school districts and Human Growth and Development Committees in choosing the most critical content based on the needs of their students and community.

See Resource 6.3 **National Sexuality Education Standards: Core Content and Skills, K–12**

Effectiveness of the Curriculum

One important factor to consider in implementing a HGD curriculum is whether it is effective. Effectiveness can be defined, and measured, in different ways. The research literature defines "effective" adolescent sexual risk behavior prevention programs as those for which "rigorous outcome evaluation has yielded evidence of a significant positive effect on adolescents' key sexual risk behaviors, pregnancy, birth, STI, or HIV infection rates—among at least one subgroup of youth in at least one evaluation study" (J. Solomon, 2004). Rigorous outcome evaluations refer to research studies that use experimental or quasi-experimental designs to analyze whether a program made a difference in terms of selected behaviors or health outcomes. Not all evaluation studies of curricula meet these rigorous criteria.

The Wisconsin Department of Public Instruction supports comprehensive sexuality education that stresses abstinence from sexual activity but also provides age-appropriate instruction on condoms and contraceptive use.

Research to date continues to support comprehensive sexuality education as more effective in reducing sexual risk behaviors, teen pregnancy rates, and STI/HIV infection rates than abstinence-only education (Blake, 2003; Chin et al, 2012; Jemmott et al, 1998; Kirby, 2007; Ruiz, 2001; Thomas 2000). Because of the numerous variables related to effectiveness, including replication and fidelity, this research literature does not imply that all comprehensive sexuality education programs are effective. At this time there is not strong scientific evidence that any abstinence-only programs have had similar significant and lasting effects (Chin et al, 2012; Hauser, 2004; Kirby, 2002).

A large-scale evaluation of abstinence education programs funded under Title V was conducted by Mathematica Policy Research, Inc. The findings from this study negated initial concerns that abstinence only programs resulted in youth engaging in more unprotected sex than their control group counterparts. However, given the lack of abstinence only education program effects on behavior, the evaluators concluded that policymakers who seek effective methods to reduce the high rate of teen sexual activity and its negative consequences should focus on continued program development. In particular, findings from the

study suggest that (a) targeting youth solely at young ages may not be sufficient and (b) efforts to sustain positive peer networks may have protective effects on youth behavior (www.mathematica-mpr.com).

Given the evidence, the Institute of Medicine, American Academy of Pediatrics, American Medical Association, the American Public Health Association, the National Education Association, the National Medical Association, the National School Boards Association, the Society for Adolescent Medicine, and other organizations support comprehensive sexuality education and recommend elimination of mandates for abstinence-only and abstinence until marriage programs. The Wisconsin Department of Public Instruction supports comprehensive sexuality education that stresses abstinence from sexual activity but also provides age-appropriate instruction on condoms and contraceptive use.

See Resource 6.4 **The Association Between Sex Education and Youth's Engagement in Sexual Intercourse**

See Resource 6.5 **Resources on Preventing Teen Pregnancy, STDs, and HIV**

Online Resource **http://www.ncbi.nlm.nih.gov/pubmed/22341164—The Effectiveness of Group-Based Comprehensive Risk Reduction and Abstinence Education Interventions**

For a variety of reasons, districts may choose to broaden their search for a curriculum that best meets the needs of students in their district. In addition to considering research and standards in health and human growth and development instruction, best practices support using a clear set of criteria associated with program effectiveness. Resource 6.6: Characteristics of Effective Curriculum-Based Programs to Reduce Teen Pregnancy, developed by Kirby, is a widely disseminated list of criteria.

See Resource 6.6 **Kirby's Characteristics of Effective Curriculum-Based Programs to Reduce Teen Pregnancy**

A majority of parents support comprehensive sex education programs for their children in middle and high schools.

Acceptability

A majority of parents support comprehensive sex education programs for their children in middle and high schools (National Public Radio et al, 2004). According to the national pol, *Sex in America* (National Public Radio, 2004), parents support school-based sexuality education because they believe the class will be helpful to their children, it will be effective in helping teens avoid HIV/AIDS and other sexually transmitted diseases and pregnancy, it will help young people make responsible decisions about sex, and the class will make it easier for parents to talk with their children about sexuality.

Some individuals express concern that teaching young people about sexuality will hasten sexual behavior. There is now significant evidence that educating

young people about sexuality does not increase sexual activity (Blake, 2003; Kirby et al, 1994). The CDC and Department of Public Instruction (DPI) recommend that sexuality education and HIV prevention education include content that is age-appropriate, medically accurate, updated periodically to reflect scientific developments, consistent with community standards, and appropriate for students' developmental levels and cultural backgrounds.

In addition to selecting curricula on the basis of evidence of effectiveness, other criteria must also be considered. Most parents, teachers, and other adults would agree that the following clear messages should be included in the HGD curriculum:

- Abstinence from all forms of sexual intercourse is the best choice for students.
- Decisions about whether or not to be sexually active, and with whom, and when, and how, are best made when an individual and his/her partner fully understand the emotional, physical, and social consequences of the decision.
- Wisconsin statutes consider sexual contact with a person under the age of 16 years of age to be a felony and sexual intercourse with a person 16 or 17 years of age to be a misdemeanor. More specifically, Wisconsin statutes are as follows:
  - Class C felony/2nd degree sexual assault to have sexual contact or intercourse with a person under 16 years old [Wis. Stat. 948.02(2)].
  - Class B felony/1st degree sexual assault to have sexual intercourse with a person under 13 years old [Wis. Stat. 948.02(1)].
  - Class A Misdemeanor to have sexual intercourse with a person under 16 years old [Wis. Stat. 948.09].

Cultural Competence

Many school classrooms are becoming increasingly diverse. Children and youth reflect diversity in race/ethnicity, socioeconomic status, family structure, first language, religion, gender, sexual orientation, and other characteristics. Some, if not all, of these differences will be particularly relevant when discussing human sexuality. There are many definitions of cultural competency, one of which is "the state of being capable of functioning effectively in the context of cultural differences" (Cross et al, 1989). To enhance our ability to teach effectively in classrooms with culturally diverse students, an important step is to become more aware of our own cultural identities and the lens with which we view the world. From this awareness teachers and other school staff can learn about other cultural groups and be better prepared to design and deliver sexuality education in ways that are appropriate, respectful, and meaningful.

To support learning by all students, DPI recommends inclusion of all cultural groups in the curriculum and encourages Wisconsin school districts to include the contributions, images, and experiences of diverse cultural groups in instruction and other classroom activities. The following factors can jeopardize the extent to which children feel included and valued as part of a school community.

- **Invisibility:** under-representation of certain groups, which leads to the implication that these groups are of less value, importance, and significance.
- **Stereotyping:** assigning only traditional and rigid roles or attributes to a group, thus limiting the abilities and potential of that group; denying students knowledge of the diversity, complexity, and variations of any group of individuals.
- **Imbalance/selectivity:** presenting only one interpretation of an issue, situation, or group; distorting reality and ignoring complex and differing viewpoints through selective presentation of materials.
- **Unreality:** presenting an unrealistic portrayal of our history and our contemporary life experience.
- **Fragmentation/isolation:** separating issues related to minorities and women from the main body of the text.
- **Linguistic bias:** excluding the role and importance of females by constant use of the generic "he" and sex-biased words.

Source: Wisconsin Department of Public Instruction. *Equity and Education from Dealing with Selection and Censorship: A Handbook for Wisconsin Schools and Libraries*. (1999).

Culturally Competent Sexuality Education Resources is an annotated bibliography published by SIECUS in 2002 that provides an extensive list of resources (and ordering information) reflecting various cultural groups (including Latinos, African Americans, Asian and Pacific Islanders, Native Americans, Lesbian, Gay, Bisexual and Transgender individuals, and others) related to sexuality. It can be downloaded from the SIECUS website: www.siecus.org.

Several handouts have been provided in this resource packet to assist school districts to be responsive to a culturally diverse world, district, and classroom.

Resource 6.7: **Lessons that Matter: LGBTQ Inclusivity and School Safety**

Resource 6.8: **Human Growth and Development (HGD): Cultural Responsiveness to Diverse Classrooms**

"A trained teacher who is comfortable with the subject matter is more likely to gain support of parents and less likely to breach any state or school policies."

–American School Health Association

Resource 6.9: **Adolescent Sexual Health and the Dynamics of Oppression: A Call for Cultural Competency**

Resource 6.10: **Vulnerable Youth: A Closer Look at Reproductive Health Outcomes**

Implementation

Although evaluation research is able to identify curricular programs that are effective when implemented in a certain way with certain populations, most school districts want to know whether these curricula or programs will work with *their* students. There's no easy answer. Implementers are urged to maintain the fidelity of programs, which means maintaining the original program's key behavioral goals, objectives, theory of behavior change on which the program is based, and core components as defined by the original program developers. Replication refers to implementing the original program with new students or participants in a way that maintains the fidelity to the program. In many cases, though, programs must be adapted so that the program better fits the new population or setting yet doesn't compromise the core components.

Teachers and other instructional school staff are the most important resource for an effective HGD program. Because of the importance and sensitivity of the topic, and the potential for controversy surrounding it, staff must be well prepared—in knowledge, comfort, and skill. Not only do skillful teachers most effectively foster learning among their students, but the American School Health Association also reminds us, "A trained teacher who is comfortable with the subject matter is more likely to gain support of parents and less likely to breach any state or school policies."

In addition to content knowledge and a repertoire of effective instructional strategies, teachers of HGD must also possess the following qualifications:

- Belief in the importance and value of HGD instruction.
- Ability to foster a safe classroom environment for all students in which a range of ideas and values can be expressed.
- Relaxed style and non-judgmental attitude that encourages communication.
- Ability and comfort to answer students' questions clearly and accurately, given the bounds established by the HGD advisory board and district.
- Knowledge, comfort, and skill in using a range of instructional strategies to foster skill development among students.

A common concern is that teachers don't have sufficient time to implement evidence-based curricula. When there are concerns about time constraints to implement a curriculum,

- Consider a different evidence-based curriculum that can be implemented fully given time available;
- Consider creative ways to make time to fully implement the curricula;
- Consider implementation of computer-based interventions;
- Adapt curriculum while retaining core components, including interactive and small group activities;
- Best practices suggest it is important for teachers to be adequately trained in the rationale, methods, and content of the curriculum so it can be delivered comfortably, confidently, and with fidelity (Kirby, 2007).

See Resource 6.11: Effective Teaching Methods for Sexuality Education

Sensitive Topics. The ways in which issues considered to be sensitive (e.g., contraceptives, abortion, masturbation, and sexual orientation) are addressed requires thoughtful planning, knowledge, and attention to the comfort level of students, teachers, parents, and administrators. It is suggested teachers abide by the following:

- Review district policy to ensure that the curriculum content and activities are developed to meet the needs of all students and are developed with attention to age and developmental appropriateness.
- If problems with content are anticipated, hold a special meeting with parents/guardians to introduce the content. Develop alternative activities for children of parents who exercise their legal right to exempt their children from this class.
- Establish classroom guidelines to ensure a supportive and respectful environment. For some, putting chairs in a circle or semi-circle can contribute to an atmosphere that encourages interaction and discussion.
- Work with students to develop classroom ground rules or guidelines. Common guidelines include:
    - Treat each other with courtesy and respect.
    - Listen carefully to others.
    - Allow others to speak without interruption.
    - Be supportive of others. No name-calling or put-downs.
    - No question is stupid or wrong.
    - Students have the right to pass during any discussion or activity that involves personal opinions, feelings, or experiences.

- Teachers and other school staff should be familiar with district policy about answering questions. The resource included below offers examples of questions by type, giving clear instructions about how to answer questions that reflect values or beliefs.

Resource 6.12: Answering Difficult Sexual Education Questions in the Classroom

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Wisconsin Standards for Health Education: **Critical Questions**

Defining The Standards

What are health education standards?

Standards specify what students should know and be able to do. Standards in health education describe the essential skills and types of health information that will contribute to a student's ability to practice behaviors that protect and promote health.

Why are health education standards necessary?

Standards serve as goals for health education instruction and learning. Setting quality standards enables students, parents, educators, and citizens to know what students should have learned at a given point in a student's education. The inclusion of standards has consequences similar to establishing goals in any pursuit. With clear goals and outcomes, students and teachers will know exactly what students should be achieving.

Our 21st century society is placing increased importance on standards-based curriculum, instruction, and assessment in all content areas. Clear statements about what students must know and be able to do are essential to ensure that Wisconsin schools offer students the opportunities to acquire the knowledge and skills necessary to develop, maintain, and enhance a healthy lifestyle. Standards guide the development of assessments to permit students to demonstrate skill and knowledge attainment.

Why are state-level academic standards for health education important?

Public education is a state responsibility. The state superintendent and legislature must ensure that all children have equal access to high quality health instruction. At a minimum, this requires clear statements of what all children in the state should know and be able to do.

Why does Wisconsin need its own standards for health education?

The citizens of Wisconsin are very serious and thoughtful about education. They expect and receive very high performance from their schools. While health education needs may be similar among states, values differ. Health education

Health is like money, we never have a true idea of its value until we lose it.

—Josh Billings

standards should reflect the collective values of the citizens and be tailored to developing, maintaining, and enhancing a healthy lifestyle.

Developing The Academic Standards

How were Standards for Health Education developed?

A coalition of health education organizations and professionals wrote the first National Health Education Standards in 1995 and a second edition in 2007. *Wisconsin's Model Academic Standards for Health Education* was published in 1997. The ten-person standards writing team, chosen by the Department of Public Instruction, began its deliberations in December 2010 with adoption of the eight broad national standards.

Over the next five months, various components of the standards document were designed to help schools address standards-based curriculum, instruction, and assessment. The next step required electronic public review and comment over a six-week period. Based on public comment, the final document was developed.

Who wrote the standards for health education and what resources were used?

The health education subject area standards were drafted by a team of leading teachers and professors, curriculum and instruction directors, and principals. This work was done after reviewing national standards in the subject area developed by the National Health Education Standards and Review Panel and standards developed by other states.

How was the public involved in the standards development process?

The Department of Public Instruction provided an opportunity for public review of the health education standards document by putting the draft copy online for public review and comment.

Using The Academic Standards

How will local districts use the standards for health education?

Adopting these standards is voluntary, not mandatory. Using the standards can lead to developmentally appropriate, quality health education programs. Districts may use this document as a guide for developing curriculum. Implementation of the standards may require some school districts to change their school and district health education curriculum. In some cases, this may result in significant changes in instructional methods and materials, local assessments that meet the needs of all learners, and professional development opportunities for the teaching staff and appropriate administrators.

What is the difference between academic standards and curriculum?

Standards are statements about what students should know and be able to do, what they may be asked to do to give evidence of learning, and how well they should be expected to know or perform it. Curriculum is the program devised by local school districts used to prepare students to meet the health education standards. It consists of activities and lessons at each grade level, instructional materials, and various instructional techniques. In short, standards define what is to be learned at certain points in time and, from a broad perspective, what performances will be accepted as evidence that the learning has occurred. Curriculum specifies the details of the day-to-day schooling at the local level.

Who should use these standards?

The standards provide a road map to lifetime skills. Programs based on these standards provide numerous opportunities for real, performance-based assessments for grading and program evaluation. Teacher preparation programs may use these in educating prospective teachers regarding common educational goals and focus areas in high quality health education programs. The standards will assist prospective teachers in learning about curriculum, instruction, and evaluation. Community agencies and organizations may use this document in designing health education programs for their school-age populations.

The appearance of a disease is swift as an arrow; its disappearance slow…

—Chinese Proverb

How do educators determine essential concepts and knowledge for the health education curriculum?

As in many other subject areas, educators use standards, locally developed curricula, and professional judgment to determine which concepts and knowledge are essential for students to learn. In building health education units of instruction and lessons, educators should identify the *essential health concepts and knowledge* needed to make health-enhancing decisions and practice health-enhancing behaviors. This is important because there are many, many health concepts that could be learned. If much of the limited time in health education is spent on learning health concepts, little will be available to learn skills that are also essential for health-related decisions and behaviors. The facts related to many health concepts are evolving with new research. Now more than ever, young people need skills to think critically, access valid health information to prepare them to learn, and apply health information that will be available only in the future.

When determining which health concepts are essential, educators can consider the following:

- Which health decisions and behaviors are important for the desired health outcome(s)?
- What health concepts are required to make these health-related decisions and to practice healthy behaviors?

- What depth of understanding of those concepts is required for such health-related decisions and behaviors?

- Which concepts are not essential for health decisions and behaviors? Can these be omitted from the curriculum without sacrificing the necessary depth of understanding or opportunities for skill development?

- How can the essential concepts be taught in lessons and strategies that also enhance critical health-related skills?

The following is a sample process educators could use to determine essential health concepts for a unit of instruction.

1. Determine the long-term health behavior outcome that a unit is designed to support. Examples include decreasing youth obesity rates, youth tobacco use, or sexually transmitted infection rates.

2. Referencing *Wisconsin Standards for Health Education*, determine the skill-based learning outcomes for the unit. Select one or more skills that are aligned with the health outcome. Examples include: demonstrating how to access accurate health information regarding food choices and beneficial activity levels; analyzing external and internal factors that can influence a student's behavior related to tobacco use; and communicating boundaries and limits with your partner in a relationship.

3. Based on these skills, determine the essential concepts needed to effectively learn, practice, and apply the skills in appropriate life situations. Critical content can be determined through data collection, health issues that are covered in the media, or research articles. It also can be determined by community interest in a topic or state statute. Critical health concepts which may be determined from within the following content areas include those related to alcohol/drugs, consumer health, environmental health, healthy eating, physical activity, interpersonal violence, personal health, mental health, safety, and other health issues.

Another way to determine essential concepts is to choose an appropriate performance assessment to assess one or more of the learning outcomes. Based on the skills and levels of competency to be demonstrated, identify the health concepts that are essential for a high quality response to the performance task.

Reviewing health-related data may also help educators determine which concepts are essential, based on local health needs. Examples of such health-related data include results of: the Youth Risk Behavior Survey, state or local; the state Youth Tobacco Survey; and needs assessments by health departments or other community organizations.

How do educators assure that all skills identified in the standards are adequately addressed in health instruction?

Seven of the eight health education standards describe skills. Educators need to determine how all skills will be addressed across the curriculum and which skills are appropriate for each major health topic. These topics generally include nutrition; physical activity; intentional and unintentional injury; family life and sexuality; mental health; personal health; consumer health; community and environmental health; and alcohol, tobacco and other drugs. Effective educators use the skill-based standards and other information to set intended learning outcomes. It is more effective to spend more time teaching fewer skills than to teach each skill for each content area. Another factor that affects determination of learning outcomes is that some skills are more complex than others. Educators can select a broad set of skills across the curriculum and a small number of skills for each unit. Many educators consider a progression of skills, where some skills form the basis for developing others. For example, accessing accurate health information and analyzing influences may serve as base skills, upon which decision making and goal setting can be developed. Interpersonal communication, self-management, and advocacy may require acquisition of the previous, lower level skills for effective development. School districts are also encouraged to identify how instruction in these skills is coordinated and reinforced across years and courses, including health education, physical education, family and consumer sciences, and other health-related instruction.

Following identification of skills to be addressed, skill-building activities can be selected and ordered for each unit. Having determined essential concepts and key skills, educators can develop or select learning activities for the following elements of effective, skill-building units of instruction.

1. ***Engage students in learning.*** Establish the relevance of the topic, and assess students' prior knowledge and, if appropriate, skills.

2. ***Introduce or review the key skill(s).*** Review the units' assessments to be sure that appropriate skills are included in unit lessons.

3. ***Provide ample opportunities for skill practice.*** Practice of skills may be intertwined, as the skills are often related in life. For example, decision making may lead to needs for communication and advocacy.

4. ***Actively engage parents or guardians.*** Include at least one activity that involves student communication with parents, guardians, or other trusted adults.

5. ***Assess student skills.*** Provide one or more opportunities for students to demonstrate skill attainment, and appropriately use accurate health concepts.

For more information and resources on using *Wisconsin Standards for Health Education* to build units of instruction and appropriate assessments, please refer to: http://dpi.wi.gov/sspw/healtheducation.html.

Applying the Academic Standards across the Curriculum

Cross-curricular connections make learning relevant and meaningful to students. Health education is a critical element in the development of these connections. One of the appendix items provides the Common Core State Standards for English Language Arts. Another provides information and a well-developed example for connecting health education to literacy development. Literacy is a part of every aspect of life. Research is linking consistent learning experiences to improved literacy. The National Literacy Strategy seeks to raise awareness of the contribution health education can make to literacy through the teaching of real-life issues in which students will be naturally engaged by increasing reading experiences, enhancing speaking strategies, and adapting meaningful writing prompts.

How do educators assure that all skills identified in the standards are adequately addressed in health instruction?

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5. ***Assess student skills.*** Provide one or more opportunities for students to demonstrate skill attainment, and appropriately use accurate health concepts.

For more information and resources on using *Wisconsin Standards for Health Education* to build units of instruction and appropriate assessments, please refer to: http://dpi.wi.gov/sspw/healtheducation.html.

National Standards for Family and Consumer Sciences Education

Developed by National Association of State Administrators of Family and Consumer Sciences (NASAFACS)

Area of Study 12.0

Human Development

Comprehensive Standard

Analyze factors that influence human growth & development.

Content Standards	Competencies
12.1 Analyze principles of human growth and development across the life span.	12.1.1 Analyze physical, emotional, social, spiritual, and intellectual development.
	12.1.2 Analyze interrelationships among physical, emotional, social, and intellectual aspects of human growth and development.
	12.1.3 Analyze current and emerging research about human growth and development, including research on brain development.
12.2 Analyze conditions that influence human growth and development.	12.2.1 Analyze the effect of heredity and environment on human growth and development.
	12.2.2 Analyze the impact of social, economic, and technological forces on individual growth and development.
	12.2.3 Analyze the effects of gender, ethnicity, and culture on individual development.
	12.2.4 Analyze the effects of life events on individuals' physical, intellectual, social, moral, and emotional development.
	12.2.5 Analyze geographic, political, and global influences on human growth and development.
12.3 Analyze strategies that promote growth and development across the life span.	12.3.1 Analyze the role of nurturance on human growth and development.
	12.3.2 Analyze the role of communication on human growth and development.
	12.3.3 Analyze the role of family and social services support systems in meeting human growth and development needs.

National Sexuality Education Standards

Core Content and Skills, K–12

FoSE
Future of Sex Education

Special thanks to the following organizations for their partnership in developing and disseminating the *National Sexuality Education Standards: Content and Skills, K–12:*

The American Association of Health Education (www.aahperd.org/aahe) serves educators and other professionals who promote the health of all people through education and health promotion strategies.

The American School Health Association (www.ashaweb.org) works to build the capacity of its members to plan, develop, coordinate, implement, evaluate and advocate for effective school health strategies that contribute to optimal health and academic outcomes for all children and youth.

The National Education Association – Health Information Network (www.neahin.org) works to improve the health and safety of the school community through disseminating information that empowers school professionals and positively impacts the lives of their students.

The Society of State Leaders of Health and Physical Education (www.thesociety.org) utilizes advocacy, partnerships, professional development and resources to build the capacity of school health leaders to implement effective health education and physical education policies and practices that support success in school, work and life.

The Future of Sex Education (FoSE) Initiative is a partnership between **Advocates for Youth, Answer** and the **Sexuality Information and Education Council of the U.S. (SIECUS)** that seeks to create a national dialogue about the future of sex education and to promote the institutionalization of comprehensive sexuality education in public schools. To learn more, please visit **www.futureofsexed.org**.

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Table of Contents

National Sexuality Education Standards: Core Content and Skills, K–12 Advisory Committee **4**

Additional Reviewers **5**

Introduction and Background **6**

Rationale for Sexuality Education in Public Schools **7**

The National Sexuality Education Standards **8**

- Role of Education Standards 8
- Goal of the National Sexuality Education Standards 9
- Guiding Values and Principles 9
- Theoretical Framework 9
- Topics and Key to Indicators 10
- Standards by Grade Level 12
- Standards by Topic Area 24

National Resources **37**

- For Teachers 36
- For School Administrators 38
- For Parents 38
- For Middle and High School Students 38

Glossary **39**

References **41**

National Sexuality Education Standards: Core Content and Skills, K–12 Advisory Committee

Laurie Bechhofer, MPH
HIV/STD Education Consultant
Michigan Department of Education

Nora Gelperin, MEd
Director of Training
Answer

Eva Goldfarb, PhD, LHD (hon)
Professor
Montclair State University

Mal Goldsmith, PhD, MCHES, FASHA, FAAHE
Professor Emeritus
Southern Illinois University

Debra Hauser, MPH
Executive Vice President
Advocates for Youth

Nora L. Howley, MA
Manager of Programs
National Education Association–Health Information Network

Barbara Huberman, RN, BSN, MEd
Director of Education and Outreach
Advocates for Youth

Leslie M. Kantor, MPH
Director of National Education Initiatives
Planned Parenthood Federation of America

Kyle Lafferty, MPH, MST, CHES
HIV Program Director
The Society of State Leaders of Health and Physical Education

Robert McGarry, EdD
Director of Training and Curriculum Development
Gay, Lesbian and Straight Education Network (GLSEN)

Linda Moore
Acting Executive Director
American Association for Health Education

Linda Morse, RN, NJ-CSN, MA, CHES
President Elect
American School Health Association

Buzz Pruitt, EdD
Professor
Texas A&M University

Monica Rodriguez, MS
President & CEO
Sexuality Information and Education Council of the United States (SIECUS)

Deborah Roffman, MS, CSE
Sexuality Educator and Consultant
The Park School of Baltimore

Elizabeth Schroeder, EdD, MSW
Executive Director
Answer

Jennifer Heitel Yakush
Director of Public Policy
Sexuality Information and Education Council of the United States (SIECUS)

Danene Sorace, MPP
Consultant, Future of Sex Education Initiative

Additional Reviewers

Drafts of the sexuality education core content and skills document were reviewed by a diverse group of professionals with expertise in sexuality, public education, public health, child and adolescent medicine, and psychology. We wish to thank these individuals for their work:

JeNeen Anderson, MPH, National Association of State Boards of Education

Deborah Arrindell, American Social Health Association

Elissa M. Barr, PhD, University of North Florida

Heather Boonstra, Guttmacher Institute

Diane Brown, EdD, Widener University

Kim Robert Clark, DrPH, San Bernardino County Superintendent of Schools, CA

Stephen Conley, PhD, American School Health Association

Sam Dercon, *Sex, Etc.* Teen Editorial Staff

Bonnie J. Edmondson, EdD, Connecticut State Department of Education

Barb Flis, Parent Action for Healthy Kids, MI

Veronica Bayetti Flores, National Latina Institute for Reproductive Health

Elizabeth Gallun, MA, Prince George's County Public Schools, MD

Melissa Grigal, East Brunswick School District, NJ

The Rev. Debra W. Haffner, MPH, M.Div., Religious Institute

Bonni C. Hodges, PhD, State University of New York College at Cortland

Heather Holaday, District of Columbia Public Schools

Mark Huffman, MTS, Independent Trainer and Consultant

Pete Hunt, MPH, MEd, Centers for Disease Control and Prevention (CDC),Division of Adolescent and School Health

Nancy Hudson, RN, MS, CHES, Council of Chief State School Officers

Linda Juszczak, National Assembly on School-Based Health Care

Maureen Kelly, Planned Parenthood of the Southern Finger Lakes

Emily Kitchen, Indiana University Student

Douglas Kirby, PhD, ETR Associates

Cynthia Lam, *Sex, Etc*. Teen Editorial Staff

Jessica Lawrence, MS, Bogli Consulting, Inc.

Konstance McCaffree, PhD, CFLE, CSE, Widener University

Ronna Popkin, MS, Columbia University

Valerie Rochester, Black Women's Health Imperative

John Santelli, MD, MPH, Columbia University

Debra Shapiro, Society for Public Health Education

Samantha Shinberg, Advocates for Youth Intern

Susan Telljohann, HSD, CHES, University of Toledo

*Melanie Tom***,** Asian Communities for Reproductive Justice

Al Vernacchio, MSEd, Friends' Central School, PA

Jenna Weiss, University Middle School, NJ

David Wiley, PhD, Texas State University

Kelly Wilson, PhD, CHES, Texas State University

Pam Wilson, MSW, Sexuality Educator and Trainer

Susan N. Wilson, MSEd, Sexuality Education Consultant

Michael Young, PhD, FAAHB, New Mexico State University

The reviewers above provided many valuable comments to the draft documents. Organizational affiliations are included for identification purposes only.

Introduction and Background

The goal of the *National Sexuality Education Standards: Core Content and Skills, K–12* is to provide clear, consistent and straightforward guidance on the *essential minimum, core content* for sexuality education that is developmentally and age-appropriate for students in grades K–12.The development of these standards is a result of an ongoing initiative, the Future of Sex Education (FoSE). Forty individuals from the fields of health education, sexuality education, public health, public policy, philanthropy and advocacy convened for a two-day meeting in December 2008 to create a strategic plan for sexuality education policy and implementation. A key strategic priority that emerged from this work was the creation of national sexuality education standards to advance the implementation of sexuality education in US public schools.

Specifically, the *National Sexuality Education Standards* were developed to address the inconsistent implementation of sexuality education nationwide and the limited time allocated to teaching the topic. Health education, which typically covers a broad range of topics including sexuality education, is given very little time in the school curriculum. According to the School Health Policies and Practices Study, a national survey conducted by the Centers for Disease Control and Prevention's Division of Adolescent School Health to assess school health policies and practices, a median total of 17.2 hours is devoted to instruction in HIV, pregnancy and STD prevention: 3.1 hours in elementary, 6 hours in middle and 8.1 hours in high school.[1]

Given these realities, the *National Sexuality Education Standards* were designed to:

- Outline what, based on research and extensive professional expertise, are the **minimum, essential content and skills** for sexuality education K–12 given student needs, limited teacher preparation and typically available time and resources.
- Assist schools in designing and delivering sexuality education K–12 that is **planned, sequential** and **part of a comprehensive school health education approach.**
- Provide a clear rationale for teaching sexuality education content and skills at different grade levels that is **evidence-informed, age-appropriate** and **theory-driven.**
- Support schools in **improving academic performance** by addressing a content area that is both **highly relevant to students** and **directly related to high school graduation rates.**
- Present sexual development as a **normal, natural, healthy part of human development** that should be a part of every health education curriculum.
- Offer clear, concise **recommendations for school personnel** on what is age-appropriate to teach students at different grade levels.
- Translate an emerging body of **research related to school-based sexuality education** so that it can be put into practice in the classroom.

The *National Health Education Standards*[2] (NHES) heavily influenced the development of the *National Sexuality Education Standards*. First created in 1995 and updated in 2007, the NHES were developed by the Joint Committee on National Health Education Standards of the American Cancer Society and widely adopted by states and local school districts. The NHES focus on a student's ability to understand key concepts and learn particular skills for using that content. These standards were developed to serve as the underpinning for health education knowledge and skills students should attain by grades 2, 5, 8 and 12. **The NHES do not address any specific health content areas, including content for sexuality education.**

The *National Sexuality Education Standards* were further informed by the work of the CDC's *Health Education Curriculum Analysis Tool (HECAT)*[3]; existing state and international education standards that include sexual health content; the *Guidelines for Comprehensive Sexuality Education: Kindergarten – 12th Grade*[4]; and the *Common Core State Standards for English Language Arts and Mathematics*[5], recently adopted by most states.

Rationale for Sexuality Education in Public Schools

For years, research has highlighted the need to provide effective, comprehensive sexuality education to young people. The US has one of the highest teen pregnancy rates in the industrialized world.[6] Each year in the US, more than 750,000 women ages 15–19 become pregnant,[7] with more than 80 percent of these pregnancies unintended.[8] Furthermore, while young people in the US ages 15–25 make up only one-quarter of the sexually active population, they contract about half of the 19 million sexually transmitted diseases (STDs) annually. This equates to one in four sexually active teenagers contracting a sexually transmitted disease each year.[9] And young people ages 13–29 account for about one-third of the estimated 50,000 new HIV infections each year, the largest share of any age group.[10]

There is also a pressing need to address harassment, bullying and relationship violence in our schools, which have a significant impact on a student's emotional and physical well-being as well as on academic success. According to the 2009 National School Climate Survey, nearly 9 out of 10 lesbian, gay, bisexual or transgender (LGBT) students reported being harassed in the previous year. Two-thirds of LGBT students reported feeling unsafe and nearly one-third skipped at least one day of school because of concerns about their personal safety. LGBT students who reported frequent harassment also suffered from lower grade point averages.[11]

Similarly, teen relationship violence continues to be a pressing problem. Although frequently under-reported, ten percent of teens are physically harmed by their boyfriend or girlfriend in a given year.[12]

Studies have repeatedly found that health programs in school can help young people succeed academically. The most effective strategy is a strategic and coordinated approach to health that includes family and community involvement, school health services, a healthy school environment and health education, which includes sexuality education.[13] [14] [15] In fact, an extensive review of school health initiatives found that **programs that included health education had a positive effect on overall academic outcomes, including reading and math scores**.[15]

Evaluations of comprehensive sexuality education programs show that many of these programs can help youth delay the onset of sexual activity, reduce the frequency of sexual activity, reduce the number of sexual partners, and increase condom and contraceptive use.[16] [17] Researchers recently examined the National Survey of Family Growth to determine the impact of sexuality education on sexual risk-taking for young people ages 15-19, and found that **teens who received comprehensive sexuality education were 50 percent less likely to report a pregnancy** than those who received abstinence-only education.[18]

The CDC has also repeatedly found that student health behaviors and good grades are related, stating: "…students who do not engage in health-risk behaviors receive higher grades than their classmates who do engage in health-risk behaviors."[19]

Further, studies show that physical and emotional health-related problems may inhibit young people from learning by reducing their motivation to learn; diminishing their feelings of connectedness to school; and contributing to absenteeism and drop out.[13] [20]

An example related to sexuality education is teen pregnancy. Teen pregnancy often takes a particular toll on school connectedness for both partners, representing a major disruption in many teens' lives and making it difficult to remain in and/or engaged in school. Many pregnant and parenting teens experience lower grades and higher dropout rates than their non-parenting peers. In fact, research shows that only 51 percent of pregnant and parenting teens graduate from high school as compared to 89 percent of their non-pregnant and parenting peers.[21]

Given the evidence that connects lower risk behaviors to academic success, schools clearly have as vested an interest in keeping students healthy as do parents and other community members. In providing comprehensive sexuality education programs, schools support student health and as such further foster young people's academic achievement.

Parents overwhelmingly favor comprehensive sexuality education in public school at the national and state

levels.[22] [23] [24] [25] In 2004, National Public Radio (NPR), the Kaiser Family Foundation and the Kennedy School of Government released a poll that indicated:

- Ninety-three percent of parents of junior high school students and 91 percent of parents of high school students believe it is very or somewhat important to have sexuality education as part of the school curriculum.
- Ninety-five percent of parents of junior high school students and 93 percent of parents of high school students believe that birth control and other methods of preventing pregnancy are appropriate topics for sexuality education programs in schools.
- Approximately 75 percent of parents believed that the topic of sexual orientation should be included in sexuality education programs and "discussed in a way that provides a fair and balanced presentation of the facts and different views in society."
- Eighty-eight percent of parents of junior high school students and 85 percent of parents of high school students believe information on how to use and where to get contraceptives is an appropriate topic for sexuality education programs in schools.[26]

The *National Sexuality Education Standards* set forth minimum, essential sexuality education core content and skills responsive to the needs of students and in service to their overall academic achievement and sexual health. They fulfill a key recommendation of the White House Office of National AIDS Policy's *National HIV and AIDS Strategy for the United States*, which calls for educating all Americans about the threat of HIV and how to prevent it. This recommendation includes the goal of educating young people about HIV and emphasizes the important role schools can play in providing access to current and accurate information. The strategy notes that it is important to provide access to a baseline of information that is grounded in the benefits of abstinence and delaying or limiting sexual activity, while ensuring that youth who make the decision to be sexually active have the information they need to take steps to protect themselves.[27]

In addition, the *National Sexuality Education Standards* satisfy a key recommendation of the Office of the Surgeon General's *National Prevention and Health Promotion Strategy,* which calls for the provision of effective sexual health education, especially for adolescents. This strategy notes that medically accurate, developmentally appropriate, and evidence-based sexual health education provides students with the skills and resources that help them make informed and responsible decisions.[28]

National Sexuality Education Standards

The Role of Education Standards

Educational standards are commonplace in public education and are a key component in developing a rich learning experience for students. The purpose of standards in general is to provide clear expectations about what students should know and be able to do by the conclusion of certain grade levels. Other equally important components of the student learning experience include pre-service teacher training, professional development and ongoing support and mentoring for teachers, clear school policies that support sexuality education implementation and the teachers who deliver sexuality education, a sequential, age-appropriate curriculum that allows students to practice key skills and assessment tools for all of these elements.

Standards are an important part of the educational process, but they do not provide specific guidance on *how* a topic area should be taught. They also generally do not address special needs students, students for whom English is their second language, or students with any of the other unique attributes of a given classroom or school setting.

In addition, although recommendations made here are based on grade level, children of the same age often develop at different rates and some content may need to be adapted based on the needs of the students.

Sexuality education standards specifically should accomplish the following:

- Provide a framework for curriculum development, instruction and student assessment.
- Reflect the research-based characteristics of effective sexuality education.
- Be informed by relevant health behavior theories and models.
- Focus on health within the context of the world in which students live.
- Focus on the emotional, intellectual, physical and social dimensions of sexual health.
- Teach functional knowledge and essential personal and social skills that contribute directly to healthy sexuality.
- Focus on health promotion, including both abstinence from and risk reduction pertaining to unsafe sexual behaviors.
- Consider the developmental appropriateness of material for students in specific grade spans.
- Include a progression from more concrete to higher-order thinking skills.

- Allow for the integration of more general health content as appropriate.[2]

Goal of the National Sexuality Education Standards

The goal of the *National Sexuality Education Standards: Core Content and Skills, K–12* is:

To provide clear, consistent and straightforward guidance on the essential minimum, core content for sexuality education that is age-appropriate for students in grades K–12.

Guiding Values and Principles

The *National Sexuality Education Standards* are informed by the following guiding values and principles based on current theory, research in the field and the *National Health Education Standards* Review and Revision Panel:

1. Academic achievement and the health status of students are interrelated, and should be recognized as such.
2. All students, regardless of physical or intellectual ability, deserve the opportunity to achieve personal health and wellness, including sexual health.
3. Instruction by qualified sexuality education teachers is essential for student achievement.
4. Sexuality education should teach both information and essential skills that are necessary to adopt, practice, and maintain healthy relationships and behaviors.
5. Students need opportunities to engage in cooperative and active learning strategies, and sufficient time must be allocated for students to practice skills relating to sexuality education.
6. Sexuality education should encourage the use of technology to access multiple valid sources of information, recognizing the significant role that technology plays in young people's lives.
7. Local curriculum planners should implement existing or develop new curricula based on local health needs.
8. Students need multiple opportunities and a variety of assessment strategies to determine their achievement of the sexuality education standards and performance indicators.
9. Improvements in public health, including sexual health, can contribute to a reduction in health care costs.
10. Effective health education can contribute to the establishment of a healthy and productive citizenry.[2]

Theoretical Framework

The *National Sexuality Education Standards* seek to address both the functional knowledge related to sexuality and the specific skills necessary to adopt healthy behaviors and reflect the tenets of social learning theory, social cognitive theory and the social ecological model of prevention. From s*ocial learning theory,* which recognizes that "learning occurs not merely within the learner but also in a particular social context,"[29] there are several key concepts addressed within the *National Sexuality Education Standards*, including:

> **Personalization.** The ability of students to perceive the core content and skills as relevant to their lives increases the likelihood that they will both learn and retain them. Ensuring that students see themselves represented in the materials and learning activities used can assist in furthering personalization.

CHARACTERISTICS OF EFFECTIVE SEXUALITY EDUCATION

Focuses on specific behavioral outcomes.

Addresses individual values and group norms that support health-enhancing behaviors.

Focuses on increasing personal perceptions of risk and harmfulness of engaging in specific health risk behaviors, as well as reinforcing protective factors.

Addresses social pressures and influences.

Builds personal and social competence.

Provides functional knowledge that is basic, accurate and directly contributes to health- promoting decisions and behaviors.

Uses strategies designed to personalize information and engage students.

Provides age-and developmentally-appropriate information, learning strategies, teaching methods and materials.

Incorporates learning strategies, teaching methods and materials that are culturally inclusive.

Provides adequate time for instruction and learning.

Provides opportunities to reinforce skills and positive health behaviors.

Provides opportunities to make connections with other influential persons.

Includes teacher information and plan for professional development and training to enhance effectiveness of instruction and student learning.[2]

Susceptibility. It is widely understood that many young people do not perceive that they are susceptible to the risks of certain behaviors, including sexual activity. Learning activities should encourage students to assess the relative risks of various behaviors, without exaggeration, to highlight their susceptibility to the potential negative outcomes of those behaviors.

Self-Efficacy. Even if students believe they are susceptible, they may not believe they can do anything to reduce their level of risk. Helping students overcome misinformation and develop confidence by practicing skills necessary to manage risk are key to a successful sexuality education curriculum.

Social Norms. Given that middle and high school students are highly influenced by their peers, the perception of what other students are, or are not, doing influences their behavior. Debunking perceptions and highlighting positive behaviors among teens (i.e., the majority of teens are abstinent in middle school and early high school and when they first engage in sexual intercourse many use condoms) can further the adoption of health-positive behaviors.

Skills. Mastery of functional knowledge is necessary but not sufficient to influence behaviors. Skill development is critical to a student's ability to apply core content to their lives.[29]

In addition to social learning theory, *social cognitive theory* (SCT) is reflected throughout the *National Sexuality Education Standards.* Like social learning theory, SCT emphasizes self-efficacy, but adds in the motivation of the learners and an emphasis on the affective or emotional learning domain, an invaluable component of learning about human sexuality.[30]

Finally, the *social ecological model of prevention* also informed the development of these standards. This model focuses on individual, interpersonal, community and society influences and the role of these influences on people over time. Developmentally, the core content and skills for kindergarten and early elementary focus on the individual student and their immediate surroundings (e.g., their family). At the middle and high school levels, core content and skills focus on the expanding world of students that includes their friends and other peers, the media, society and cultural influences.[31]

Topics and Key Indicators

There are seven topics chosen as the minimum, essential content and skills for K–12 sexuality education:

Anatomy and Physiology *(AP)* provides a foundation for understanding basic human functioning.

Puberty and Adolescent Development *(PD)* addresses a pivotal milestone for every person that has an impact on physical, social and emotional development.

Identity *(ID)* addresses several fundamental aspects of people's understanding of who they are.

Pregnancy and Reproduction *(PR)* addresses information about how pregnancy happens and decision-making to avoid a pregnancy.

Sexually Transmitted Diseases and HIV *(SH)* provides both content and skills for understanding and avoiding STDs and HIV, including how they are transmitted, their signs and symptoms and testing and treatment.

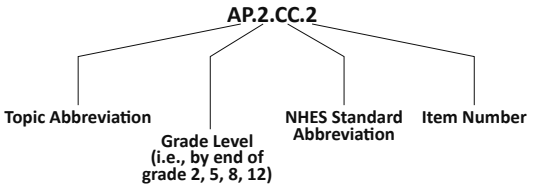
Healthy Relationships *(HR)* offers guidance to students on how to successfully navigate changing relationships among family, peers and partners. Special emphasis is given in the *National Sexuality Education Standards* to the increasing use and impact of technology within relationships.

Personal Safety *(PS)* emphasizes the need for a growing awareness, creation and maintenance of safe school environments for all students.

These seven topics are organized following the eight *National Health Education Standards.*

The *National Sexuality Education Standards* present performance indicators – what students should know and be able to do by the end of grades 2, 5, 8, and 12 – based on the eight *National Health Education Standards* listed in the following table. In addition, the standards are divided into seven specific sexuality education topics. The key to reading the indicators appears to the right. The tables on the following pages present the standards and performance indicators first by grade level and then by topic areas.

Key To Indicators



NATIONAL HEALTH EDUCATION STANDARDS

Core Concepts CC	Standard 1 Students will comprehend concepts related to health promotion and disease prevention to enhance health.
Analyzing Influences INF	Standard 2 Students will analyze the influence of family, peers, culture, media, technology and other factors on health behaviors.
Accessing Information AI	Standard 3 Students will demonstrate the ability to access valid information and products and services to enhance health.
Interpersonal Communication IC	Standard 4 Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
Decision-Making DM	Standard 5 Students will demonstrate the ability to use decision-making skills to enhance health.
Goal–Setting GS	Standard 6 Students will demonstrate the ability to use goal-setting skills to enhance health.
Self Management SM	Standard 7 Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
Advocacy ADV	Standard 8 Students will demonstrate the ability to advocate for personal, family and community health.

Standards by Grade Level

GRADE K-2

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
ANATOMY & PHYSIOLOGY								
By the end of the 2nd grade, students should be able to:	Use proper names for body parts, including male and female anatomy **AP.2.CC.1**							
PUBERTY AND ADOLESCENT DEVELOPMENT								
	No items							
IDENTITY								
By the end of the 2nd grade, students should be able to:	Describe differences and similarities in how boys and girls may be expected to act **ID.2.CC.1**	Provide examples of how friends, family, media, society and culture influence ways in which boys and girls think they should act **ID.2.INF.1**						
PREGNANCY AND REPRODUCTION								
By the end of the 2nd grade, students should be able to:	Explain that all living things reproduce **PR.2.CC.1**							
SEXUALLY TRANSMITTED DISEASES AND HIV								
	No items							
HEALTHY RELATIONSHIPS								
By the end of the 2nd grade, students should be able to:	Identify different kinds of family structures **HR.2.CC.1**			Demonstrate ways to show respect for different types of families **HR.2.IC.1**				
	Describe the characteristics of a friend **HR.2.CC.2**			Identify healthy ways for friends to express feelings to each other **HR.2.IC.2**				

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
PERSONAL SAFETY								
By the end of the 2nd grade, students should be able to:	Explain that all people, including children, have the right to tell others not to touch their body when they do not want to be touched **PS.2.CC.1**		Identify parents and other trusted adults they can tell if they are feeling uncomfortable about being touched **PS.2.AI.1**	Demonstrate how to respond if someone is touching them in a way that makes them feel uncomfortable **PS.2.IC.1**			Demonstrate how to clearly say no, how to leave an uncomfortable situation, and how to identify and talk with a trusted adult if someone is touching them in a way that makes them feel uncomfortable **PS.2.SM.1**	
	Explain what bullying and teasing are **PS.2.CC.2**							
	Explain why bullying and teasing are wrong **PS.2.CC.3**		Identify parents and other trusted adults they can tell if they are being bullied or teased **PS.2.AI.2**	Demonstrate how to respond if someone is bullying or teasing them **PS.2.IC.2**				

GRADE 3-5

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
ANATOMY & PHYSIOLOGY								
By the end of the 5th grade, students should be able to:	Describe male and female reproductive systems including body parts and their functions **AP.5.CC.1**		Identify medically-accurate information about female and male reproductive anatomy **AP.5.AI.1**					
PUBERTY AND ADOLESCENT DEVELOPMENT								
By the end of the 5th grade, students should be able to:	Explain the physical, social and emotional changes that occur during puberty and adolescence **PD.5.CC.1**	Describe how friends, family, media, society and culture can influence ideas about body image **PD.5.INF.1**	Identify medically-accurate information and resources about puberty and personal hygiene **PD.5.AI.1**				Explain ways to manage the physical and emotional changes associated with puberty **PD.5.SM.1**	
	Explain how the timing of puberty and adolescent development varies considerably and can still be healthy **PD.5.CC.2**		Identify parents or other trusted adults of whom students can ask questions about puberty and adolescent health issues **PD.5.AI.2**					
	Describe how puberty prepares human bodies for the potential to reproduce **PAD.5.CC.3**							
IDENTITY								
By the end of the 5th grade, students should be able to:	Define sexual orientation as the romantic attraction of an individual to someone of the same gender or a different gender **ID.5.CC.1**		Identify parents or other trusted adults of whom students can ask questions about sexual orientation **ID.5.AI.1**				Demonstrate ways to treat others with dignity and respect **ID.5.SM.1**	Demonstrate ways students can work together to promote dignity and respect for all people **ID.5.ADV.1**

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
PREGNANCY AND REPRODUCTION								
By the end of the 5th grade, students should be able to:	Describe the process of human reproduction **PR.5.CC.1**							
SEXUALLY TRANSMITTED DISEASES AND HIV								
By the end of the 5th grade, students should be able to:	Define HIV and identify some age appropriate methods of transmission, as well as ways to prevent transmission **SH.5.CC.1**							
HEALTHY RELATIONSHIPS								
By the end of the 5th grade, students should be able to:	Describe the characteristics of healthy relationships **HR.5.CC.1**	Compare positive and negative ways friends and peers can influence relationships **HR.5.INF.1**	Identify parents and other trusted adults they can talk to about relationships **HR.5.AI.1**	Demonstrate positive ways to communicate differences of opinion while maintaining relationships **HR.5.IC.1**			Demonstrate ways to treat others with dignity and respect **HR.5.SM.1**	
PERSONAL SAFETY								
By the end of the 5th grade, students should be able to:	Define teasing, harassment and bullying and explain why they are wrong **PS.5.CC.1**	Explain why people tease, harass or bully others **PS.5.INF.1**	Identify parents and other trusted adults they can tell if they are being teased, harassed or bullied **PS.5.AI.1**	Demonstrate ways to communicate about how one is being treated **PS.5.IC.1**			Discuss effective ways in which students could respond when they are or someone else is being teased, harassed or bullied **PS.5.SM.1**	Persuade others to take action when someone else is being teased, harassed or bullied **PS.5.ADV.1**
	Define sexual harassment and sexual abuse **PS.5.CC.2**		Identify parents or other trusted adults they can tell if they are being sexually harassed or abused **PS.5.AI.2**	Demonstrate refusal skills (e.g. clear "no" statement, walk away, repeat refusal) **PS.5.IC.2**				

GRADES 6-8

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
ANATOMY AND PHYSIOLOGY								
By the end of the 8th grade, students should be able to:	Describe male and female sexual and reproductive systems including body parts and their functions **AP.8.CC.1**		Identify accurate and credible sources of information about sexual health **AP.8.AI.1**					
PUBERTY AND ADOLESCENT DEVELOPMENT								
By the end of the 8th grade, students should be able to:	Describe the physical, social, cognitive and emotional changes of adolescence **PD.8.CC.1**	Analyze how friends, family, media, society and culture can influence self-concept and body image **PD.8.INF.1**	Identify medically-accurate sources of information about puberty, adolescent development and sexuality **PD.8.AI.1**		Demonstrate the use of a decision-making model and evaluate possible outcomes of decisions adolescents might make **PD.8.DM.1**			
IDENTITY								
By the end of the 8th grade, students should be able to:	Differentiate between gender identity, gender expression and sexual orientation **ID.8.CC.1**	Analyze external influences that have an impact on one's attitudes about gender, sexual orientation and gender identity **ID.8.INF.1**	Access accurate information about gender identity, gender expression and sexual orientation **ID.8.AI.1**	Communicate respectfully with and about people of all gender identities, gender expressions and sexual orientations **ID.8.IC.1**				Develop a plan to promote dignity and respect for all people in the school community **ID.8.ADV.1**
	Explain the range of gender roles **ID.8.CC.2**							
PREGNANCY AND REPRODUCTION								
By the end of the 8th grade, students should be able to:	Define sexual intercourse and its relationship to human reproduction **PR.8.CC.1**							
	Define sexual abstinence as it relates to pregnancy prevention **PR.8.CC.2**	Examine how alcohol and other substances, friends, family, media, society and culture influence decisions about engaging in sexual behaviors **PR.8.INF.1**		Demonstrate the use of effective communication skills to support one's decision to abstain from sexual behaviors **PR.8.IC.1**				

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
PREGNANCY AND REPRODUCTION (CONTINUED)								
By the end of the 8th grade, students should be able to:	Explain the health benefits, risks and effectiveness rates of various methods of contraception, including abstinence and condoms **PR.8.CC.3**		Identify medically-accurate resources about pregnancy prevention and reproductive health care **PR.8.AI.1**	Demonstrate the use of effective communication and negotiation skills about the use of contraception including abstinence and condoms **PR.8.IC.2**	Apply a decision-making model to various sexual health decisions **PR.8.DM.1**		Describe the steps to using a condom correctly **PR.8.SM.1**	
	Define emergency contraception and its use **PR.8.CC.4**		Identify medically-accurate information about emergency contraception **PR.8.AI.2**					
	Describe the signs and symptoms of a pregnancy **PR.8.CC.5**		Identify medically-accurate sources of pregnancy-related information and support including pregnancy options, safe surrender policies and prenatal care **PR.8.AI.3**					
	Identify prenatal practices that can contribute to a healthy pregnancy **PR.8.CC.6**							
SEXUALLY TRANSMITTED DISEASES AND HIV								
By the end of the 8th grade, students should be able to:	Define STDs, including HIV, and how they are and are not transmitted **SH.8.CC.1**		Identify medically-accurate information about STDs, including HIV **SH.8.AI.1**					
	Compare and contrast behaviors, including abstinence, to determine the potential risk of STD/HIV transmission from each **SH.8.CC.2**	Analyze the impact of alcohol and other drugs on safer sexual decision-making and sexual behaviors **SH.8.INF.1**		Demonstrate the use of effective communication skills to reduce or eliminate risk for STDs, including HIV **SH.8.IC.1**		Develop a plan to eliminate or reduce risk for STDs, including HIV **SH.8.GS.1**	Describe the steps to using a condom correctly **SH.8.SM.1**	

GRADES 6-8 (CONTINUED)

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
SEXUALLY TRANSMITTED DISEASES AND HIV (CONTINUED)								
By the end of the 8th grade, students should be able to:	Describe the signs, symptoms and potential impacts of STDs, including HIV **SH.8.CC.3**		Identify local STD and HIV testing and treatment resources **SH.8.AI.2**					
HEALTHY RELATIONSHIPS								
By the end of the 8th grade, students should be able to:	Compare and contrast the characteristics of healthy and unhealthy relationships **HR.8.CC.1**	Analyze the ways in which friends, family, media, society and culture can influence relationships **HR.8.INF.1**					Explain the criteria for evaluating the health of a relationship **HR.8.SM.1**	
	Describe the potential impacts of power differences such as age, status or position within relationships **HR.8.CC.2**							
	Analyze the similarities and differences between friendships and romantic relationships **HR.8.CC.3**			Demonstrate communication skills that foster healthy relationships **HR.8.IC.1**				
	Describe a range of ways people express affection within various types of relationships **HR.8.CC.4**			Demonstrate effective ways to communicate personal boundaries and show respect for the boundaries of others **HR.8.IC.2**				
	Describe the advantages and disadvantages of communicating using technology and social media **HR.8.CC.5**	Analyze the impact of technology and social media on friendships and relationships **HR.8.INF.2**		Demonstrate effective skills to negotiate agreements about the use of technology in relationships **HR.8.IC.3**		Develop a plan to stay safe when using social media **HR.8.GS.1**	Describe strategies to use social media safely, legally and respectfully **HR.8.SM.2**	

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
PERSONAL SAFETY								
By the end of the 8th grade, students should be able to:	Describe situations and behaviors that constitute bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence **PS.8.CC.1**		Identify sources of support such as parents or other trusted adults that they can go to if they are or someone they know is being bullied, harassed, abused or assaulted **PS.8.AI.1**	Demonstrate ways to communicate with trusted adults about bullying, harassment, abuse or assault **PS.8.IC.1**			Describe ways to treat others with dignity and respect **PS.8.SM.1**	Advocate for safe environments that encourage dignified and respectful treatment of everyone **PS.8.ADV.1**
	Discuss the impacts of bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence and why they are wrong **PS.8.CC.2**						Demonstrate ways they can respond when someone is being bullied or harassed **PS.8.SM.2**	
	Explain that no one has the right to touch anyone else in a sexual manner if they do not want to be touched **PS.8.CC.3**							
	Explain why a person who has been raped or sexually assaulted is not at fault **PS.8.CC.4**							

GRADES 9-12

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
ANATOMY AND PHYSIOLOGY								
By the end of the 12th grade, students should be able to:	Describe the human sexual response cycle, including the role hormones play **AP.12.CC.1**							
PUBERTY AND ADOLESCENT DEVELOPMENT								
By the end of the 12th grade, students should be able to:	Analyze how brain development has an impact on cognitive, social and emotional changes of adolescence and early adulthood **PD.12.CC.1**	Analyze how friends, family, media, society and culture can influence self-concept and body image **PD.12.INF.1**			Apply a decision-making model to various situations relating to sexual health **PD.12.DM.1**			
IDENTITY								
By the end of the 12th grade, students should be able to:	Differentiate between biological sex, sexual orientation, and gender identity and expression **ID.12.CC.1**	Analyze the influence of friends, family, media, society and culture on the expression of gender, sexual orientation and identity **ID.12.INF.1**					Explain how to promote safety, respect, awareness and acceptance **ID.12.SM.1**	Advocate for school policies and programs that promote dignity and respect for all **ID.12.ADV.1**
	Distinguish between sexual orientation, sexual behavior and sexual identity **ID.12.CC.2**							
PREGNANCY AND REPRODUCTION								
By the end of the 12th grade, students should be able to:	Compare and contrast the advantages and disadvantages of abstinence and other contraceptive methods, including condoms **PR.12.CC.1**	Analyze influences that may have an impact on deciding whether or when to engage in sexual behaviors **PR.12.INF.1**	Access medically-accurate information about contraceptive methods, including abstinence and condoms **PR.12.AI.1**	Demonstrate ways to communicate decisions about whether or when to engage in sexual behaviors **PR.12.IC.1**	Apply a decision-making model to choices about contraception, including abstinence and condoms **PR.12.DM.1**		Describe the steps to using a condom correctly **PR.12.SM.1**	

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
PREGNANCY AND REPRODUCTION (CONTINUED)								
By the end of the 12th grade, students should be able to:	Define emergency contraception and describe its mechanism of action **PR.12.CC.2**		Access medically-accurate information and resources about emergency contraception **PR.12.AI.2**					
	Identify the laws related to reproductive and sexual health care services (i.e., contraception, pregnancy options, safe surrender policies, prenatal care) **PR.12.CC.3**							
	Describe the signs of pregnancy **PR.12.CC.4**	Analyze internal and external influences on decisions about pregnancy options **PR.12.INF.2**	Access medically-accurate information about pregnancy and pregnancy options **PR.12.AI.3**					
	Describe prenatal practices that can contribute to or threaten a healthy pregnancy **PR.12.CC.5**	Analyze factors that influence decisions about whether and when to become a parent **PR.12.INF.3**	Access medically-accurate information about prenatal care services **PR.12.AI.4**		Assess the skills and resources needed to become a parent **PR.12.DM.2**			
	Compare and contrast the laws relating to pregnancy, adoption, abortion and parenting **PR.12.CC.6**							

GRADES 9-12 (CONTINUED)

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
SEXUALLY TRANSMITTED DISEASES AND HIV								
By the end of the 12th grade, students should be able to:	Describe common symptoms of and treatments for STDs, including HIV **SH.12.CC.1**		Explain how to access local STD and HIV testing and treatment services **SH.12.AI.1**	Demonstrate skills to communicate with a partner about STD and HIV prevention and testing **SH.12.IC.1**	Apply a decision-making model to choices about safer sex practices, including abstinence and condoms **SH.12.DM.1**		Analyze individual responsibility about testing for and informing partners about STDs and HIV status **SH.12.SM.1**	
	Evaluate the effectiveness of abstinence, condoms and other safer sex methods in preventing the spread of STDs, including HIV **SH.12.CC.2**	Analyze factors that may influence condom use and other safer sex decisions **SH.12.INF.1**	Access medically-accurate prevention information about STDs, including HIV **SH.12.AI.2**			Develop a plan to eliminate or reduce risk for STDs, including HIV **SH.12.GS.1**	Describe the steps to using a condom correctly **SH.12.SM.2**	Advocate for sexually active youth to get STD/HIV testing and treatment **SH.12.ADV.1**
	Describe the laws related to sexual health care services, including STD and HIV testing and treatment **SH.12.CC.3**							
HEALTHY RELATIONSHIPS								
By the end of the 12th grade, students should be able to:	Describe characteristics of healthy and unhealthy romantic and/or sexual relationships **HR.12.CC.1**	Explain how media can influence one's beliefs about what constitutes a healthy sexual relationship **HR.12.INF.1**	Demonstrate how to access valid information and resources to help deal with relationships **HR.12.AI.1**	Demonstrate effective strategies to avoid or end an unhealthy relationship **HR.12.IC.1**				
	Describe a range of ways to express affection within healthy relationships **HR.12.CC.2**							
	Define sexual consent and explain its implications for sexual decision-making **HR.12.CC.3**	Analyze factors, including alcohol and other substances, that can affect the ability to give or perceive the provision of consent to sexual activity **HR.12.INF.2**		Demonstrate effective ways to communicate personal boundaries as they relate to intimacy and sexual behavior **HR.12.IC.2**			Demonstrate respect for the boundaries of others as they relate to intimacy and sexual behavior **HR.12.SM.1**	

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
HEALTHY RELATIONSHIPS								
By the end of the 12th grade, students should be able to:	Evaluate the potentially positive and negative roles of technology and social media in relationships **HR.12.CC.4**						Describe strategies to use social media safely, legally and respectfully **HR.12.SM.2**	
PERSONAL SAFETY								
By the end of the 12th grade, students should be able to:	Compare and contrast situations and behaviors that may constitute bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence **PS.12.CC.1**		Access valid resources for help if they or someone they know are being bullied or harassed, or have been sexually abused or assaulted **PS.12.AI.1**	Demonstrate effective ways to communicate with trusted adults about bullying, harassment, abuse or assault **PS.12.IC.1**				Advocate for safe environments that encourage dignified and respectful treatment of everyone **PS.12.ADV.1**
	Analyze the laws related to bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence **PS.12.CC.2**	Describe potential impacts of power differences (e.g., age, status or position) within sexual relationships **PS.12.INF.1**	Demonstrate ways to access accurate information and resources for survivors of sexual abuse, incest, rape, sexual harassment, sexual assault and dating violence **PS.12.AI.2**	Identify ways in which they could respond when someone else is being bullied or harassed **PS.12.IC.2**				
	Explain why using tricks, threats or coercion in relationships is wrong **PS.12.CC.3**	Analyze the external influences and societal messages that impact attitudes about bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence **PS.12.INF.2**						
	Explain why a person who has been raped or sexually assaulted is not at fault **PS.12.CC.4**							

Standards by Topic Area

ANATOMY AND PHYSIOLOGY

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 2ND GRADE, STUDENTS SHOULD BE ABLE TO:								
	Use proper names for body parts, including male and female anatomy **AP.2.CC.1**							
BY THE END OF THE 5TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe male and female reproductive systems including body parts and their functions **AP.5.CC.1**		Identify medically-accurate information about female and male reproductive anatomy **AP.5.AI.1**					
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe male and female sexual and reproductive systems including body parts and their functions **AP.8.CC.1**		Identify accurate and credible sources about sexual health **AP.8.AI.1**					
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe the human sexual response cycle, including the role hormones play **AP.12.CC.1**							

PUBERTY AND ADOLESCENT DEVELOPMENT

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 2ND GRADE, STUDENTS SHOULD BE ABLE TO:								
	No items							
BY THE END OF THE 5TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Explain the physical, social, and emotional changes that occur during puberty and adolescence **PD.5.CC.1**	Describe how peers, media, family, society and culture influence ideas about body image **PD.5.INF.1**	Identify medically-accurate information and resources about puberty and personal hygiene **PD.5.AI.1**				Explain ways to manage the physical and emotional changes associated with puberty **PD.5.SM.1**	
	Explain how the timing of puberty and adolescent development varies considerably and can still be healthy **PD.5.CC.2**		Identify parents or other trusted adults of whom they can ask questions about puberty and adolescent health issues **PD.5.AI.2**					
	Describe how puberty prepares human bodies for the potential to reproduce **PD.5.CC.3**							
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe the physical, social, cognitive and emotional changes of adolescence **PD.8.CC.1**	Analyze how peers, media, family, society and culture influence self-concept and body image **PD.8.INF.1**	Identify medically-accurate sources of information about puberty, adolescent development and sexuality **PD.8.AI.1**		Demonstrate the use of a decision- making model to evaluate possible outcomes of decisions adolescents might make **PD.8.DM.1**			
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Analyze how brain development has an impact on cognitive, social and emotional changes of adolescence and early adulthood **PD.12.CC.1**	Analyze how peers, media, family, society, religion and culture influence self-concept and body image **PD.12.INF.1**			Apply a decision-making model to various situations relating to sexual health **PD.12.DM.1**			

IDENTITY

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 2ND GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe differences and similarities in how boys and girls may be expected to act **ID.2.CC.1**	Provide examples of how friends, family, media, society and culture influence ways in which boys and girls think they should act **ID.2.INF.1**						
BY THE END OF THE 5TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Define sexual orientation as romantic attraction to an individual of the same gender or of a different gender **ID.5.CC.1**		Identify parents or other trusted adults to whom they can ask questions about sexual orientation **ID.5.AI.1**				Demonstrate ways to treat others with dignity and respect **ID.5.SM.1**	Demonstrate ways students can work together to promote dignity and respect for all people **ID.5.ADV.1**
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Differentiate between gender identity, gender expression and sexual orientation **ID.8.CC.1**	Analyze external influences that have an impact on one's attitudes about gender, sexual orientation and gender identity **ID.8.INF.1**	Access accurate information about gender identity, gender expression and sexual orientation **ID.8.AI.1**	Communicate respectfully with and about people of all gender identities, gender expressions and sexual orientations **ID.8.IC.1**				Develop a plan to promote dignity and respect for all people in the school community **ID.8.ADV.1**
	Explain the range of gender roles **ID.8.CC.2**							
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Differentiate between biological sex, sexual orientation, and gender identity and expression **ID.12.CC.1**	Analyze the influence of peers, media, family, society, religion and culture on the expression of gender, sexual orientation and identity **ID.12.INF.1**					Explain how to promote safety, respect, awareness and acceptance **ID.12.SM.1**	Advocate for school policies and programs that promote dignity and respect for all **ID.12.ADV.1**
	Distinguish between sexual orientation, sexual behavior and sexual identity **ID.12.CC.2**							

PREGNANCY AND REPRODUCTION

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 2ND GRADE, STUDENTS SHOULD BE ABLE TO:								
	Explain that all living things reproduce **PR.2.CC.1**							
BY THE END OF THE 5TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe the process of human reproduction **PR.5.CC.1**							
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Define sexual intercourse and its relationship to human reproduction **PR.8.CC.1**							
	Define sexual abstinence as it relates to pregnancy prevention **PR.8.CC.2**	Examine how alcohol and other substances, peers, media, family, society and culture influence decisions about engaging in sexual behaviors **PR.8.INF.1**		Demonstrate the use of effective communication skills to support one's decision to abstain from sexual behaviors **PR.8.IC.1**				
	Explain the health benefits, risks and effectiveness rates of various methods of contraception, including abstinence and condoms **PR.8.CC.3**		Identify medically-accurate resources about pregnancy prevention and reproductive health care **PR.8.AI.1**	Demonstrate the use of effective communication and negotiation skills about contraception including abstinence and condoms **PR.8.IC.2**	Apply a decision-making model to various sexual health decisions **PR.8.DM.1**		Describe the steps to using a condom correctly **PR.8.SM.1**	
	Define emergency contraception and its use **PR.8.CC.4**		Identify medically-accurate information about emergency contraception **PR.8.AI.2**					

PREGNANCY AND REPRODUCTION (CONTINUED)

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe the signs and symptoms of a pregnancy **PR.8.CC.5**		Identify medically-accurate sources of pregnancy-related information and support including pregnancy options, safe surrender policies and prenatal care **PR.8.AI.3**					
	Identify prenatal practices that can contribute to a healthy pregnancy **PR.8.CC.6**							
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Compare and contrast the advantages and disadvantages of abstinence and other contraceptive methods, including, condoms **PR.12.CC.1**	Analyze influences that may have an impact on deciding whether or when to engage in sexual behaviors **PR.12.INF.1**	Access medically-accurate information about contraceptive methods, including emergency contraception and condoms **PR.12.AI.1**	Demonstrate ways to communicate decisions about whether or when to engage in sexual behaviors **PR.12.IC.1**	Apply a decision-making model to choices about contraception, including abstinence and condoms **PR.12.DM.1**		Describe the steps to using a condom correctly **PR.12.SM.1**	
	Define emergency contraception and describe its mechanism of action **PR.12.CC.2**		Access medically-accurate information and resources about emergency contraception **PR.12.AI.2**					
	Identify the laws related to reproductive and sexual health care services (i.e., contraception, pregnancy options, safe surrender policies, prenatal care) **PR.12.CC.3**							

Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:							
Describe the signs of pregnancy **PR.12.CC.4**	Analyze internal and external influences on decisions about pregnancy options **PR.12.INF.2**	Access medically-accurate information about pregnancy options **PR.12.AI.3**					
Describe prenatal practices that can contribute to or threaten a healthy pregnancy **PR.12.CC.5**	Analyze factors that influence decisions about whether and when to become a parent **PR.12.INF.3**	Access medically-accurate information about prenatal care services **PR.12.AI.4**		Assess the skills and resources needed to become a parent **PR.12.DM.2**			
Compare and contrast the laws relating to pregnancy, adoption, abortion and parenting **PR.12.CC.6**							

SEXUALLY TRANSMITTED DISEASES AND HIV

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 2ND GRADE, STUDENTS SHOULD BE ABLE TO:								
	No Items							
BY THE END OF THE 5TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Define HIV and identify some age-appropriate methods of transmission, as well as ways to prevent transmission **SH.5.CC.1**							
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Define STDs, including HIV, and how they are and are not transmitted **SH.8.CC.1**		Identify medically-accurate information about STDs, including HIV **SH.8.AI.1**					
	Compare and contrast behaviors, including abstinence, to determine the potential risk of STD/HIV transmission from each **SH.8.CC.2**	Analyze the impact of alcohol and other drugs on safer sexual decision-making and sexual behaviors **SH.8.INF.1**		Demonstrate the use of effective communication skills to reduce or eliminate risk for STDs, including HIV **SH.8.IC.1**		Develop a plan to eliminate or reduce risk for STDs, including HIV **SH.8.GS.1**	Describe the steps to using a condom correctly **SH.8.SM.1**	
	Describe the signs, symptoms and potential impacts of STDs, including HIV **SH.8.CC.3**		Identify local STD and HIV testing and treatment resources **SH.8.AI.2**					
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe common symptoms of and treatments for STDs, including HIV **SH.12.CC.1**		Explain how to access local STD and HIV testing and treatment services **SH.12.AI.1**	Demonstrate skills to communicate with a partner about STD and HIV prevention and testing **SH.12.IC.1**	Apply a decision-making model to choices about safer sex practices, including abstinence and condoms **SH.12.DM.1**		Analyze individual responsibility about testing for and informing partners about STDs and HIV status **SH.12.SM.1**	

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Evaluate the effectiveness of abstinence, condoms and other safer sex methods in preventing the spread of STDs, including HIV **SH.12.CC.2**	Analyze factors that may influence condom use and other safer sex decisions **SH.12.INF.1**	Access medically-accurate prevention information about STDs, including HIV **SH.12.AI.2**			Develop a plan to eliminate or reduce risk for STDs, including HIV **SH.12.GS.1**	Describe the steps to using a condom correctly **SH.12.SM.2**	Advocate for sexually active youth to get STD/HIV testing and treatment **SH.12.ADV.1**
	Describe the laws as they relate to sexual health care services, including STD and HIV testing and treatment **SH.12.CC.3**							

HEALTHY RELATIONSHIPS

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 2ND GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe the characteristics of a friend **HR.2. CC.2**			Identify healthy ways for friends to express feelings to each other **HR.2.IC.2**				
BY THE END OF THE 5TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe the characteristics of healthy relationships (e.g., family, friends, peers) **HR.5.CC.1**	Compare positive and negative ways friends and peers can influence relationships **HR.5.INF.1**	Identify parents and other trusted adults they can talk to about relationships **HR.5.AI.1**	Demonstrate positive ways to communicate differences of opinion while maintaining relationships **HR.5.IC.1**			Demonstrate ways to treat others with dignity and respect **HR.5.SM.1**	
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Compare and contrast the characteristics of healthy and unhealthy relationships **HR.8.CC.1**	Analyze the ways in which family, friends, peers, media, society and culture can influence relationships **HR.8.INF.1**					Explain the criteria for evaluating the health of a relationship **HR.8.SM.1**	
	Describe the potential impacts of power differences such as age, status or position within relationships **HR.8.CC.2**							
	Analyze the similarities and differences between friendships and romantic relationships **HR.8.CC.3**			Demonstrate communication skills that foster healthy relationships **HR.8.IC.1**				
	Describe a range of ways people express affection within various types of relationships **HR.8.CC.4**			Demonstrate effective ways to communicate personal boundaries and show respect for the boundaries of others **HR.8.IC.2**				

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe the advantages and disadvantages of communicating using technology and social media **HR.8.CC.5**	Analyze the impact of technology and social media on friendships and relationships **HR.8.INF.2**		Demonstrate effective skills to negotiate agreements about the use of technology in relationships **HR.8.IC.3**		Develop a plan to stay safe when using social media **HR.8.GS.1**	Describe strategies to use social media safely, legally and respectfully **HR.8.SM.2**	
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe characteristics of healthy and unhealthy romantic and/or sexual relationships **HR.12.CC.1**	Explain how media can influence one's beliefs about what constitutes a healthy sexual relationship **HR.12.INF.1**	Demonstrate how to access valid information and resources to help deal with relationships **HR.12.AI.1**	Demonstrate effective strategies to avoid or end an unhealthy relationship **HR.12.IC.1**				
	Describe a range of ways to express affection within healthy relationships **HR.12.CC.2**							
	Define sexual consent and explain its implications for sexual decision-making **HR.12.CC.3**	Analyze factors, including alcohol and other substances, that can affect the ability to give or perceive the provision of consent to sexual activity **HR.12.INF.2**		Demonstrate effective ways to communicate personal boundaries as they relate to intimacy and sexual behavior **HR.12.IC.2**			Demonstrate respect for the boundaries of others as they relate to intimacy and sexual behavior **HR.12.SM.1**	
	Evaluate the potentially positive and negative roles of technology and social media in relationships **HR.12.CC.4**						Describe strategies to use social media safely, legally and respectfully **HR.12.SM.2**	

PERSONAL SAFETY

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 2ND GRADE, STUDENTS SHOULD BE ABLE TO:								
	Explain that all people, including children, have the right to tell others not to touch their body when they do not want to be touched **PS.2.CC.1**		Identify parents and other trusted adults they can tell if they are feeling uncomfortable about being touched **PS.2.AI.1**	Demonstrate how to respond if someone is touching them in a way that makes them feel uncomfortable **PS.2.IC.1**			Demonstrate how to clearly say no, how to leave an uncomfortable situation, and how to identify and talk with a trusted adult if someone is touching them in a way that makes them feel uncomfortable **PS.2.SM.1**	
	Explain what bullying and teasing are **PS.2.CC.2**							
	Explain why bullying and teasing are wrong **PS.2.CC.3**		Identify parents and other trusted adults they can tell if they are being bullied or teased **PS.2.AI.2**	Demonstrate how to respond if someone is bullying or teasing them **PS.2.IC.2**				
BY THE END OF THE 5TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Define teasing, harassment and bullying and explain why they are wrong **PS.5.CC.1**	Explain why people tease, harass or bully others **PS.5.INF.1**	Identify parents and other trusted adults students can tell if they are being teased, harassed or bullied **PS.5.AI.1**	Demonstrate ways to communicate about how one is being treated **PS.5.IC.1**			Discuss effective ways in which students could respond when they are or someone else is being teased, harassed or bullied **PS.5.SM.1**	Persuade others to take action when someone else is being teased, harassed or bullied **PS.5.ADV.1**
	Define sexual harassment and sexual abuse **PS.5.CC.2**		Identify parents or other trusted adults they can tell if they are being sexually harassed or abused **PS.5.AI.2**	Demonstrate refusal skills (clear "no" statement, walk away, repeat refusal) **PS.5.IC.2**				

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Describe situations and behaviors that constitute bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence **PS.8.CC.1**		Identify sources of support such as parents or other trusted adults that they can go to if they are or someone they know is being bullied, harassed, abused or assaulted **PS.8.AI.1**	Demonstrate ways to communicate with trusted adults about bullying, harassment, abuse or assault **PS.8.IC.1**			Describe ways to treat others with dignity and respect **PS.8.SM.1**	Advocate for safe environments that encourage dignified and respectful treatment of everyone **PS.8.ADV.1**
	Discuss the impacts of bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence and why they are wrong **PS.8.CC.2**						Demonstrate ways they can respond when someone is being bullied or harassed **PS.8.SM.2**	
	Explain that no one has the right to touch anyone else in a sexual manner if they do not want to be touched **PS.8.CC.3**							
	Explain why a person who has been raped or sexually assaulted is not at fault **PS.8.CC.4**							
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Compare and contrast situations and behaviors that may constitute bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence **PS.12.CC.1**		Access valid resources for help if they or someone they know are being bullied or harassed, or have been sexually abused or assaulted **PS.12.AI.1**	Demonstrate effective ways to communicate with trusted adults about bullying, harassment, abuse or assault **PS.12.IC.1**				Advocate for safe environments that encourage dignified and respectful treatment of everyone **PS.12.ADV.1**

PERSONAL SAFETY (CONTINUED)

	Core Concepts CC	Analyzing Influences INF	Accessing Information AI	Interpersonal Communication IC	Decision-Making DM	Goal Setting GS	Self-Management SM	Advocacy ADV
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO:								
	Analyze the laws related to bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence **PS.12.CC.2**	Describe potential impacts of power differences (e.g., age, status or position) within sexual relationships **PS.12.INF.1**	Demonstrate ways to access accurate information and resources that provide help for survivors of sexual abuse, incest, rape, sexual harassment, sexual assault and dating violence **PS.12.AI.2**	Identify ways in which they could respond when someone else is being bullied or harassed **PS.12.IC.2**				
	Explain why using tricks, threats or coercion in relationships is wrong **PS.12.CC.3**	Analyze the external influences and societal messages that impact attitudes about bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence **PS.12.INF.2**						
	Explain why a person who has been raped or sexually assaulted is not at fault **PS.12.CC.4**							

National Resources

For Teachers

Teachers can find print resources, learn about professional development opportunities and obtain technical assistance through the following national organizations:

Advocates for Youth
2000 M Street NW, Suite 750
Washington, D.C. 20036
(202) 419-3420
www.advocatesforyouth.org

American Association for Health Education
1900 Association Drive
Reston, VA 20191
(800) 213-7191
www.aahperd.org/aahe

American School Health Association
4340 East West Highway Suite 403
Bethesda, MD 20814
(800) 455-2742
www.ashaweb.org

American Social Health Association
P.O. Box 13827
Research Triangle Park, NC 27709
(919) 361-8400
www.iwannaknow.org

Answer
41 Gordon Road, Suite C
Piscataway, NJ 08854
(732) 445-7929
http://answer.rutgers.edu

Association for Middle Level Education
(formerly National Middle School Association)
4151 Executive Parkway, Suite 300
Westerville, OH 43081
(614) 895-4730
www.amle.org

Gay, Lesbian & Straight Education Network
90 Broad Street, 2nd Floor
New York, NY 10004
(212) 727-0135
www.glsen.org

Guttmacher Institute
125 Maiden Lane, 7th Floor
New York, NY 10038
(212) 248-1111
www.guttmacher.org

Healthy Teen Network
1501 Saint Paul Street, Suite 124
Baltimore, MD 21202
(410) 685-0419
www.healthyteennetwork.org

National Association of School Nurses
8484 Georgia Avenue, #420
Silver Spring, MD 20910
(240) 821-1130
www.nasn.org

NEA Health Information Network
1201 16th Street, NW #216
Washington, DC 20036
(202) 822.7570
www.neahin.org

Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400
www.kff.org

Rape, Abuse & Incest National Network (RAINN)
2000 L Street NW, Suite 406
Washington, DC 20036
(202) 544-1034
www.rainn.org

Resource Center for Adolescent Pregnancy Prevention
(ReCAPP)
ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061
(800) 321-4407
www.etr.org/recapp

Sexuality Information and Education Council of the United States (SIECUS)
90 John Street, Suite 402
New York, NY 10038
(212) 819-9770
www.siecus.org
www.sexedlibrary.org

The National Campaign to Prevent Teen and Unplanned Pregnancy
1776 Massachusetts Avenue NW, Suite 200
Washington, D.C. 20036
(202) 478-8500
www.teenpregnancy.org

Planned Parenthood Federation of America
434 West 33rd Street
New York, NY 10001
(212) 541-7800
www.plannedparenthood.org

The Society of State Leaders in Health and Physical Education
PO Box 40186
Arlington, VA 22204
(202) 286-9138
www.thesociety.org

For School Administrators

There is a great deal of support available for school administrators in supporting the implementation of comprehensive sexuality education in public schools. These organizations can help:

American School Health Association
4340 East West Highway, Suite 403
Bethesda, MD 20814
(800) 455-2742
www.ashaweb.org

American Association for Health Education
1900 Association Drive
Reston, VA 20191
(800) 213-7191
www.aahperd.org/aahe

Association for Middle Level Education
(formerly National Middle School Association)
4151 Executive Parkway, Suite 300
Westerville, OH 43081
(614) 895-4730
www.amle.org

National Association of School Nurses
8484 Georgia Avenue, #420
Silver Spring, MD 20910
(240) 821-1130
www.nasn.org

National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722
www.nsba.org

National Association of State Boards of Education
2121 Crystal Drive Suite #350
Arlington, VA 22202
(703) 684-4000

The Society of State Leaders in Health and Physical Education
PO Box 40186
Arlington, VA 22204
(202) 286-9138
www.thesociety.org

For Parents

Parents and other adult caregivers play invaluable roles in educating their children about sexuality and relationships. Each organization maintains resources that can support parents in providing accurate information to their children comfortably and within the context of their values.

Advocates for Youth
2000 M Street NW, Suite 750
Washington, DC 20036
(202) 419-3420
www.advocatesforyouth.org/parents-sex-ed-center-home

Answer
41 Gordon Road, Suite C
Piscataway, NJ 08854
(732) 445-7929
http://answer.rutgers.edu/page/parentresources

Sexuality Information and Education Council of the United States (SIECUS)
90 John Street, Suite 402
New York, NY 10038
(212) 819-9770
www.siecus.org/index.cfm?fuseaction=page.viewPage&pageID=632&nodeID=1

For Middle and High School Students

Schools provide an important venue through which to teach young people about sexuality, but young people often have additional questions that they may not feel comfortable directing to their teachers. These organizations all have resources for teens that are age-appropriate and medically accurate:

Advocates for Youth
2000 M Street NW, Suite 750
Washington, D.C. 20036
(202) 419-3420
www.advocatesforyouth.org
www.amplifyyourvoice.org/youthresource

American Social Health Association
PO Box 13827
Research Triangle, NC 27709
(919) 361-8400
www.iwannaknow.org

Answer's Teen-to-Teen Sexuality Education Initiative, *Sex, Etc*.
41 Gordon Road, Suite C
Piscataway, NJ 08854
(732) 445-7929
www.sexetc.org

Rape, Abuse & Incest National Network (RAINN)
2000 L Street NW, Suite 406
Washington, DC 20036
(800) 656-HOPE (24 hour telephone hotline)
www.rainn.org

Glossary

Abortion
A medical intervention that ends a pregnancy.

Abstinence
Choosing to refrain from certain sexual behaviors for a period of time. Some people define abstinence as not having vaginal intercourse, while others define it as not engaging in any sexual activity.

Age of Consent
The age a person is legally able to consent to sexual activity. It varies from state to state, but ranges from 14 to 18 years of age in the United States.

Abstinence-Only Programs
Programs exclusively focused on refraining from all sexual behaviors. They do not necessarily put a condition on when a person might choose to no longer be abstinent.

Abstinence-Only-Until-Marriage Programs
Programs focused exclusively on refraining from all sexual behaviors outside of the context of a heterosexual marriage.

Age-Appropriate
Designed to teach concepts, information, and skills based on the social, cognitive, emotional, and experience level of most students at a particular age level.

AIDS
Acquired Immune Deficiency Syndrome. AIDS is caused by the Human Immunodeficiency Virus (HIV). People do not die from AIDS, they die from one of the infections their body acquires as a result of their weakened immune system. (also see HIV).

Biological Sex
Our sex as determined by our chromosomes (such as XX or XY), our hormones and our internal and external anatomy. Typically, we are assigned the sex of male or female at birth. Those whose chromosomes are different from XX or XY at birth are referred to as "intersex."

Bisexual
A term used to describe a person whose attraction to other people is not necessarily determined by gender. This is different from being attracted to all men or all women.

Body Image
How people feel about their body. This may or may not match a person's actual appearance.

Bullying
Physically, mentally, and/or emotionally intimidating and/or harming an individual or members of a group.

Comprehensive Sexuality Education
Sexuality education programs that build a foundation of knowledge and skills relating to human development, relationships, decision-making, abstinence, contraception, and disease prevention. Ideally, comprehensive sexuality education should start in kindergarten and continue through 12th grade. At each developmental stage, these programs teach age-appropriate, medically accurate information that builds on the knowledge and skills that were taught in the previous stage.

Consensual
When a person agrees to engage in sexual behaviors with another person. "Consensual sex" means that no one was forced or manipulated in any way to participate in a sexual behavior.

Contraception
Any means to prevent pregnancy, including abstinence, barrier methods such as condoms and hormonal methods such as the pill, patch, injection and others.

Dating Violence
Controlling, abusive and/or aggressive behavior within the context of a romantic relationship. It can include verbal, emotional, physical and/or sexual abuse, be perpetrated against someone of any gender and happen in any relationship regardless of sexual orientation.

Gay
A term used to describe people who are romantically and sexually attracted to people of their same gender. Gay women will often use the word "lesbian."

Gender
The emotional, behavioral and cultural characteristics attached to a person's assigned biological sex. Gender can be understood to have several components, including gender identity, gender expression and gender role (see below).

Gender Expression
The manner in which people outwardly expresses their gender.

Gender Identity
People's inner sense of their gender. Most people develop a gender identity that corresponds to their biological sex, but some do not.

Gender Roles
The social expectations of how people should act, think and/or feel based on their assigned biological sex.

Harassment
Unwelcome or offensive behavior by one person to another. Examples are making unwanted sexual comments to another person, sending unwanted sexual texts, bullying or intimidation.

Heterosexual
A term used to describe people who are romantically and sexually attracted to people of a different gender from their own.

HIV
The Human Immunodeficiency Virus (HIV), which causes AIDS (Acquired Immune Deficiency Syndrome). The virus weakens a person's immune system so that the person cannot fight off many everyday infections. HIV is transmitted through exposure to an infected person's blood, semen, vaginal fluids or breast milk.

Homosexual
A term used to describe people who are romantically and sexually attracted to people of their own gender. Most often referred to as "gay" or "lesbian."

Incest
Sexual contact between persons who are so closely related that marriage between those two people would be considered illegal (e.g., a parent or step parent and a child, siblings, etc.).

Lesbian
A term used to describe women who are romantically and sexually attracted to other women.

Medically-Accurate
Grounded in evidence-based, peer-reviewed science and research.

Puberty
A time when the pituitary gland triggers production of testosterone in boys and estrogen and progesterone in girls. Puberty typically begins between ages 9 and 12 for girls, and between the ages of 11 and 14 for boys, and includes such body changes as hair growth around the genitals, menstruation in girls, sperm production in boys, and much more.

Rape
A type of sexual assault that involves forced vaginal, anal, or oral sex using a body part or object.

Sexual Abuse
Sexual abuse is any sort of unwanted sexual contact often over a period of time. A single act of sexual abuse is usually referred to as a "sexual assault" (see below).

Sexual Assault
Any unwanted sex act committed by a person or people against another person.

Sexual Harassment
Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual Intercourse
When a penis is inserted into a vagina, mouth or anus.

Sexual Orientation
Romantic and sexual attraction to people of one's same and/or other genders. Current terms for sexual orientation include gay, lesbian, bisexual, heterosexual and others.

Sexually Transmitted Diseases (STDs)
Diseases caused by bacteria, viruses or parasites that are transmitted from one person to another during sexual contact. Also called sexually transmitted infections or STIs.

Transgender
A gender identity in which a person's inner sense of their gender does not correspond to their assigned biological sex.

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Original article

The Association Between Sex Education and Youth's Engagement in Sexual Intercourse, Age at First Intercourse, and Birth Control Use at First Sex

Trisha E. Mueller, M.P.H.*, Lorrie E. Gavin, Ph.D., and Aniket Kulkarni, M.B.B.S., M.P.H.

Centers for Disease Control and Prevention, Division of Reproductive Health, Atlanta, Georgia

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Abstract

Purpose: Sex education is intended to provide youth with the information and skills needed to make healthy and informed decisions about sex. This study examined whether exposure to formal sex education is associated with three sexual behaviors: ever had sexual intercourse, age at first episode of sexual intercourse, and use of birth control at first intercourse.

Methods: Data used were from the 2002 National Survey of Family Growth, a nationally representative survey. The sample included 2019 never-married males and females aged 15–19 years. Bivariate and multivariate analyses were conducted using SUDAAN. Interactions among subgroups were also explored.

Results: Receiving sex education was associated with not having had sexual intercourse among males (OR = .42, 95% CI = .25–.69) and postponing sexual intercourse until age 15 among both females (OR = .41, 95% CI = .21–.77) and males (OR = .29, 95% CI = .17–.48). Males attending school who had received sex education were also more likely to use birth control the first time they had sexual intercourse (OR = 2.77, 95% CI = 1.13–6.81); however, no associations were found among females between receipt of sex education and birth control use. These patterns varied among sociodemographic subgroups.

Conclusions: Formal sex education may effectively reduce adolescent sexual risk behaviors when provided before sexual initiation. Sex education was found to be particularly important for subgroups that are traditionally at high risk for early initiation of sex and for contracting sexually transmitted diseases.

Keywords: Adolescents; Sex education; Sexual behavior; Contraception; Age at sexual initiation

Although the appropriate content is debated, 93% of Americans support some form of sex education being taught in schools [1]. Similarly, a number of professional organizations have recommended that adolescents be counseled about sex to provide them with the information and skills needed to make healthy and informed decisions about sexual behavior [2–5]. Equipping youth with the necessary skills and knowledge to make responsible decisions about sex may help to reduce the more than 750,000 pregnancies among teens [6,7] and the approximately 9 million cases of sexually transmitted disease (STD) infections among youth aged 15–24 years old [8,9] that occur in the United States each year.

However, existing population-level research on the impact of sex education on reducing adolescent sexual risk behavior has suggested that the effect is, in fact, weak. Several population-based studies conducted during the 1970s through the early 1990s demonstrated that sex education had little or no effect on the likelihood of youth engaging in sexual intercourse [10–14]. Sex education appeared to be somewhat more influential in the contraceptive decisions of youth, with some studies showing that sex education had a positive effect on greater contraceptive use at first episode of sexual intercourse (referred to in this study as "first sex") [10,11,13,15–17].

*Address reprint requests to: Trisha Mueller, M.P.H., 4770 Buford Highway, MS K22, Atlanta, GA 30341.

E-mail address: tmueller@cdc.gov

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During the past two decades, however, a number of changes have occurred in how sex education is provided to adolescents [18]. First, sex education has become more widespread [6,19]. In 2002, more than 80% of 15–19-year-old youth reported being taught "how to say no" to sex, and more than 65% reported receiving education on birth control methods [6]. In contrast, only 60% of females and 52% of males reported receiving any sex education by the age of 19 years in 1984 [11]. Second, youth are receiving sex education at earlier ages than in the past. Studies show that during the 1980s, 21%–47% of youth received a sex education course by the time they reached their 15th birthday [10,11]. In a recent national study of middle school teachers, 72% of fifth- and sixth-grade teachers reported that sex education was taught in their schools at one or both grade levels [15]. According to 2002 data, two thirds of teens reported being taught about "how to say no" before they entered high school, whereas education on birth control methods occurred later [6]. In addition, researchers have also demonstrated that abstinence-only education has increased in recent years, and education on birth control methods has decreased since 1995 [18].

Evidence from intervention efficacy research accumulated during the past 20 years shows that some, but not all, sex education curricula can effectively reduce adolescent sexual risk behavior [20,21]. However, the extent to which these effective sex education programs have been implemented is not well understood. A recent study of school-based substance-use prevention programs suggests poor uptake of evidence-based programs by providers; only 14% of substance-abuse prevention providers used evidence-based content and delivery methods [22].

No recent national studies have been conducted to assess the effect of sex education on the sexual behaviors of youth. It is possible that the changes in how and when sex education is provided (i.e., increased coverage of sex education, providing sex education at earlier ages, and availability of evidence-based curricula) will have translated into a greater impact at the population level. This study was developed by using a recent, nationally representative survey to explore the association between adolescents' receipt of sex education with sexual risk behaviors, including initiation of sexual intercourse, age at first sex, and birth control use at first sex. Previous studies have not included an extensive analysis of the impact of sex education on subgroups of youth; therefore, this study also explored how those associations vary among different sociodemographic subgroups of adolescents.

Methods

Sample

The data analyzed were from the 2002 National Survey of Family Growth (NSFG), a nationally representative survey of male and female individuals 15–44 years of age that was designed to provide estimates of sexual activity, use of contraception, and births. The survey methodology has been described previously [23]. The overall response rate among 15–19-year-olds in the 2002 NSFG was 81%. Our sample was limited to males and females aged 15–19 years who had never been married; among respondents who reported a history of sexual activity, we excluded those who had their first sexual intercourse at or before age 10 ($n = 10$). Youth who reported their race as other than white, Hispanic, or African American were excluded from the analysis because of the small sample size ($n = 117$). When exclusion criteria were applied, the total sample comprised 2019 adolescents ($n = 1026$ males and 993 females).

Measures

Adolescents were asked whether they had ever received any formal instruction on "how to say no" to sex and any formal education on methods of birth control. These items were asked as separate questions. If respondents answered yes to either question, they were then asked at what grade level they had received the education. "Formal" sex education included any sex education that was provided in schools, in churches, or by community organizations. Exposure to sex education was coded as "ever" received sex education on either "how to say no" to sex or methods of birth control versus "never" received any education on these two topics. Variables indicating the timing of sex education (i.e., before or after a respondent's first sexual intercourse) were also created. The age at which females and males received formal sex education was determined by adding 5 to the grade level that they reported as having received sex education, a method consistent with previous research [19]. By comparing the age at which the respondents received formal sex education with the age at first sexual intercourse, we were able to determine whether the education occurred before or after the respondents had sexual intercourse for the first time. If the age at first sex and age at sex education were the same, sex education was determined to have occurred after first sex. For respondents who reported not having had sexual intercourse but having received formal sex education, the education was coded as having occurred before first sex.

Three behavioral outcomes were included in this analysis. Sexual intercourse was classified as "ever" versus "never" having had sexual intercourse. Age at first sex was dichotomized into "under 15 at first sex" and "equal to or greater than 15 at first sex." We chose 15 years to be consistent with the Healthy People 2010 goal of increasing the proportion of adolescents who abstain from sex until at least age 15 years [24]. Youth who reported they had not had sexual intercourse were classified as having sex at age 15 or older. Birth control use at first sex was assessed only among sexually experienced adolescents. Youth who indicated

that they did not use effective or modern methods of birth control the first time that they had sexual intercourse or who had used withdrawal, natural family planning, or rhythm method were classified as not using a method of birth control at first sex.

Six sociodemographic covariates were used in the analysis. Age at interview and age at first sex were coded as continuous variables. Family income, race/ethnicity, family situation at age 14 years (living with one parent/other or living with two parents), school status (in-school/graduated from school or dropout), and residence status were treated as categorical variables (Table 1).

Data analysis

Data were weighted to adjust for varying probabilities of selection and nonresponse. All analyses were conducted using the statistical software package SUDAAN (version 8), which accounts for the complex sampling design used in this survey and provides appropriate standard errors [25].

Bivariate analyses examined associations between (1) the exposure variable (receipt of sex education) and the demographic covariates and (2) the exposure variable and the three behavioral outcomes. Bivariate relationships were examined using the χ^2 test.

Two multivariable analyses were performed for each of the three outcomes. In the first analysis, multivariable logistic regression was used to determine whether the association between the exposure and outcome variables remained after adjusting for all sociodemographic covariates. The covariates were included in the model irrespective of their significance level.

In the second multivariable analysis, to determine whether the effect of sex education differed among subgroups, we examined for interaction terms between the exposure and the following four sociodemographic variables: race/ethnicity, family situation at age 14, school status, and residence. Age at interview (only for the association between receipt of sex education and ever having had sexual intercourse), age at first sex (only for the association between receipt of sex education and use of birth control at first sex), and family income were treated as confounders and were adjusted for regardless of their significance level in the interaction model. The interaction model included all main effects variables (exposure and confounders), and all possible two-way interaction variables. Direct backward elimination technique was used to remove the two-way interaction variables one at a time until the model included all possible two-way interactions at the .05 significance level (Wald F test, $p < .05$). If any of the four covariates (race/ethnicity, family situation at age 14 years, school status, or residence) did not interact with the exposure, it was treated as a confounder. Three-way interactions were examined if the model had more than two two-way interactions, but none were significant at a level of $p < .05$. Odds ratios (OR) were calculated manually using the final model, which included all the main effects variables, and significant two-way interactions.

Table 1 presents the sociodemographic characteristics of the study sample. Substantial variation existed in family incomes, with 19%–24% below the federal poverty level, 40%–45% between 100% and 300% of or above the federal poverty level, and 32%–41% more than 300% above the federal poverty level. The sample was predominantly white (68% of females and 68% of males), with smaller percentages of African Americans (17% of females and 15% of males) and Hispanics (15% of females and 17% of males). Most youth lived in a home with two parents/guardians (78% of females and 82% of males), and the vast majority either attended or had graduated from high school (92% of females and 91% of males). Approximately three fourths of the sample lived in a MSA-central city/MSA-other (78% of females and 81% of males), with the remainder living outside of an MSA. Less than half of the adolescents were sexually experienced (42% of females and 44% of males; data not shown), and a relatively small percentage reported having sexual intercourse before age 15 years (12% of females and 14% of males; data not shown). Among sexu-

Table 1
Sociodemographic characteristics of study sample*

Characteristic	Total	
	Females *n* (%)	Males *n* (%)
Youth age (years)		
15	207 (20)	190 (19)
16	207 (21)	218 (20)
17	208 (21)	185 (18)
18	191 (19)	244 (23)
19	180 (18)	189 (19)
Family income†		
<100%	251 (24)	206 (19)
100%–199%	241 (24)	205 (22)
200%–299%	187 (21)	202 (19)
300%–399%	138 (15)	177 (19)
400%–499%	105 (11)	144 (13)
>500%	71 (6)	92 (9)
Race/ethnicity		
White	562 (68)	606 (68)
African American	232 (17)	197 (15)
Hispanic	199 (15)	223 (17)
Family situation at age 14 years		
Lived with two parents	726 (78)	800 (82)
Lived with one parent/other	267 (22)	226 (18)
School status		
In school	921 (92)	926 (91)
Dropout	72 (8)	100 (9)
Residence		
MSA, central city or MSA, other	805 (78)	855 (81)
Non-MSA	188 (22)	171 (19)

MSA = Metropolitan Statistical Area.

* All *n* values are presented as unweighted frequencies; percentages are given as weighted percentages.

† Family income in relation to federal poverty level.

Table 2
Bivariate associations between exposure to formal sex education and youth's sexual risk behaviors, 2002

	Received sex education before first sex†			
	Females *n* (%)		Males *n* (%)	
	Yes	No	Yes	No
Ever had sexual intercourse	357 (41)	75 (54)*	397 (42)	98 (64)***
Age at first sex at age <15 years‡	79 (9)	40 (22)**	93 (10)	62 (32)***
Used birth control at first sex	269 (76)	45 (59)*	331 (83)	75 (72)

† Youth were considered to have received sex education prior to first sexual intercourse if they met one of two conditions: (1) they reported receiving sex education prior to the year of first sexual intercourse; or (2) they reported receiving sex education but not having had sexual intercourse.

‡ Exposure to formal sex education is defined as exposure to any formal sex education before first sexual intercourse AND before the age of 15 for this sexual risk behavior.

* $p < .05$; ** $p < .01$; *** $p < .001$.

ally experienced youth, the majority reported using an effective or modern method of birth control at first sex (73% of females and 80% of males; data not shown).

Table 2 shows the results of bivariate analyses examining the association between exposure to sex education before first sex and three sexual risk behaviors. Adolescent females who had received sex education before first sex were less likely to have had sexual intercourse than females who had not had sex education before first sex (41% vs. 54%, $p < .05$). Adolescent females who had received sex education before first sex were also less likely to have had sexual intercourse before age 15 years than females who had not had sex education before first sex (9% vs. 22%, $p < .01$). Sexually experienced females who had had sex education before first sex were more likely to have reported using some form of birth control at first sex than those who had not had sex education before first sex (76% vs. 59%, $p < .05$). Males who had received sex education before first sex were less likely than those who had not received sex education to have had sexual intercourse before first sex (42% vs. 64%, $p < .001$). Males who had received sex education before first sex were also less likely than those who had not had sex education before first sex to have had sexual intercourse before age 15 (10% vs. 32%, $p < .001$). Among sexually experienced males, no significant difference was found between used and did not use birth control at first sex based on history of sex education (83% vs. 72%, $p = .147$).

Among females, no association was found between exposure to sex education before first sex and having had sex after adjusting for all sociodemographic characteristics (Table 3). However, the following significant interactions were found: urban African American females were less likely to have had sexual intercourse if they had received sex education before first sex (OR = 0.12, 95% confidence interval [CI] = .04–.36) and non-MSA white females were more likely to have had sexual intercourse if they had received sex education before first sex (OR = 3.16, 95% CI = 1.01–9.87). Among males, those who received sex education before first sex were less likely to have had sexual intercourse after adjusting for all sociodemographic characteristics (OR = .42, 95% CI = .25–.69), and no significant interactions were found between exposure to sex education before first sex and sociodemographic characteristics.

Among females, a statistically significant association was found between receipt of sex education before first sex and age at sexual initiation after adjusting for all sociodemographic characteristics (OR = .41, 95% CI = .21–.77) (Table 4). Significant interactions were also found between receiving sex education before first sex and several sociodemographic characteristics. Among African American females who either were attending or had graduated from high school, those who had received sex education before first sex were less likely to have had sexual intercourse before age 15 years than those who had not received sex education before first sex (OR = .09, 95% CI = .04–.22). Among both white and Hispanic females who were not enrolled in high school or had dropped out, those who had received sex education before first sex were more likely to have reported having had sexual intercourse before age 15 than those who had not had sex education before first sex (for whites, OR = 10.18, 95% CI = 1.25–82.86; for Hispanics, OR = 14.44, 95% CI = 1.68–123.97).

Among males, those who had received sex education before first sex were more likely to have abstained from sex until at least age 15 years, even after controlling for sociodemographic characteristics (OR = .29, 95% CI = .17–.48). Two significant interactions were noted: (1) among males who lived in a two-parent home, those who had received sex education before first sex were less likely than those who had not received sex education before first sex to have had sexual intercourse before age 15 (OR = .38, 95% CI = .21–.68); and (2) among males who lived in a one-parent/other home, those who received sex education before first sex were less likely than those who had not received sex

Table 3
Results of multivariate regression analysis using "ever had sexual intercourse" as dependent variable, separately for females and males 15–19 years of age, 2002

	Females		Males	
	OR	95% CI	OR	95% CI
Exposure				
Received sex education	.64	(.37–1.11)[a]	.42*	(.25–.69)[a]
Did not receive sex education	1.0		1.0	
Significant interactions				
SexEd*Residence*Race				
MSA + white				
Received sex education	.59	(.29–1.23)[b]	—	—
Did not receive sex education	1.0			
MSA + African American				
Received sex education	.12*	(.04–.36)[b]	—	—
Did not receive sex education	1.0			
MSA + Hispanic				
Received sex education	.66	(.19–2.27)[b]	—	—
Did not receive sex education	1.0			
Non-MSA + white				
Received sex education	3.16*	(1.01–9.87)[b]	—	—
Did not receive sex education	1.0			
Non-MSA + African American				
Received sex education	.63	(.13–2.97)[b]	—	—
Did not receive sex education	1.0			
Non-MSA + Hispanic				
Received sex education	3.49	(.71–17.12)[b]	—	—
Did not receive sex education	1.0			

CI = confidence interval; OR = odds ratio; MSA = metropolitan statistical area.
[a] Adjusted for youth's age at interview, family income, race, family structure, school status, and residence.
[b] Adjusted for youth's age at interview, family income, family structure, and school status.
* Denotes significant odds ratio.

education before first sex to have had sexual intercourse before age 15 (OR = .13, 95% CI = .06–.30).

Among females, the association between sex education before first sex and use of effective or modern methods of birth control at first sex was not significant after adjusting for sociodemographic characteristics (Table 5); similarly, no significant interactions were found. Among males, no significant association was found after adjusting for all covariates; however, some significant interactions were noted. Among males who either were attending or had graduated from high school, those who had received sex education before first sex were more likely to have used an effective or modern method of birth control at first sex than males attending high school or that had graduated from high school who had not received sex education before first sex (OR = 2.77, 95% CI = 1.13–6.81).

Discussion

Overall, results suggest that receiving formal sex education before first sex was associated with abstaining from sexual intercourse, delaying initiation of sexual intercourse, and greater use of contraception at first sex. Receiving sex education before first sexual intercourse may help contribute to reaching the Healthy People 2010 goals of reducing the number of adolescents who have sexual intercourse, reducing the number of adolescents younger than age 15 years who have sexual intercourse, and increasing the number of adolescents who use contraceptive methods. This analysis provides results from recent data using a nationally representative sample of youth to demonstrate these findings. Unlike many previous studies, our results suggest that sex education before first sex protects youth from engaging in sexual intercourse at an early age [10,11,13,16]. Among all females, those who received sex education before first sex were more likely to postpone having sexual intercourse until at least age 15. In addition, results suggest that sex education may be particularly beneficial for certain subgroups of youth, many of which are traditionally considered to be at high risk for adverse sexual health outcomes. Specifically, urban African American females were more likely to have not had sex and African American females attending school were more likely to have postponed sexual initiation until at least age 15 if they had received sex education before first sex.

Similar positive findings were demonstrated among males. Those who had received sex education before first sex were more likely than those who had not received sex education before first sex to have not had sexual intercourse and to have postponed sexual intercourse until at least age

Table 4
Results of multivariate regression analysis using "had sexual intercourse before age 15 years" as dependent variable, separately for females and males 15–19 years of age, 2002

	Females		Males	
	OR	95% CI	OR	95% CI
Exposure				
Received sex education	.41*	(.21–.77)[a]	.29*	(.17–.48)[a]
Did not receive sex education	1.0		1.0	
Significant interactions				
SexEd*Race*School Status				
White + in school				
Received sex education	.47	(.16–1.36)[b]	—	—
Did not receive sex education	1.0			
White + dropout				
Received sex education	10.18*	(1.25–82.86)[b]	—	—
Did not receive sex education	1.0			
African American + in school				
Received sex education	.09*	(.04–.22)[b]	—	—
Did not receive sex education	1.0			
African American + dropout				
Received sex education	2.01	(.30–13.74)[b]	—	—
Did not receive sex education	1.0			
Hispanic + in school				
Received sex education	.67	(.19–2.35)[b]	—	—
Did not receive sex education	1.0			
Hispanic + dropout				
Received sex education	14.44*	(1.68–123.97)[b]	—	—
Did not receive sex education	1.0			
SexEd*Family situation				
Living with 2 parents				
Received sex education	—	—	.38*	(.21–.68)[c]
Did not receive sex education			1.0	
Living with 1 parent				
Received sex education	—	—	.13*	(.06–.30)[c]
Did not receive sex education			1.0	

CI = confidence interval; OR = odds ratio.
[a] Adjusted for family income, race/ethnicity, family situation, school status, and residence.
[b] Adjusted for family income, family situation, and residence.
[c] Adjusted for family income, race/ethnicity, school status, and residence.
* Denotes significant odds ratio.

15 years. Sex education seems to be more beneficial in postponing sexual intercourse until age 15 in single parent homes. Previous research shows that youth from one-parent households are more likely to report sexual experience and earlier initiation of sex [26–28]. With the growing population of youth in single-parent households [29], this research highlights the potential benefit of sex education before first sex among these youth in postponing sexual intercourse.

Our study demonstrates positive associations between receiving sex education before first sex with several sexual risk behaviors, whereas many previous studies did not find associations with postponing sexual intercourse [11–13]. Reasons for our positive findings may be related to the fact that we were able to control for the sequence of events (i.e., whether sex education was provided before or after sexual intercourse), whereas earlier studies were not able to do this [13,14]. In addition, greater proportions of youth are now receiving sex education as well as receiving it at younger ages than in the past. These changes in how and when sex education is provided may account for youth attaining the skills and knowledge needed to influence their decision making about responsible sexual behavior. Another possible explanation is that schools, community centers, and faith-based institutions are using more effective curricula. During the past two decades, a substantial number of effective sex education programs have been developed [30]. Although the extent to which schools and community organizations are using these programs and maintaining fidelity to the curricula are not known, the use of these programs may be a contributing factor to the positive effects of sex education found in our study. Future research should investigate the prevalence of evidence-based programs used in formal settings as well as determine their effectiveness when implemented on a large scale. There is also a need to better understand the process of scaling up the implementation of evidence-based programs.

Table 5
Results of multivariate regression analysis using "used birth control* at first sexual intercourse" as dependent variable, separately for females and males 15–19 years of age, 2002

	Females		Males	
	OR	95% CI	OR	95% CI
Exposure				
Received sex education	1.80	(.98–.29)[a]	1.84	(.76–4.47)[a]
Did not receive sex education	1.0			
Significant interactions				
SexEd*School status				
In school				
Received sex education	—	—	2.77[†]	(1.13–6.81)[b]
Did not receive sex education			1.0	
Dropout				
Received sex education	—	—	.28	(.07–1.06)[b]
Did not receive sex education			1.0	

CI = confidence interval; OR = odds ratio.
* Excludes withdrawal, rhythm method, and natural family planning.
[†] Denotes significant odds ratio.
[a] Adjusted for age at first sexual intercourse, family income, school status, race/ethnicity, family situation, and residence.
[b] Adjusted for age at first sexual intercourse, family income, race/ethnicity, family situation, and residence.

In addition to this study's positive findings, some unexpected results were noted, suggesting that sex education may not be protective for some subgroups. Exposure to sex education was significantly associated with ever having had sexual intercourse for non-MSA (i.e., rural) females and was significantly associated with early initiation of sexual intercourse for white and Hispanic females who dropped out of school. These findings may have several possible explanations. First, these results may be due to the small numbers of youth in these subcategories, which resulted in unstable estimates as evidenced by the wide confidence intervals surrounding each point estimate. In addition, because of the numerous tests of significance completed for this analysis ($n = 28$), we could expect to find one to two statistical tests to be significant by chance. Thus, these unexpected findings may have been found by chance. Alternatively, the effect may be real, and certain subgroups may not benefit from sex education in the same way as the larger population of youth. The content of education and fidelity to programs may also be a problem among these populations, although we are not able to address this issue with this data. Future research on youth dropouts and rural youth may be justified to determine whether this study's findings can be validated and, if so, the reasons for them.

The findings of this study must be considered in light of the study's strengths and limitations. The study included a nationally representative sample of adolescents and considered the timing of sex education in relation to the initiation of sexual intercourse. However, the study was limited by the fact that it relied on self-reported measures; respondents may have given socially acceptable answers, and recall bias should be considered. Also, sex education is not the only factor that influences the sexual behaviors of youth; parents, peers, media, and other outside influences are among many influences that may also need to be considered. No conclusions about type of sex education (i.e., comprehensive sex education vs. focus on abstinence-only) can be drawn from this analysis. Because the content, as well as the quantity and quality of sex education can vary between locations, further research must be conducted to examine sex education content and also whether differences in sexual behaviors of youth occur based on type of sex education received.

Our analyses suggest that sex education before first sex helps protect youth from risky sexual behaviors. For population groups that are often considered the most disadvantaged (i.e., urban, African American females), sex education seems to be the most beneficial. Researchers have recently documented the contribution of delayed sexual initiation and improved contraceptive use to the decreased teen pregnancy rate [31]; findings from our analysis suggest that sex education received before first sex by youth in formal settings may contribute to this positive outcome. Sex education should continue to be implemented in schools, community centers, and churches and, to be most effective, should occur before youth engage in sexual intercourse for the first time. Sex education provides youth with the knowledge and skills to make healthy and informed decisions about sex, and this study indicates that sex education is making a difference in the sexual behaviors of American youth.

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Resources on Preventing Teen Pregnancy, STDs, and HIV

Wisconsin Department of Public Instruction
Spring 2012

Evidence-Based Programs Lists

Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Disease
A matrix list of sex education programs that support both abstinence and the use of contraception for sexually active teens have now shown positive effects in delaying first intercourse, improving contraceptive use, and preventing pregnancy or sexually transmitted disease among teens.
http://www.thenationalcampaign.org/ea2007/postitive_impact.pdf

The National Campaign to Prevent Teen and Unplanned Pregnancy: Interventions with Evidence of Success
This searchable database includes interventions that have some evidence of success in changing behavior related to teen pregnancy. More specifically, the programs had to delay the initiation of sex, improve contraceptive use, and/or decrease teen pregnancy (including secondary pregnancy/births).
http://www.thenationalcampaign.org/resources/programs.aspx

Not Yet: Programs to Delay First Sex Among Teens
Detailed research paper focused on programs found to delay sexual initiation for teens. In addition to providing results from program evaluations, *Not Yet* contains practical information on the costs and availability of program curriculum, and lengthy descriptions of what is covered in each curriculum.
http://www.teenpregnancy.org/works/pdf/NotYet.pdf

Office of Adolescent Health Evidence-Based Programs
The following program models met the effectiveness criteria in the United States Department of Health and Human Services (HHS) pregnancy prevention research review of more than 1,000 studies. These are programs that were found to be effective at preventing teen pregnancies or births, reducing sexually transmitted infections, or reducing rates of associated sexual risk behaviors (defined by sexual activity, contraceptive use, or number of partners).
http://www.hhs.gov/ash/oah/oah-initiatives/tpp/programs.html

Science and Success: Science-Based Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections among Hispanics/Latinos
This is an excerpt of a report that addresses specifically the Hispanic/Latino population for teen pregnancy, HIV and Sexually Transmitted Infections. Full Report (pdf):
http://www.advocatesforyouth.org/storage/advfy/documents/sslatino.pdf

Human Growth and Development Curricula

The following are some examples of curricula from public agencies.

Milwaukee Public Schools Human Growth and Development Curriculum
Milwaukee Public Schools developed this resource. All materials are available online, free of charge.
http://www.wellnessandpreventionoffice.org/health.html#ca

Compiled by Lori Stern, HIV Prevention Consultant
Lori.Stern@dpi.wi.gov or 608-264-9550

Michigan Model for Health
A comprehensive K-12 health education curriculum that has been evaluated and is included in Substance Abuse and Mental Health Services Administration (SAMHSA's) National Registry of Evidence-Based Programs and Practices.
http://www.emc.cmich.edu/mm/default.htm

Family Life and Sexual Health (FLASH)
A comprehensive sexuality education curriculum developed by the Seattle/King County Department of Public Health. Includes a unit specifically for Special Education students.
http://www.kingcounty.gov/healthservices/health/personal/famplan/educators/FLASH.aspx?print=1

Assessing Curricula Resources

Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs (TAC)
This tool is designed to assess, select, improve, or design a sex or STD/HIV education program. ETR and Healthy Teen Network have designed a one-day training to provide an overview of the characteristics and guidance on using the TAC. Contact them at http://www.healthyteennetwork.org

Health Education Curriculum Analysis Tool (HECAT)
The purpose of the HECAT is to provide state, regional, and local education agencies with a common set of tools to assist with the selection or development of health education curricula. The HECAT contains guidance, analysis tools, scoring rubrics, and resources for carrying out a clear, complete, and consistent examination of health education curricula. Link to the sexual health module:
http://www.cdc.gov/healthyyouth/hecat/pdf/HECAT_Module_SH.pdf

Guidelines and Standards for Sexual Health Education/Human Growth and Development

Wisconsin Standards for Health Education
http://dpi.wi.gov/cal/pdf/health-stds.pdf

National Sexuality Education Standards
http://www.futureofsexed.org/documents/josh-fose-standards-web.pdf

National Standards for Health Education
http://www.cdc.gov/healthyyouth/sher/standards/index.htm

Compiled by Lori Stern, HIV Prevention Consultant
Lori.Stern@dpi.wi.gov or 608-264-9550

Kirby's Characteristics of Effective Curriculum-Based Programs to Reduce Teen Pregnancy

Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, by Douglas Kirby, Ph.D., identified programs that increased age of first sex, improved use of condoms or contraception among sexually active teens, and/or reduced teen pregnancy. Common characteristics among the effective curriculum-based programs are identified below.

Effective Curriculum-based Programs

1. Have a specific, narrow focus on behavior.
2. Are based on theoretical approaches that have been effective in influencing other risky health-related behavior.
3. Provide clear messages about sex and protection against STDs or pregnancy.
4. Provide basic, not detailed, information.
5. Address peer pressure.
6. Teach communication skills.
7. Include activities that are interactive.
8. Reflect the age, sexual experience, and culture of the young people in the program.
9. Last longer than several hours.
10. Carefully select leaders and train them.

What this means is…

- Implement programs that have been demonstrated to be effective with other youth in other places.
- When this is not possible, select or design programs that incorporate these characteristics.
- Each of these characteristics appears to be necessary for the program to be effective.

Source: The National Campaign to Prevent Teen Pregnancy. *Science Says: Characteristics of Effective Curriculum-Based Programs*. Number 4, September 2003.

More Information about the Common Characteristics of Effective Curricula

Source: The following excerpt is from D. Kirby. ***Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy***. National Campaign to Prevent Teen Pregnancy. Washington D.C., May 2001.

The ten characteristics appear to be necessary characteristics—that is, when evaluated programs lacked one or more of these characteristics, they were typically found to be ineffective at changing behavior. However, there is little evidence specifying which of these factors or combinations of factors contributes most to the overall success of the programs.

1. **Effective programs focused on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.** These programs focused narrowly on a small number of specific behavioral goals, such as delaying the initiation of intercourse or using condoms or other forms of contraception; relatively little time was spent addressing other sexuality issues, such as gender roles, dating, or parenthood. Nearly every activity was directed toward the behavioral goals.

   Few studies evaluated the impact of a focused and potentially effective curriculum unit that was embedded in a larger more comprehensive sexuality education program. Such units may or may not effectively change behavior, but only additional research will answer this question.

2. **Effective programs were based on theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviors**—such as social cognitive theory (Bandura, 1986), social influence theory (McGuire, 1972), social inoculation theory (Homans, 1965), cognitive behavioral theory (Bandura, 1986; Schinke et al., 1981), theory of reasoned action (Fishbein & Ajzen, 1975), and theory of planned behavior (Ajzen, 1985). These theories together address many of the individual sexuality-related antecedents identified in Chapter 2. They recognize the fact that the beliefs and values of youth are influenced directly through education by parents, schools, and others, and indirectly through observing the behavior of others and the consequences that befall them. In additional, social influence theories address societal pressures on youth and the importance of helping young people understand those pressures and resist the negative ones. Thus, these programs strive to go far beyond the cognitive level; they focus on recognizing social influences, changing individual values, changing group norms and perceptions of those norms, and building social skills.

   These theories help to specify which particular antecedents the interventions are trying to change (e.g., the beliefs, attitudes, norms, confidence, and skills related to sexual behavior) so that changes in these antecedents would lead to voluntary change in sexual or contraceptive behavior. Thus, each activity was designed to change one or more antecedents specified by the particular theoretical model for the curriculum, and each important antecedent in the theoretical model was addressed by one or more activities. While all of the effective curricula focused on antecedents specified by their adopted theories, some program developers actually surveyed students and empirically determined which possible antecedents best predicted desired behavior. Activities in their programs then focused on those particular antecedents.

By focusing on specific behavior (characteristic #1), by identifying particular antecedents causally related to that behavior, and by designing activities to change each of those important antecedents, the developers of these programs were, in fact, designing "logic models" and basing their interventions on those models (Kirby, 2000). Logic models are discussed in Chapter 6.

3. **Effective programs gave a clear message about sexual activity and condom or contraceptive use and continually reinforced that message.** This particular characteristic appeared to be one of the most important criteria that distinguished effective from ineffective curricula. The effective programs did not simply lay out the pros and cons of different sexual choices and implicitly let the students decide which was right for them; rather, most of the curriculum activities were directed toward convincing the students that abstaining from sex, using condoms consistently, or using other forms of contraception consistently was the right choice, and that unprotected sex was clearly an undesirable choice. To the extent possible, they tried to use group activities to change group norms about what was the expected behavior.

4. **Effective programs provided basic, accurate information about the risks of teen sexual activity and about methods of avoiding intercourse or using protection against pregnancy and STDs.** Effective programs provided basic information that students needed to assess risks and avoid unprotected sex. Typically, this information was not detailed or comprehensive. For example, the curricula did not provide detailed information about all methods of contraception or different types of STDs. Instead, they provided a foundation: they emphasized the basic facts needed to persuade youth to avoid unprotected sex, and they provided information that would lead to changes in beliefs, attitudes, and perceptions of peer norms. Some curricula also provided more detailed information about how to use condoms correctly.

5. **Effective programs included activities that address social pressures that influence sexual behavior.** These activities took a variety of forms. For example, several curricula discussed situations that might lead to sex. Most of the curricula discussed "lines" that are typically used to get someone to have sex, and some discussed how to overcome social barriers to using condoms (e.g., embarrassment about buying condoms). Some of them also addressed peer norms about having sex or using condoms. For example, some curricula provided data showing that many youth *do not* have sex or *do* use condoms, or they had students engage in activities in which they concluded that students should abstain from sex or use condoms and then expressed those beliefs to other students. At least one curriculum addressed media influences (e.g., how sex is used to sell products and how television often depicts characters having unprotected intercourse but rarely experiencing negative consequences).

6. **Effective programs provided modeling of and practice with communication, negotiation, and refusal skills.** Typically, the programs provided information about skills, demonstrated the effective use of those skills, and then provided some type of skill rehearsal and practice (e.g., verbal role-playing and written practice). Some curricula taught different ways to say "no" to sex or unprotected sex, how to insist on the use of condoms or other methods of contraception, how to use body language that reinforced the verbal message, how to repeatedly refuse sex or insist on condom use, how to suggest alternative activities, and how to help build the relationship while refusing unprotected sex or refusing to have sex at all. Some curricula started with easier scenarios in role-playing and then moved to more challenging ones. Some started with fully scripted role plays and moved to more improvisational ones, in which the youth resisting unprotected sex had to use their own words. Although all effective curricula gave some attention to skills, there were significant variations in the quality of activities designed to teach skills and also in the time devoted to practicing the skills.

7. **Effective programs employed a variety of teaching methods designed to involve the participants and have them personalize the information.** Instructors reached students by engaging them in the learning process, not through didactic instruction. Students were involved in numerous experiential classroom and homework activities, such as small group discussions, games or simulations, brainstorming, role-playing, written exercises, verbal feedback and coaching, interviewing parents, locating contraception in local drugstores, and visiting or telephoning family planning clinics. In addition to these experiential activities, a few effective curricula used peer educators or videos with characters (either real or acted) who resembled the students and with whom the students could identify. All of these activities kept the students more involved in the program, got them to think about the issues, and helped them personalize the information in their own lives.

8. **Effective programs incorporated behavioral goals, teaching methods, and materials that were appropriate to the age, sexual experience, and culture of the students.** For example, programs for younger youth in junior high school, few of whom had engaged in intercourse, focused on delaying the onset of intercourse. Programs designed for high school students, some of whom had engaged in intercourse and some of whom had not, emphasized that students should avoid unprotected intercourse, that abstinence was the best method of avoiding unprotected sex, and that condoms or contraception should always be used if they did have sex. And programs for higher-risk youth, most of whom were already sexually active, emphasized the importance of always using condoms and avoiding high-risk situations. Some of the curricula, such as *Becoming a Responsible Teen* and *Making a Difference*, were designed for specific racial or ethnic groups and emphasized statistics, values, and approaches that were tailored to those groups.

9. **Effective programs lasted a sufficient length of time to complete important activities adequately.** In general, it requires considerable time and multiple activities to change the most important antecedents of sexual risk-taking and to thereby have a real influence on behavior. Thus, short programs that lasted only a couple of hours did not appear to be effective, while longer programs that had many activities had a greater effect. More specifically, effective programs tended to fall into two categories: (1) those that lasted 14 or more hours and (2) those that lasted a smaller number of hours but recruited youth who voluntarily participated and then worked with these youth in small group settings with a leader for each group. (When youth volunteer to participate, they may be more open to instruction than if they are required to sit in a school class. And when they work in small groups, instructors may be able to involve the youth more completely, to tailor the material to each group, and to cover more material and more concerns more quickly.)

10. **Effective programs selected teachers or peer leaders who believed in the program they were implementing and then provided them with training.** Given the challenges of implementing programs that focused on a sensitive topic and incorporated a variety of interactive activities, the effective programs carefully selected teachers and provided them with training. The training ranged from approximately six hours to three days. In general, the training was designed to give teachers and peer leaders information on the program as well as practice using the teaching strategies included in the curricula (e.g., conducting role-playing exercises and leading group discussions). Some of the teachers in these effective programs also received coaching and/or follow-up training to improve the quality of their teaching.

Safe Schools Research Brief 14

Lessons That Matter: LGBTQ Inclusivity and School Safety

Introduction

Data from the California Safe Schools Coalition 2004-2006 Preventing School Harassment (PSH) survey illustrates the importance of LGBTQ-inclusive curriculum on student safety.[1] In particular, students who answered that they learned about LGBTQ people or issues as part of a classroom lesson were more likely to feel safer, more likely to report a stronger sense of school belonging, and less likely to report being harassed based on sexual orientation or gender identity. However, this data did not reveal what kinds of LGBTQ-inclusive lessons students were learning in school, or in what classes students were most likely to learn about LGBTQ topics. The data also did not reveal what types of lessons and in which classes inclusion most effectively impacts school safety.

In an effort to learn more, a new set of questions were included in the 2008 PSH survey. In particular, students reported on specific classes in which they learned about LGBTQ people and issues along with what classes were the most supportive of LGBTQ people and issues.

The 2008 PSH survey data reveal the pervasiveness and supportiveness[2] of LGBTQ-inclusive lessons in school. The data also show how different types of inclusive curriculum (presented in different school contexts and/or classes) impact both individual students and/or the entire school community as a whole. Finally, the data illustrate how the existence of Gay-Straight Alliance (GSA) clubs contribute to school safety in both schools with and schools without LGBTQ-inclusive curriculum.

The analysis places student respondents into two groups: LGBTQ and allied students, and heterosexual students who do not participate in GSA clubs. "LGBTQ" refers to lesbian, gay, bisexual, transgender, and queer students, and "allied students" refers to heterosexual students who participate in GSAs. Findings are consistent across both groups unless explicitly stated otherwise.

Pervasiveness and Supportiveness of LGBTQ-Inclusive Lessons

Key Finding 1: LGBTQ-inclusive classroom lessons are common, but less likely to be rated as "supportive" of LGBTQ people or issues.

Forty percent of students report learning about LGBTQ people/issues in the classroom (see Figure 1), but lessons that include LGBTQ people/issues are rated as "neutral/mixed" as often as they are rated as "mostly supportive" (see Figure 2). In several types of classes, heterosexual students even report that up to one third of lessons were "mostly not supportive" of LGBTQ people/issues.

LGBTQ-inclusive lessons are most likely to appear in sexuality education or health classes, followed by English and social studies classes. Additionally, students perceive lessons in these classes to be the most supportive of LGBTQ people/issues. On the other hand, LGBTQ-inclusive lessons are both more rare and rated as more "neutral/mixed" or "mostly not supportive" in science, physical education, and math classes.

LGBTQ and allied students are more likely than non-GSA-participating heterosexual peers to report that LGBTQ-inclusive lessons are "mostly supportive" of LGBTQ people/issues. The reason for this finding is unclear, but it may be that LGBTQ and allied students select classes with supportive teachers, or that LGBTQ and allied students interpret any mention of LGBTQ people/issues as supportive events.

Figure 1. Presence of LGBTQ-Inclusive Lessons in Class

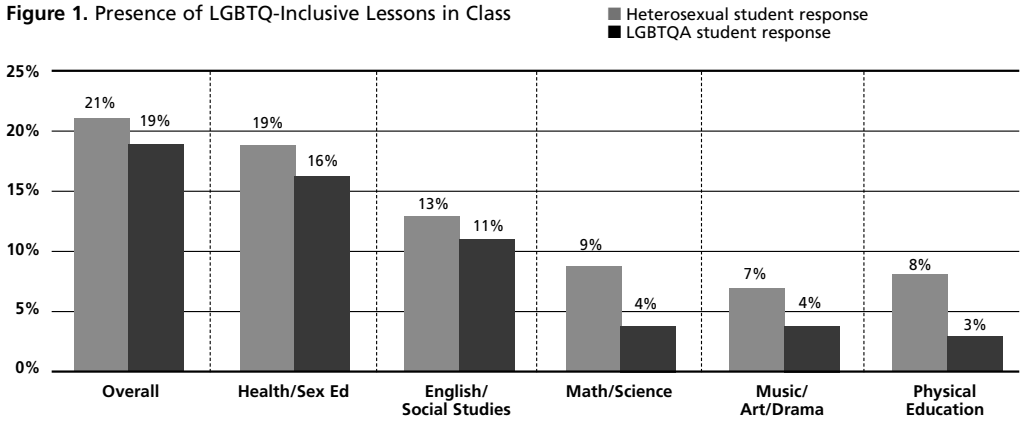
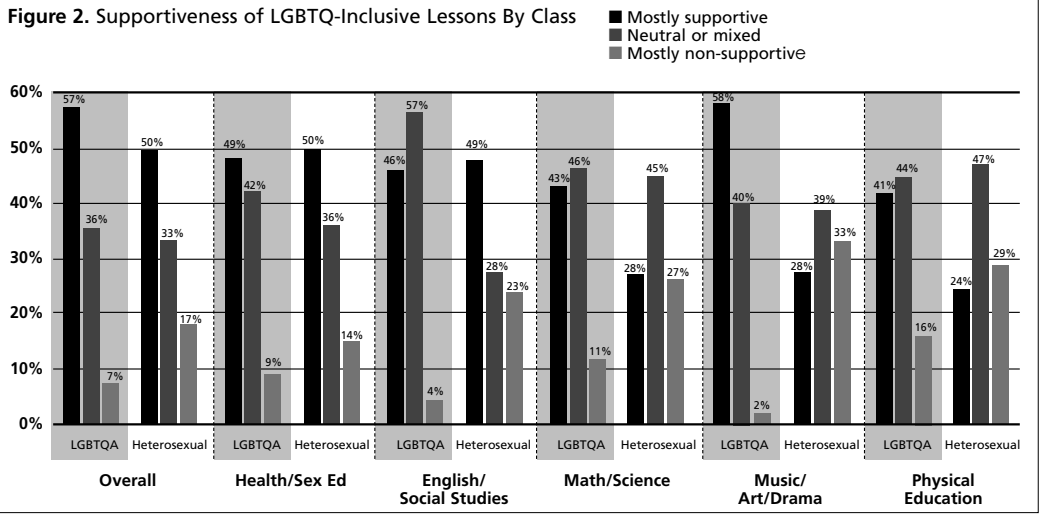


Figure 2. Supportiveness of LGBTQ-Inclusive Lessons By Class



Impacts on Individual Students

Key Finding 2: Any mention of LGBTQ people/issues in class increases individual students' feelings of safety.

Students of any sexual orientation who learn anything about LGBTQ people/issues in any type of class (with the exception of physical education, see below) feel safer and more included in school. This finding is true regardless of whether or not LGBTQ-inclusive lessons are rated by students as "mostly supportive," "neutral/mixed," or "mostly not supportive" of LGBTQ people/issues (see Figure 3).

Special Case: Physical Education

The type of class where LGBTQ-inclusive lessons take place affects the strength and breadth of positive outcomes for students' feelings of safety. Physical education (PE) is the *only* type of class in which LGBTQ-inclusive lessons that are rated as "neutral/mixed" have *negative* effects on individual students' feelings of safety, as opposed to a positive effect or no impact at all. The negative impact of neutral or mixed lessons could be associated with the particularly unsafe environment for LGBTQ or gender-nonconforming students that PE classes generally present. For example, 17% of LGBTQ and allied students and 27% of non-GSA-participating heterosexual students rate LGBTQ-inclusive lessons in PE as "mostly not supportive," which is more than twice the percentage reported in health and sexuality education classes (see Figure 2).

Key Finding 3: Students experience more positive outcomes when LGBTQ-inclusive lessons are rated as "mostly supportive" as opposed to "neutral/mixed" or "mostly not supportive."

As noted above, students of any sexual orientation who learn about LGBTQ people/issues in class feel safer and more included in school. They are more likely to agree with statements such as "I feel safe at my school" and "My school is safe for students of all races," and they also report a greater sense of belonging at school. An important distinction, however, is that students are even more likely to agree with a wider range of such positive statements when they rate LGBTQ-inclusive lessons as "mostly supportive" of LGBTQ people/issues. For example, there is a correlation between LGBTQ-inclusive lessons and agreement with the statement "teachers care about students" only when the LGBTQ-inclusive lesson is rated as "mostly supportive" of LGBTQ people/issues (see Figures 3 and 4).

Figure 3. Effects of Presence and Supportiveness of LGBTQ-Inclusive Lessons in PE and Other Classes

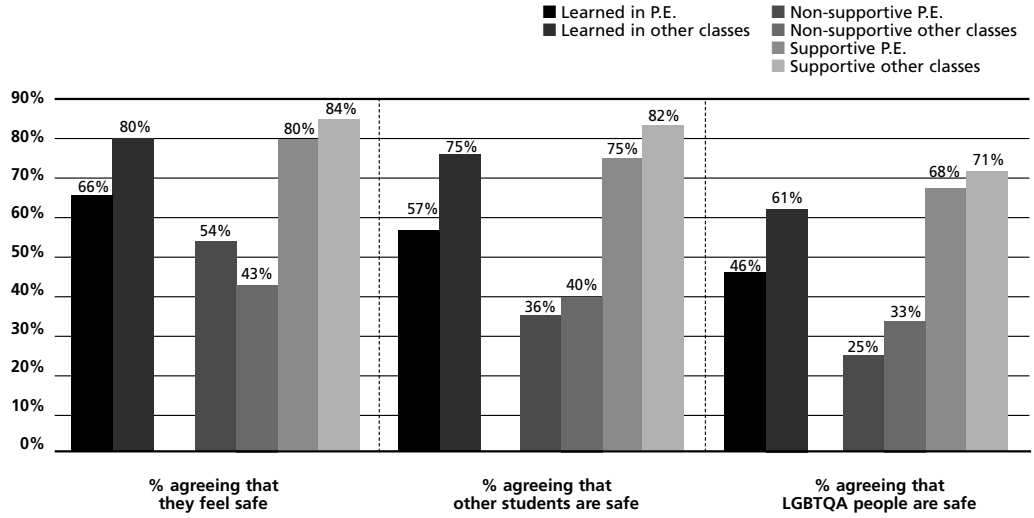
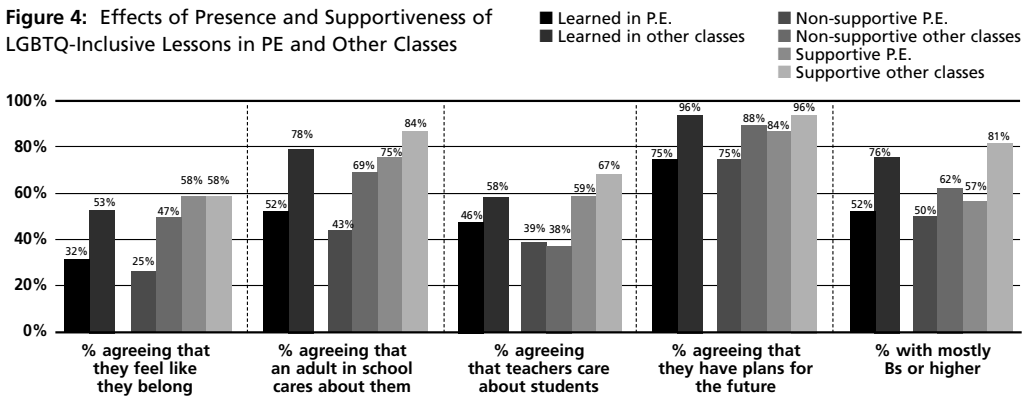


Figure 4: Effects of Presence and Supportiveness of LGBTQ-Inclusive Lessons in PE and Other Classes



Special Case: Physical Education

In addition to the fact that PE is the *only* type of class in which LGBTQ-inclusive lessons that are rated as "neutral/mixed" have *negative* effects on individual students' feelings of safety, our data also show that when LGBTQ-inclusive lessons in PE are rated as "mostly supportive" they have *the most* significant effect on students' feelings of safety (see Figures 3 and 4).

Impacts on School Climate

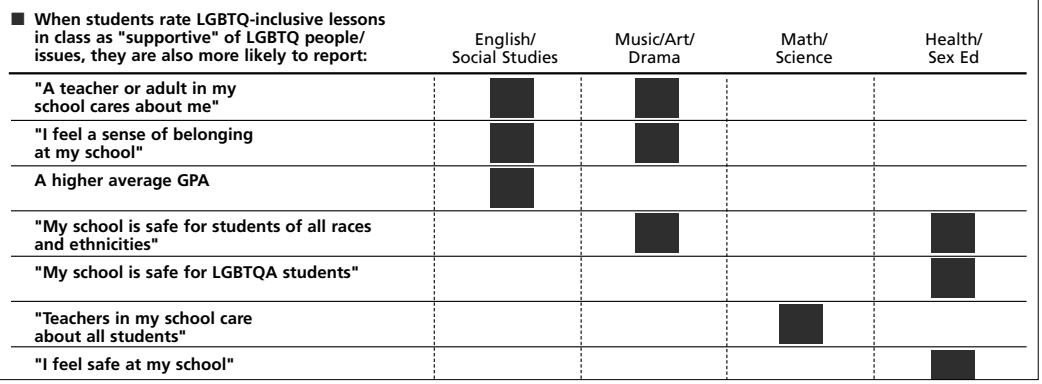
Key Finding 4: LGBTQ-inclusive lessons that are rated as "mostly supportive" of LGBTQ people/issues positively affect school climate as a whole.

Unlike outcomes for individual students outlined above, the school climate as a whole is not necessarily positively affected by any "neutral/mixed" inclusion of LGBTQ people/issues in classroom lessons. However, when LGBTQ-inclusive lessons in class are rated as "mostly supportive," the school climate as a whole is positively affected (see Figure 5).

This finding is true across the board, regardless of whether students already rated the school climate as generally safe or generally unsafe. For example, regardless of overall reports of safety in any particular school, schools that generally have supportive class lessons on LGBTQ people/issues in English/Social Studies courses also have: more students who feel cared about by adults in school; more students who feel a sense of school belonging; and higher GPAs on average.

Furthermore, schools that generally have supportive class lessons on LGBTQ people/issues in music/arts/drama courses also have: more students who feel cared for by adults in school; more students who feel a sense of school belonging; and more students who feel people of all races are safe at their school.

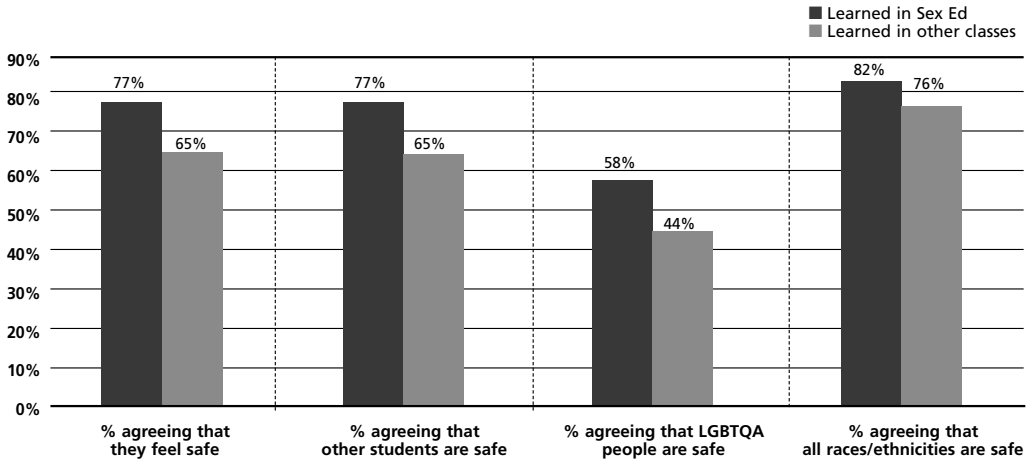
Figure 5: Effects of Supportive LGBTQ-Inclusive Lessons on School Climate



Special Case: Health/Sexuality Education

In every other discipline except health class, it is only when students report that the LGBTQ-inclusive lessons are supportive that there is a correlation with reports of positive school climate. However, it is the case that merely any inclusion of LGBTQ issues/people in health/sexuality education classes is associated with a positive school climate as a whole (see Figure 6). Schools in which students learn about LGBTQ people/issues at all in health/sexuality education courses have: more students who feel a sense of school belonging; and more students who feel that LGBTQ and allied people, people of all races, and other students in general are safe at their school.

Figure 6: Impact of LGBTQ-Inclusive Lessons in Health/Sexuality Education on School Climate



The Gay-Straight Alliance Club (GSA) Effect

Key Finding 5: Individual students who are members of their school's GSA club report the most positive effects of LGBTQ-inclusive lessons.

The *most positive effects* of LGBTQ-inclusive lessons in class are for individual students who are also members of their school's GSA club. This finding is true regardless of a students' sexual orientation and regardless of whether LGBTQ-inclusive lessons are rated as "mostly supportive," "neutral/mixed" or "mostly not supportive." For example, GSA members who learn about LGBTQ people/issues in English or social studies classes have higher GPAs and a stronger sense of school belonging than both non-GSA members and those who do not learn about LGBTQ people/issues.

Key Finding 6: LGBTQ students who are not in GSAs and who have not had access to LGBTQ-inclusive lessons in school report the most negative perceptions of school safety.

LGBTQ students who are not in GSAs and do not report learning about LGBTQ people/issues in class consistently report the most negative school safety outcomes, while students (regardless of sexual orientation) who are GSA members and learn about LGBTQ people/issues in class report the most positive school safety outcomes. For example, LGBTQ students who are not in GSAs and do not report learning about LGBTQ people/issues in any school setting report lower GPAs and a weaker sense of school belonging. A possible explanation for these differences could be that having a GSA and including LGBTQ issues in classroom lessons both promote feelings of safety among students, and students who feel safe at school are more likely to have higher GPAs.[3]

Conclusion

Previous data[4] illustrate a correlation between LGBTQ-inclusive lessons and student safety at school. However, the data did not reveal what kinds of LGBTQ-inclusive lessons students are learning in school, or in what classes students are most likely to learn about LGBTQ topics. In an effort to learn more about the correlation between LGBTQ inclusivity and student safety, researchers added new questions to the 2008 Preventing School Harassment (PSH) survey.

Data from the 2008 PSH survey reveal new information about the pervasiveness and supportiveness of LGBTQ-inclusive lessons. First, while LGBTQ-inclusive classroom lessons are found to be common, they are also less likely to be described as supportive of LGBTQ people/issues. However, in classes where LGBTQ-inclusive lessons are most likely to appear (health/sexuality education, English and social studies), the lessons are more likely to be described as supportive of LGBTQ people/issues. In contrast, in classes where LGBTQ-inclusive lessons are the least likely to appear (science, physical education, and math) the lessons are less likely to be described as supportive of LGBTQ people/issues.

Second, students who reported any mention of LGBTQ people/issues in a classroom setting were also more likely to report feeling safe at school. Furthermore, students are even more likely to report positive outcomes regarding school safety when LGBTQ-inclusive lessons are described as "mostly supportive" as opposed to "neutral/mixed," or "mostly not supportive." This finding is true regardless of students' sexual orientation.

There is, however, a significant variation when it comes to physical education (PE) classes. For example, LGBTQ-inclusive lessons in PE classes that are described as "neutral/mixed" have *negative* effects on individual students' feelings of safety while lessons described as "mostly supportive" have *the most* positive effects on individual students' feelings of safety. This finding is especially interesting considering the fact that LGBTQ and allied students rate lessons in PE as "mostly not supportive" at twice the rate as lessons in other classes.

LGBTQ-inclusive lessons also impact school climate as a whole. For example, unlike outcomes for individual students, school climate as a whole is not necessarily positively affected when LGBTQ-inclusive lessons are rated as "neutral/mixed." However, school climate as a whole *is* positively affected by LGBTQ-inclusive lessons that are rated as "mostly supportive." This finding is true regardless of whether or not the school was previously reported to be especially safe or unsafe overall. Findings vary for health and sexuality education classes where school climate as a whole is positively affected when *any* LGBTQ-inclusive lesson is included in those classes.

Finally, the most positive impact of LGBTQ-inclusive lessons is found for individual students of any sexual orientation who are also members of their school's GSA. Conversely, LGBTQ students who are not in GSAs and who do not have access to LGBTQ-inclusive lessons are the most likely to report a weaker sense of school belonging, and lower GPAs, among other negative outcomes.

Overall, all students, regardless of sexual orientation, show a substantial increase in feelings of safety from LGBTQ-inclusive lessons, especially when they are rated as "mostly supportive" of LGBTQ people/issues and especially when those students are also members of GSAs.

Recommendations

Based on these findings it is important that LGBTQ-inclusive lessons be regularly incorporated into classrooms at school. Below are recommendations for teachers and school site staff, local school officials and administrators, parents, guardians, community members, and students.

Recommendations for teachers and school site staff

LGBTQ-inclusive lessons positively impact school safety in almost all contexts. However, LGBTQ-inclusive lessons that are rated as "mostly supportive" of LGBTQ people (as opposed to "neutral/mixed," or "mostly not supportive") have *the greatest* impact on school safety. In an effort to create safer schools, teachers and school site staff should receive professional development so that they have the skills and resources to be able to include LGBTQ lessons that students experience as supportive of LGBTQ people/issues. However, a special effort should be made to train teachers and staff to be successful in the following contexts:

1. Physical Education: LGBTQ-inclusive lessons rated as "mostly supportive" have the greatest potential to dramatically increase individual students' feelings of safety while lessons that are rated as "neutral/mixed" or "mostly not supportive" have the greatest potential to dramatically decrease individual students' feelings of safety.
2. Health and Sexuality Education: There is a strong correlation between LGBTQ inclusivity in health and sexuality education classes and a positive impact on the entire school climate as a whole.
3. History and Social Studies: The recent passage of the FAIR Education Act adds LGBT people to the list of already underrepresented groups that social studies and history teachers are required to include in class lessons. Since LGBTQ-inclusive lessons that are rated as "mostly supportive" of LGBTQ people/issues have a particularly positive impact on individual students' feelings of safety and the school climate as a whole, it is important that social studies and history teachers are adequately trained on how to incorporate LGBTQ people and issues into their lessons.
4. Gay-Straight Alliance (GSA) Clubs: Students, regardless of sexual orientation, who are members of their school's GSA and learn about LGBTQ people/issues in class, report the most positive school safety outcomes. Conversely, LGBTQ students who are not in GSAs and who have not had access to LGBTQ-inclusive lessons are the most likely to report a weaker sense of school belonging, and lower GPAs, among other negative outcomes. Teachers and school site staff should support the creation and/or continued success of a GSA club.

FAIR Education Act

The recent passage of California's Fair, Accurate, Inclusive and Respectful (FAIR) Education Act, which became law on January 1, 2012, updates the California Education Code to integrate age-appropriate, factual information about the roles and contributions of lesbian, gay, bisexual, and transgender Americans and people with disabilities into social studies classes.

Recommendations for local school officials and administrators

Previous studies illustrating the importance of LGBTQ-inclusive lessons helped lead to important legislation such as California's FAIR Education Act. In an effort to comply with the updates to the California Education Code and incorporate the findings in this report, local school officials and administrators should:

1. Provide training for history and social studies teachers so that they are prepared to comply with the education code requirements updated by the FAIR Education Act.
2. Provide training for all staff and faculty on the importance of LGBTQ-inclusive lessons in all disciplines and their effect on school climate.
3. Invite parents, teachers, administrators and other key stakeholders to identify and/or participate in the development of age-appropriate LGBTQ-inclusive lessons that teachers can use in their classrooms.
4. Identify and eliminate barriers to the formation of Gay-Straight Alliances and other student anti-bias clubs, and support their formation.

Recommendations for parents, guardians, and community members

Parents, guardians, and other members of the school community have a role to play in ensuring that school environments are safe places for all students to learn. Parents, guardians, and community members should:

1. Ask their children if their lessons are LGBTQ-inclusive.
2. Ask their children if LGBTQ-inclusive lessons are supportive of LGBTQ people, subjects and issues.
3. Ask their children if they feel safe at school and/or think other students feel safe at school.
4. Speak out in support of LGBTQ-inclusive lessons and a safe school climate for all students.
5. Participate in the identification and/or development of age-appropriate LGBTQ-inclusive lessons that teachers can use in their classrooms.

Recommendations for students:

Students have a right to feel safe at school. They also have a right to a fair, accurate, inclusive and respectful education. Students should:

1. Educate themselves about the FAIR Education Act and find out if their social studies, history and/or government classes incorporate LGBTQ-inclusive lessons about historical events, current events and/or the historical contributions of lesbian, gay, bisexual, and transgender people.
2. Ask their teachers to teach about all relevant subjects, including factual information about social movements, current events and the historical contributions of lesbian, gay, bisexual and transgender people.
3. Consider LGBTQ current events or history as a topic for a presentation or paper.
4. Speak out in support of their school district and teachers in their efforts to include factual information about social movements, current events and the historical contributions of lesbian, gay, bisexual and transgender people.
5. Encourage their school site or district curriculum committee to adopt LGBTQ-inclusive lessons for all core 11th grade classes like history or other social science classes such as 12th grade government class.
6. Start a Gay-Straight Alliance to help fight harassment and discrimination at school, or join the club if one already exists.
7. Speak out in support of specific steps school districts and schools can take to make sure that lessons in many types of classes are LGBTQ-inclusive and schools are safe.

Safe Schools Research Brief 14

Lessons That Matter: LGBTQ Inclusivity and School Safety

About the Research

Data are from the 2008 Preventing School Harassment (PSH) survey. The PSH survey was designed to study the experiences of lesbian, gay, bisexual, transgender, queer, and questioning high school students and their straight allies, and the steps schools can take to make schools safer. The PSH survey was developed by the California Safe Schools Coalition, and administered by the Gay-Straight Alliance Network. Data from 1,232 students were collected from 154 schools. Students were asked about their experiences of safety at school, and about the steps schools can take to make schools safer. Specifically, students were asked questions about the pervasiveness of LGBTQ-inclusive lessons at school and the relative supportiveness of inclusive lessons.

[1]Russell, S.T., Kostroski, O., McGuire, J. K., Laub, C., & Manke, E. (2006). LGBT Issues in the Curriculum Promotes School Safety. (California Safe Schools Coalition Research Brief No. 4). San Francisco, CA: California Safe Schools Coalition.
[2]The 2008 Preventing School Harassment survey asks students if they "have learned about LGBTQ people or issues as part of a lesson in [their] classes at school," or "at school [outside of the classroom setting]." Students who answer "yes," are asked to rate "how supportive [the lessons are] of LGBTQ people/issues" by choosing one of the following options: "Mostly supportive; Neutral/mixed; Mostly not supportive."
[3]See California Safe Schools Coalition Research Briefs 3, 4, and 7.
[4]Ibid. 1.

Suggested citation:
Burdge, H., Sinclair, K., Laub, C., Russell, S. T. (2012). Lessons That Matter: LGBTQ Inclusivity and School Safety. (Gay-Straight Alliance Network and California Safe Schools Coalition Research Brief No. 14). San Francisco, CA: Gay-Straight Alliance Network.

Human Growth and Development (HGD):Cultural Responsiveness to Diverse Classrooms

Becoming Culturally Responsive

Being culturally responsive to diverse classrooms is the mark of a competent and caring professional educator. Building this responsiveness has three parts: exploring your own beliefs and culture, getting to know your students as individuals and not as representatives of their cultural group, and developing culturally responsive curriculum and instruction.

1. **Exploring your own beliefs and culture**

   Often, our cultural ways are so natural to us that we fail to realize that not everyone shares them. These unexamined biases are barriers to working effectively with students who are different from yourself, as surely students in your classroom will be.

   Some questions that might begin the process of examining your cultural background and life experiences include[1]:

   ### Acculturation

   - If your family immigrated to the United States, how long has your family been here? How long have you been in the United States? Did your family come voluntarily to the United States?
   - If you are American Indian, what is your family's history?
   - What values, beliefs, customs, traditions, or behaviors have you retained or adopted from your family history? Has that changed over the years?

   ### Citizenship Status

   - What is your citizenship status? What is the status of members of your family? What are the reasons behind having or not having U.S. citizenship in your family? Do you or any of your family have dual citizenship?
   - Do you or your family members plan to stay in the U.S., or do you or they hope to return to your family's homeland?

   ### Communication

   - What language or dialect is spoken in your home? Is it different or similar to the language used in your household growing up? Is there a generational split among your family members with regard to speaking English versus another language?

[1] From SA Messina, *A Youth Leader's Guide to Building Cultural Competence* (Washington, D.C.: Advocates for Youth, 1994).

- Are there certain nonverbal signals that you consider polite or rude, such as eye contact, physical closeness, or tone of voice?
- Do children or teens in your family have the same rights to speak as adults?

Family

- What is your family structure? Who is considered to be a member of your family? Are there individuals who are not blood relatives but who are considered family such as longtime friends, neighbors, or godparents?
- What are/were the expectations of the responsibilities you have to your parents or family? What responsibilities did/do your parents and other family members have to you?
- Are there any openly gay, lesbian, bisexual, or transgender members of your family, including you? Are they acknowledged? Accepted?

Gender

- Did your family encourage both yourself and members of the other sex to stay in school? Play sports? Help at home? Be assertive? Go to college? To work outside the home?
- Did your family expect either males or females to be more knowledgeable, interested, or experienced in dating, sex, parenting, or wage-earning? Were you allowed to socialize in co-ed groups? Is one gender supposed to be more interested in monogamy or abstinence before marriage?

Health and Safety

- How is illness treated in your family? Do certain behaviors or beliefs play a role in illness? What behaviors or remedies were used to prevent or cure illness?
- Are emotional, mental, physical, and spiritual factors included in your definition of health?
- When and how do you seek medical treatment? Do you have medical insurance?
- What is the degree of violence in your community? How has that had an impact on you?

Poverty and Economic Concerns

- What was the standard of living in your family when you were growing up?
- Have you or your family members ever received public assistance? How has that influenced your perspectives?

Race and Ethnicity

- What races and ethnicities are represented in your family? How often do you think about your race or ethnicity?
- How has the United States treated people of similar race and ethnicity to you and your family? What laws and policies have affected people of similar race and ethnicity to you?

Sexual Orientation

- What is your sexual orientation? Are you gay, lesbian, bisexual, or transgender? If yes, when did you come out to yourself? Are you out to friends? Family? Employers and co-workers? Why or why not?
- How have people of similar sexual orientation been treated by our society? How has that had an impact on you?

2. **Getting to know the young people in your program as individuals and not as representatives of their cultural group**[2]

   As a caring adult who works with youth, you already know how important it is to become acquainted with the unique personalities of each young person in your classroom. You know that every teenager has his or her own likes, dislikes, experiences, sense of humor, ambitions, attention span, skills, personal style, and family situations. A big part of the fun of working with a group of young people is getting to know them as individuals and working with the diversity they bring to the group.

   As you focus on building cultural competence, be sure that you *continue* to view the young people in your program as individuals. Beware of the temptation to quickly explain behavior as the result of culture. Do not expect any individual student to be the ambassador for their racial or ethnic group or to be able to explain the group's entire range of cultural beliefs.

3. **Developing culturally responsive interactions, curriculum and instruction, and classroom climate.**

   Being colorblind is not the answer! Culturally responsive teaching demonstrates the teacher's commitment to his or her students because the teacher recognizes that race, ethnicity, class, gender, ability, sexual orientation, and other factors influence how students learn. It is critical to create a curriculum and teach students in a way that honors and shares these different influences. One manifestation of the teacher's commitment is to design curriculum and instruction with input and attention to as many of the cultural factors as possible.

   It may not be possible for you to learn in depth about every one of the cultural components that are represented in your students. Focus your efforts on learning what is most important to know about the specific cultural backgrounds from which your students come. Working on HGD, you already know that you will want to concentrate on cultural beliefs, attitudes, and behaviors about sexuality, gender roles, communication, health, families, and children.

You will want to pay particular attention to issues around poverty and money, which are often "hidden" cultural factors. Research indicates that the sexual behaviors that put young people at risk for HIV/AIDS and unwanted pregnancy are tied to what teens see in their future, which corresponds often to socio-economic status. To provide your students with culturally responsive and useful information related to HGD, consider providing information on the availability of low- or no-cost contraception, including condoms, and the availability of community resources for medical, housing, and other assistance for your students and their families.

[2] From SA Messina, *A Youth Leader's Guide to Building Cultural Competence* (Washington, D.C.: Advocates for Youth, 1994).

Strategies for Building Cultural Competence[3]

As a teacher who cares about cultural competence, you want to provide students with effective programs that engage them, speak to their cultural experience, reinforce positive health messages received at home, and help them be comfortable with their racial, ethnic, gender, ability, sexual orientation, and other identities. Some tips for doing that include the following:

1. Find the cultural beliefs and practices that reinforce the attitudes and skills your program seeks to build. Be creative and accurate in using traditions that can inform and shape a variety of program activities.

2. Include guest speakers or volunteers who share the same race, ethnic, gender, ability, socio-economic, sexual orientation, etc., background as students. Have both men and women involved in your classroom.

3. Assume there is a wide range of views, particularly about sexuality issues, in your classroom. Understand how some of the HGD messages might be the same as, or different from, family values and practices.

4. Model willingness to hear and accept ideas different from your own.

5. Encourage the involvement of your teens' family members in classroom curriculum and activities.
   - Reach out to families. Plan family-based experiences during hours convenient for families.
   - In planning family involvement, however, bear in mind that not all families show involvement in the same way that you would show family involvement.

6. Make sure that activities, discussions, videos, written materials, and guest speakers reflect the cultural and ethnic diversity of the students, the community, and society in general. Choose wisely: a terrific video featuring urban African American teens would be an excellent selection for urban African American teens, but may be inappropriate for a middle class suburban African American group.

7. Build alliances across student groups by using structured and purposeful activities. Mix students up in teams and partnerships and have them work together to reach a common goal.

8. Support young people's exploration of their ethnic and racial identity.
   - Help young people understand that loyalty to one group does not mean disloyalty to another. Ethnic or racial pride does not mean rejection of other groups. Bi- and multi-racial teens, in particular, need help in this area.
   - Recognize the power of your influence on the students in your classroom, and be mindful of biases you might have about what identities teens should assume.

[3] From SA Messina, *A Youth Leader's Guide to Building Cultural Competence* (Washington, D.C.: Advocates for Youth, 1994).

9. Support young people's sexual orientation.
    - Learn about the range of issues related to teens and sexual orientation. Seek further resources if this topic is unfamiliar.
    - Know that it is highly likely that some young people in your classroom may identify themselves as gay, lesbian, bisexual, or transgender. Understand that they may or may not have engaged in same-gender sexual behavior; a lesbian, gay, bisexual, or transgender orientation involves more than just sexual identity.
    - Make your classroom a safe place for lesbian, gay, bisexual, and transgender young people by ensuring that disrespectful language and comments are not allowed to pass unchallenged.
    - Know what community resources exist to support lesbian, gay, bisexual, and transgender youth.
10. Engage young people in open and on-going dialogues regarding stereotypes, bias, and discrimination and the limits they impose.
11. Seek multicultural training opportunities for yourself and continue the process of building cultural competence in all ways available to you.

Developed by Courtney Reed Jenkins, Gender Equity Consultant, WI Department of Public Instruction (July 2001).

ISSUES AT A GLANCE

Rights. Respect. Responsibility.

Adolescent Sexual Health and the Dynamics of Oppression

A Call for Cultural Competency

Youth who face prejudice and discrimination by virtue of their identity, life experience, or family circumstances disproportionately experience teen pregnancy and sexually transmitted infections (STIs), including HIV. Such young people may include youth of color, those from low-income families, immigrants, and gay, lesbian, bisexual, and transgender (GLBT) youth. Research demonstrates the relationship between socioeconomic factors[1] —such as poverty, family distress, sexual networks[2], and access to health care as well as the impact of race/ethnicity, being young[3], gender (including young men)[4], class, and/or perceived sexual orientation[5] on negative health outcomes.

This paper encourages those who work with youth to understand the impact of prejudice and discrimination on vulnerable adolescents, to assess and address their needs, and to build on their assets. In prevention programming, it is essential to empower young participants by involving them in all aspects of developing and implementing programs for youth. It is equally essential to provide culturally appropriate interventions, with culturally competent adult and youth staff.

STEP ONE: UNDERSTAND THE IMPACT OF PREJUDICE AND DISCRIMINATION ON YOUNG PEOPLE

Learn as much as possible about the connections between oppression and the sexual and reproductive health of young people. Prejudice and discrimination have a powerful impact on vulnerable youth. Policy makers and program planners need to recognize that:

1) The historical and cultural context of reproductive and sexual rights, especially for women of color and low-income women, is one of persistent inequality. In designing prevention programs, service providers must recognize the impact of inequality on youth, especially on young women of color and youth from impoverished communities. Persistent inequality in U.S. health care has resulted in communities having painful memories of medical abuses, as well as anger, distrust, and suspicion of public health and medical providers and government agencies.[6] Prevention programs that work with young women of color must not overlook the United States' history of reproductive rights violations. For example, by 1982, approximately 24 percent of African American women, 35 percent of Puerto Rican women, and 42 percent of Native American women had been sterilized, compared to 15 percent of white women.[6] The eugenics movement, the Tuskegee syphilis study, and recent efforts to restrict states from offering health services to immigrants all reflect racist and discriminatory reproductive health policies in the United States, as do efforts focused on distributing Norplant and Depo-Provera to low-income adolescents and welfare recipients.[6]

2) Prejudice and discrimination have strongly negative impacts on the health of young people. Prejudice and discrimination, at individual and institutional levels, contribute to high morbidity and mortality rates among youth.

African Americans suffer from negative sexual health outcomes at greatly disproportionate rates, with young women and young men who have sex with men particularly at risk.[7,8] A common misconception is that young African Americans simply are not as careful as whites in protecting their sexual and reproductive health – but studies have shown that even with equal or fewer sexual risk behaviors, African Americans/Blacks are more at risk. An individual's risk is not solely a result of personal risk behavior, but is also a function of the "pool" of disease in their sexual network.[9] Poverty, unemployment, unstable neighborhoods, and unequal rates of incarceration all contribute to unequal access to health care and raise a young person's risk of contracting HIV or an STI.[10]

Research also demonstrates that institutionalized homophobia results in high rates of violence toward GLBT youth in schools and communities. The Gay, Lesbian and Straight Education Network's (GLSEN) 2007 report on the experiences of gay, lesbian, bisexual and transgender (GLBT) students surveyed 6,209 middle and high school students and found that nearly 9 out of 10 GLBT students (86.2 percent) experienced harassment at school in the past year, three-fifths (60.8 percent) felt unsafe at school because of their sexual orientation and about a third (32.7 percent) skipped a day of school in the past month because of feeling unsafe.[11] Service providers estimate that 25 to 40 percent of homeless youth may be GLBT.[12] According to one study, 50 percent of gay teens experienced a negative reaction from their parents when they came out and 26 percent were kicked out of their home.[13]

Thus, it is evident that prejudice and discrimination often have an increasingly negative impact on the health of young people — with young people who are members of more than one minority group facing even greater challenges.

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Prejudice and discrimination, at individual and institutional levels, contribute to negative sexual health outcomes among young people.

3) Young people face barriers and obstacles in sexual and reproductive health programs. Culture in the United States reflects extremely ambivalent feelings about the rights of minors, especially in regard to sexuality and reproductive health care. Contradictions and age-based discrimination are clearly evident in reproductive health programs and policies. Americans want teens to be sexually responsible. Yet, Americans also develop and fund programs that deny teens the information and services they need to protect themselves from unintended pregnancy or HIV/STIs. Numerous legal barriers, such as confidentiality restrictions and parental consent or notification laws, restrict teens from obtaining adequate reproductive and sexual health information and services. While all youth are negatively affected by these age-related restrictions, some youth face additional barriers posed by prejudice and discrimination. For example, lack of health insurance among the working poor can prevent teens from these families from receiving urgently needed care, such as contraception and testing and treatment for HIV and other STIs. Immigrant youth face additional barriers as well due to lack of culturally and linguistically appropriate services.

4) Teens who experience prejudice and discrimination may have less self-esteem and fewer resources and skills to meet the challenges that all teens face. During adolescence, teens experience a variety of physical, social, cognitive, and emotional developmental changes. For high self-esteem and a strong self-concept, teens need to feel that they belong (peer identification), and they need positive role models. Research indicates that adolescents with high condom use self-efficacy, optimism about the future, and reported behavior change attributable to HIV/AIDS are significant predictors of condom use at most recent intercourse.[14] Teens with less self-esteem may feel less effective at negotiating safer sex, communicating with peers and partners, and accessing health care. Feeling less effective can leave teens unwilling to act—unwilling to negotiate, communicate, or take other important steps to protect their health. For example, one study among GLBT people found that young adults were one of the groups with disadvantaged social well-being. This study also suggested that these conditions can be mediated by a sense of positive community connectedness.[15]

5) Media strongly influence adolescents' self-perceptions and self-concept. Mass media, policy debates, and community programs often present an image of young people as problems. Too often, the focus is on school failure, substance use, gang violence, teen pregnancy, and/or HIV/STIs. Cultural images fluctuate from that of the uncontrollable, hard-to-reach, angry, and rebellious teen to the poor, disconnected, and distraught teen. Meanwhile, advertising builds the image of the sexy, carefree teen. What happens when adolescents repeatedly see and hear these images, internalize them, and then struggle to live into an idealized or distorted picture inconsistent with youth's true identity? For example, Many GLBT youth report relying on television to learn what it means to be lesbian or gay. In one study, 80 percent of these youth ages 14 to 17 believed media stereotypes that depicted gay men as effeminate and lesbians as masculine. Half believed that all homosexual people were unhappy.[13]

STEP TWO: ASSESS THE NEEDS AND ASSETS OF YOUTH IN THE COMMUNITY

Understanding the connections between different forms of oppression and adolescent sexual and reproductive health is the first step in building effective programs. The next step requires an examination of community programs and services.

1) Assess the health status of youth and the accessibility of services. Gather demographic information on youth in the community: age, gender, race/ethnicity, and family income levels, as well as health, education, and economic indicators. Assess the extent to which substance use, teen births and abortions, HIV/STI, and school failure and dropout affect different populations of youth. Evaluate teens' access to health care and social services by examining fee schedules, hours of operation, locations, the availability of public transportation, and laws and policies on confidentiality. Evaluate neighborhood environments by assessing the local availability of healthy foods and fresh produce, recreational facilities, employment opportunities, and quality health services. Involve youth and adult members of the community in the process of creating assessment tools and making decisions about assessment techniques, such as surveys, focus groups, or interviews.

2) Assess the cultural appropriateness of services. Program planners must assess the environment of their organization, including management, operations, outreach, community involvement, and service delivery. This means evaluating the mission and activities of the organization; the level of cultural competence among board members, staff, and volunteers; agency policies and procedures on discrimination and harassment; staff training; whether programs are culturally appropriate and/or multicultural;

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and the reading levels and appropriateness of the educational materials for young people at different developmental stages. Is the staff representative of the target population? Who conducts community outreach and how? Each staff member needs meaningful ways to examine attitudes, beliefs, and knowledge in regard to adolescent sexuality and reproduction, adolescent relationships, and teen parenting. What experience influences staff's perceptions of adolescent sexual health? Does staff have biases or hold stereotypes? In what subtle or blatant ways might staff be communicating these biases to young people? The ability of staff to interact with each individual openly, flexibly, and respectfully will affect the program's success. In the end, there is no magic solution—just continuous efforts— for working effectively with diverse youth.

3) Learn about the cultural and family background, health beliefs, and religious practices of each young person in the program. Values, attitudes, and beliefs, levels of knowledge, and communication patterns about health, sexuality, relationships, contraception, and childbearing vary significantly across cultural and ethnic groups and from family to family. Tailoring programs to the cultural background(s) of participating youth can increase the program's effectiveness.

4) Assess the experience and knowledge of youth in the community. Needs assessment tools and techniques typically provide statistical facts and figures on which to evaluate adolescents' behaviors and their sexual health. Focusing exclusively on objective data and trends, however, can cause adults to overlook the insights and experiences of teens and to measure teens' health solely in relation to adult standards. Finding ways to record teens' perspectives, interpretations, and viewpoints—through surveys, focus groups, and interview—can help to ensure that a program truly meets the needs of the community's youth.

STEP THREE: EMPOWER YOUTH AND OFFER CULTURALLY COMPETENT PROGRAMS IN THE COMMUNITY

Information from the needs assessment will help inform the design, operations, and continuous improvement of programs. Planners can use the information from the needs assessment to develop strategies that will empower teens and ensure that programs are culturally appropriate.

1) Support peer education and the leadership of youth. Adolescent health professionals increasingly recognize the powerful effect that teens exert when they speak out for themselves, define the issues that matter to them, and craft an agenda to address those issues. Youth can create initiatives that address inequities and disparities in health care, drawing upon other social movements, such as civil rights, women's rights, and HIV/AIDS activism. For example, the civil rights movement challenged *separate but equal* as being inherently racist. Is *separate but equal* applied today to adolescents? What rights do minors share with adults? What rights do they not share? Young people could use *consciousness-raising*—a term from the turbulent 1960's and 1970's in the United States—to explore attitudes and beliefs among today's youth and to raise concerned awareness of youth's social issues. *Consciousness-raising* is distinctly different from educational sessions where adults teach, and young people learn, specific skills and knowledge. Or, youth might utilize *I have a dream* to envision their future. These types of work focus attention on the assets, contributions, strengths, and skills of young people.

2) Create opportunities for youth to talk openly and frankly about racism, sexism, homophobia, class discrimination, and other forms of oppression. Programs should offer a safe environment where teens can feel comfortable talking about individual identity, experiences, hopes, and fears. Teens need to feel and understand how they and others have experienced prejudice and discrimination. Interactive and experiential exercises, such as case studies and role-playing, can help teens think through the barriers and obstacles that oppression creates. For example, youth can better understand gender discrimination by exploring how ideas about gender roles limit young people's growth and future and how gender role stereotypes can damage relationships. Or, youth might explore economic issues by analyzing the costs and benefits to a teen with little money of spending allowance or hard-earned dollars on condoms. Role-playing can allow youth to experience how someone of a different race/ethnicity might feel at a clinic staffed only by clinicians and counselors of a different racial/ethnic background. In this way, activities can frame reproductive and sexual health decisions within the overall context of adolescents' lives and help teens to understand how oppression affects them and others.

3) Replicate and adapt HIV/STI and pregnancy prevention programs that have been evaluated and shown to achieve positive outcomes for young women, youth of color, low-income youth, and/or GLBT youth. A number of strategies and programs have been proven to work at the community level to influence sexual risk behaviors.

Effective programs value diversity and address behavioral, cultural, and institutional barriers which negatively impact young people's health.

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These include sex education that includes messages about both abstinence and contraception; contraceptive and condom availability programs; and youth development programs that offer mentoring, community service, tutoring, and employment training.[16] Planners should culturally adapt evidence-based programs for the community's youth.*

4) Ensure that prevention efforts are culturally specific. Youth-serving organizations are most successful when their programs and services are respectful of the cultural beliefs and practices of the youth they serve. A culturally competent program values diversity, conducts self-assessment, addresses issues that arise when different cultures interact, acquires and institutionalizes cultural knowledge, and adapts to the cultures of the individuals and communities served. This may mean providing an environment in which youth from diverse cultural and ethnic backgrounds feel comfortable discussing culturally derived health beliefs and sharing their cultural practices. Creating culturally competent programs is not difficult, but it requires conscientious attention and the understanding that it is a life long process of learning and adaptation.

In conclusion, programs must recognize and deal with the broad social, economic, and political framework within which teens live. Program planners must ensure that services are both culturally appropriate for and also friendly to young people. Focusing on the young people's right to information and services can also empower young people to demand honest, accurate, culturally relevant information and unrestricted access to health services. Empowering youth can encourage adolescents to take responsibility for their own reproductive and sexual health and to envision their own future.

* For information on evaluated programs, contact Advocates for Youth or visit www.advocatesforyouth.org

Written by Laura Davis. Revised by Urooj Arshad, Associate Director, Racial Disparities and Social Justice

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PUTTING WHAT WORKS TO work
A PROJECT OF THE NATIONAL CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY

SEPTEMBER 2009

Child TRENDS

Vulnerable Youth: A Closer Look at Reproductive Health Outcomes

Introduction

Existing research indicates that children and adolescents who come into contact with service systems—including child welfare, juvenile justice, and runaway/homelessness services—are at risk for a number of negative outcomes as they transition to adulthood. As young adults, these "vulnerable youth" experience deficits in educational attainment, employment, and earnings.[1,2] They are more likely to experience physical and mental illness and to engage in criminal activity.[1-4] Additionally, research has linked contact with service systems with negative reproductive health outcomes, such as higher levels of sexual activity during adolescence, a greater number of sexual partners, lower levels of contraceptive use, elevated risk of sexually transmitted infection (STI), and higher levels of teen pregnancy and childbearing.[1,5-8]

Although estimating the total number of children/adolescents that come in contact with service systems before the age of 18 is difficult, the numbers are not insignificant. Based on 2006 data, approximately half a million children are in foster care at any time,[9] and the families of six million children are investigated by child protective services agencies each year.[10] Runaway and homeless youth are particularly challenging to measure but researchers estimate that approximately 1.7 million children/adolescents under the age of 18 run away each year.[11] Additionally, in 2007, 1.3 million adolescents under the age of 18 were arrested.[12]

This *Science Says* brief uses data from the National Longitudinal Study of Adolescent Health (Add Health) to explore rates of sexual activity, contraceptive use, births, and other measures among vulnerable youth in young adulthood. The brief also examines the association between cumulative risk and later reproductive health outcomes. We explore five groups of vulnerable youth in contact with three service systems (child welfare, juvenile justice, homeless/runaway). Youth were identified through retrospective reporting at ages 18 to 26: 1) those whose families were investigated by social services at least once before the youth was in sixth grade; 2) those who ever lived in foster care; 3) those who came into contact with the juvenile justice system by being arrested before the age of 18; 4) those who had run away from home for at least one night and; 5) those who had ever been homeless/lived in a group home. We compare the reproductive outcomes of vulnerable youth in young adulthood to the outcomes for those who had no contact with the three service systems studied (non-vulnerable youth). We also compare "highly vulnerable" youth—those belonging to more than one of the five risk groups studied—to those belonging to only one risk group as well as to non-vulnerable youth. We expand upon previous research by drawing our vulnerable youth samples from a nationally representative survey of students in grades 7 to 12 during the 1994-1995 school year who were followed into young adulthood (ages 18 - 26 in 2002).

Summary

- Approximately one-quarter of youth in the sample were considered vulnerable, that is, they reported belonging to one of the five identified risk groups mentioned above. Of these, 23% were considered highly vulnerable—belonging to two or more identified risk groups.

- Vulnerable youth reported similar reproductive health behavior and outcomes regardless of their specific risk group.
- Reproductive health behavior and outcomes were poorer among vulnerable youth as compared to non-vulnerable youth.
    - 49% of vulnerable youth and 61% of highly vulnerable youth reported having sex before age 16 compared to 29% of non-vulnerable youth.
    - In young adulthood, vulnerable youth were much less likely to report using contraception (including condoms) consistently in the past year compared to non-vulnerable youth.
    - 17% of vulnerable youth reported having a birth as a teenager and 25% reported ever having an unintended birth compared to 9% and 16% of non-vulnerable youth respectively.
    - 11% of highly vulnerable youth tested positive for an STI compared to 7% of vulnerable youth and 6% of non-vulnerable youth.
- Vulnerable youth were also more likely than non-vulnerable youth to report that they had ever experienced forced sex (28% versus 15% respectively).

Prevalence of Vulnerable Youth

Figure 1 shows the distribution of vulnerable youth by our definition, with information for the full sample and by gender.

- Youth who ever ran away from home comprised the largest risk group. Approximately 15% of youth in the sample ran away from home for at least one night. Youth living in foster care was the smallest risk group; less than 2% of youth in the sample ever lived in foster care (Figure 1).
- Females were more likely than males to have ever run away (17% versus 13% of males) and were much less likely to have been arrested before 18 (2% versus 9% of males).
- In our sample, 23% of youth were considered vulnerable—belonging to one or more of the risk groups studied. Among vulnerable youth, approximately three-quarters (77%) belonged to one risk group while almost one-quarter (23%) belonged to two or more (Figure 2).

Highly Vulnerable Youth

Highly vulnerable youth—those belonging to two or more risk groups—were more prevalent among certain vulnerable youth groups. Figure 3 displays the percentage of youth in each risk group that belonged to at least one other risk group.

- Those who had run away from home and those who were

FIGURE 1. Distribution of Vulnerable Youth

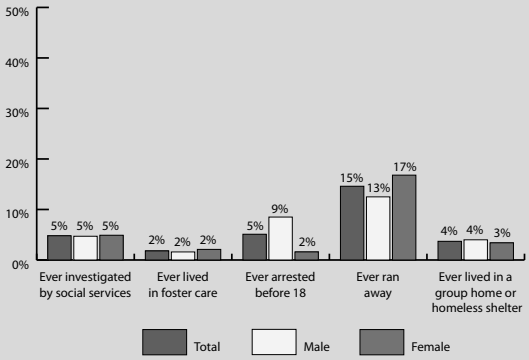


FIGURE 2. Vulnerable Youth Distribution

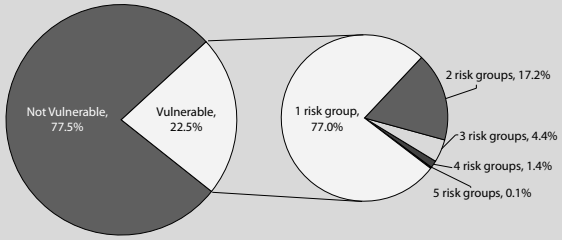


FIGURE 3. Percentage of Youth Belonging to Two or More Risk Groups, by Type of Risk Group

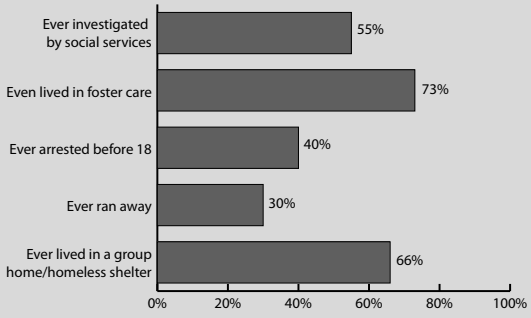


FIGURE 4. Vulnerable Youth by Select Demographic Characteristics

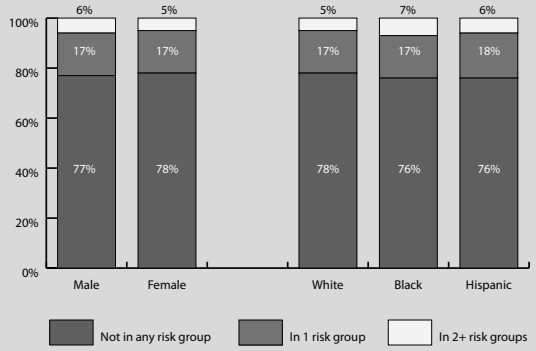
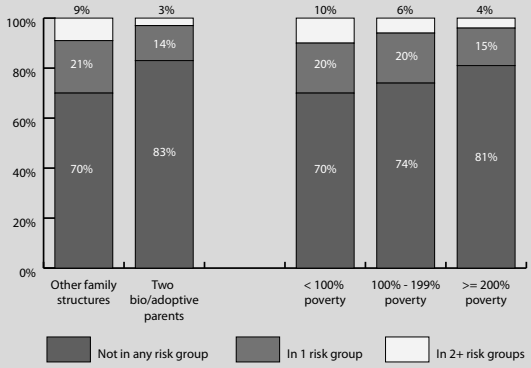


FIGURE 5. Vulnerable Youth by Select Demographic Characteristics



arrested before age 18 were less likely to be highly vulnerable as compared to those who had been in families investigated by social services, lived in a group home/homeless shelter, or lived in foster care.

- For instance, 73% of those in foster care were in at least one other risk group. In contrast, only 30% of those who had ever run away from home were in at least one other risk group.

Socio-demographic Differences in Vulnerable Populations

The distribution of youth belonging to a vulnerable group was similar across gender and racial/ethnic groups. Family background characteristics, however, were linked with vulnerability.

- Regardless of gender, race, or ethnicity, approximately 22% to 24% of youth belonged to a risk group and 5% to 7% to two or more risk groups (Figure 4). These findings are somewhat surprising given previous research that finds that minorities are overrepresented in social services systems such as child welfare and juvenile justice.[13,14] It is possible that minority youth who have contact with the social systems examined here are less likely to be enrolled in school and therefore not captured by the Add Health survey. Given the high rates of dropout among black and Hispanic students as compared to whites, this could be important.[15] A population-based survey may show a higher percentage of vulnerable youth among blacks and Hispanics.
- There were very small differences by race/ethnicity in the type of risk group to which youth belonged (results not shown). Blacks were more likely than whites and Hispanics to have ever been in families investigated by social services (7% of blacks versus 5% of whites and 4% of Hispanics). Blacks were also more likely than whites (but not Hispanics) to have lived in a group home or homeless shelter (5% of blacks versus 3% of whites). Finally, Hispanics were more likely than whites or blacks to have run away (17% of Hispanics versus 13% of blacks and 14% of whites).
- Those living in a non-intact family during middle school/high school were more likely than those who were living with two biological or adoptive parents to be in a vulnerable group during their childhood/adolescence. Almost one in three (30%) of those living outside a two biological/adoptive parent family in adolescence belonged to at least one risk group. Additionally, almost 10% of those living outside of a two biological/adoptive parent family in adolescence belonged to two or more risk groups. In comparison, 17% of those living with two biological/adoptive parents in adolescence belonged to at least one risk group and 3% of those living with two biological/adoptive parents belonged to two or more risk groups (Figure 5).
- A higher percentage of adolescents living in low-income or poor households during middle school/high school were considered vulnerable as compared to adolescents whose family income was at or above 200% of the federal poverty line (Figure 5). Almost one-third (30%) of those in poverty (below 100% of the poverty line) and 26% of those living in low-income families (100-199% of the poverty line) belonged to a vulnerable group during their childhood/adolescence. Adolescents whose families were below 100% of the poverty line were more likely to belong to multiple risk groups (10%) than their low-income counterparts (6%).

Reproductive Health Behavior

Regardless of the specific risk group examined, vulnerable youth demonstrated poorer reproductive health in young adulthood (age 18-26) compared to those young adults who were not previously in a risk group.[a]

As an example, Figure 6 shows the distribution of youth who had sexual intercourse before age 16 across the five vulnerable youth groups studied, as well as among those who did not belong to any risk group. The percentage of youth who had sex before age 16 ranged from 49% among those who ever ran away from home to 57% among those who were arrested before age 18—considerably higher than the 29% of non-vulnerable youth who had sex before age 16.

Given the similarities in reproductive health across vulnerable groups noted above, this section focuses on vulnerable youth as compared to non-vulnerable youth. We also compare vulnerable youth who belonged to only one risk group to highly vulnerable youth—those who belonged to two or more groups. Sexual experiences differed between vulnerable and non-vulnerable youth, and vulnerable youth belonging to more than one risk group were at even higher risk than their peers belonging to only one risk group.

- Less than one-third (29%) of non-vulnerable youth were younger than 16 the first time they had sex, compared with almost half (49%) of vulnerable youth belonging to one risk group and almost two-thirds (61%) of highly vulnerable youth who first had sex at an early age (Figure 7).
- Among non-vulnerable youth, 15% said they had been forced to have sex as compared to 28% of those belonging to one risk group and 36% of those belonging to two or more risk groups (Figure 7).
- Vulnerable youth used contraception less consistently as young adults than non-vulnerable youth. There were no significant differences, however, in consistency of contraceptive use (including condoms) between vulnerable youth belonging to one risk group and those belonging to two or more risk groups (Figure 8). As young adults, half of non-vulnerable youth used contraception every time they had sex in the past year while just over one-third of vulnerable youth reported consistent use. Additionally, less than one in five vulnerable youth used a condom 100% of the time compared to approximately one in four non-vulnerable youth.
- Highly vulnerable youth had higher rates of STIs—Chlamydia, gonorrhea, or trichomoniasis as young adults compared to youth who belonged to only one or no risk group (Figure 9). Among vulnerable youth belonging to two or more risk groups, 11% tested positive for an STI on the biomarker assessment administered by the Add Health survey team. This

FIGURE 6. Percentage of Youth Who Had Sex Before Age 16 Across Risk Groups

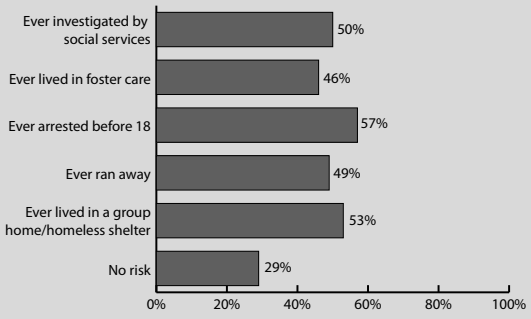


FIGURE 7. Sexual Experience Outcomes by Number of Risk Groups

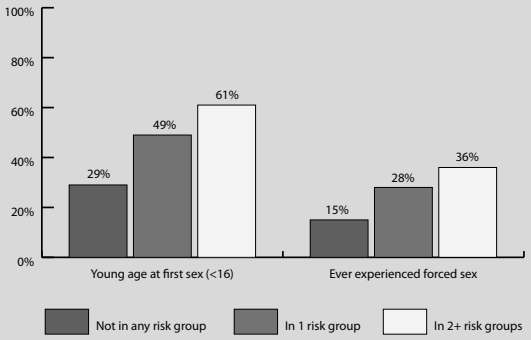


FIGURE 8. Contraceptive/Condom Consistency by Number of Risk Groups

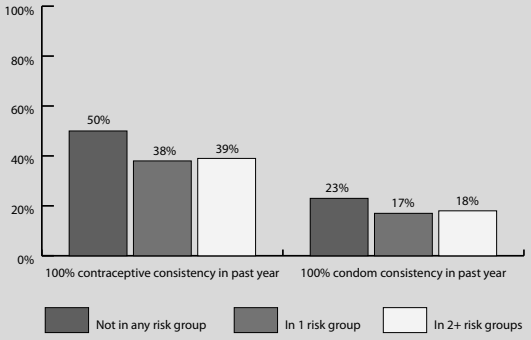


FIGURE 9. STI Prevalence by Number of Risk Groups

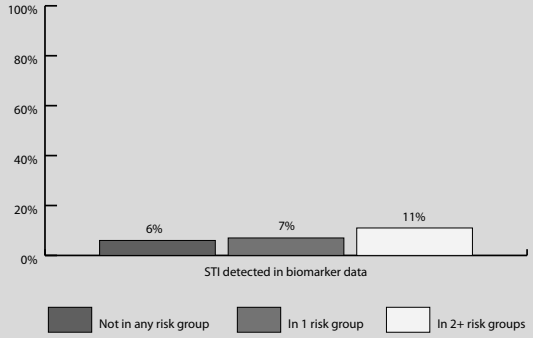
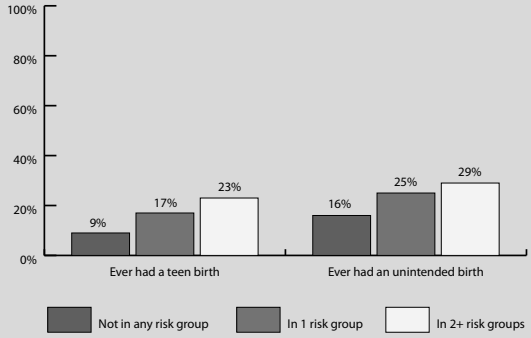


FIGURE 10. Childbearing by Number of Risk Groups



is higher than the 6% of non-vulnerable youth and 7% of vulnerable youth who belonged to only one risk group that tested positive for an STI. There were, however, no statistically significant differences between youth belonging to no risk groups and youth belonging to one risk group.

- Vulnerable youth had higher rates of teen and unintended births as compared to non-vulnerable youth (Figure 10). Almost one-quarter (23%) of highly vulnerable youth and 17% of vulnerable youth belonging to one risk group had a birth before the age of 20 as compared to 9% of non-vulnerable youth. Among non-vulnerable youth, 16% had an unintended birth as compared to 25% of youth belonging to one risk group and 29% of youth belonging to two or more risk groups. As compared to their counterparts belonging to only one risk group, highly vulnerable youth were more likely to have a teen birth, but not an unintended birth.

What it All Means

Overall, almost one in four (23%) young adults in the sample belonged to at least one of the five vulnerable youth groups studied. Add Health represents approximately 22 million adolescents who were enrolled in grades 7 to 12 during the 1994-1995 school year, meaning that approximately 5 million students were considered vulnerable based on the five risk groups identified in this brief. It is important to note that the Add Health is a school-based sample, so adolescents who were not enrolled in school would not be counted in this estimate. As a result, it is likely that the survey misses a number of vulnerable youth, particularly those who drop-out of school and those in juvenile detention centers at the time of the study.

Equal proportions of males and females reported being vulnerable (belonging to one vulnerable group) and highly vulnerable (belonging to two or more vulnerable groups), although the type of risk group they belonged to differed by gender. Specifically, males were more likely to have ever been arrested, while females were more likely to have run away from home. Additionally, the likelihood of belonging to a risk group did not differ dramatically by the youth's race/ethnicity. Poverty and family structure were associated with belonging to a vulnerable youth group, and those youth at greater disadvantage (those who either lived outside a two-parent home, or those who's families were poor, as measured during middle school or high school) were more likely than their more advantaged peers (those who either lived in a two-parent home, or who were non-poor) to belong to a risk group. Given that vulnerable youth had poorer reproductive health outcomes than non-vulnerable youth, these findings suggest that it is important to ensure that teens and families in disadvantaged communities receive reproductive health interventions, information, and services.

Reproductive health outcomes were similarly poor across the vulnerable youth groups, indicating that youth with any of the vulnerabilities studied are at risk of poor reproductive health in young adulthood. While our analyses did not test for causality, differences in reproductive health were dramatic across all measures. Results suggest that there are multiple points of intervention for reaching vulnerable youth, and that all youth-related service systems should be equipped to address the reproductive health needs of their populations. These findings also reinforce the importance of and need for programs targeted to the unique situation of vulnerable populations—including those linked to the foster care, child welfare, juvenile justice systems, and runaway

and homeless youth. Although some programs have been targeted to these populations (for example, *Power Through Choices* is a teen pregnancy prevention program developed specifically for youth in foster care),[16] more research on how to best tailor/create programs to meet the reproductive health needs of vulnerable populations is greatly needed.

Highly vulnerable youth, those belonging to two or more risk groups, constituted 23% of the vulnerable youth sample. These youth were at even greater risk of poor reproductive health outcomes than their counterparts belonging to only one risk group. Thus, it is critical that service systems such as child welfare, juvenile justice, and runaway/homelessness services communicate and coordinate on issues related to reproductive health in order to have a greater potential positive influence with this highly vulnerable population of youth.

About the Putting What Works to Work Project

Putting What Works to Work (PWWTW) is a project of The National Campaign to Prevent Teen and Unplanned Pregnancy funded, in part, by the Centers for Disease Control and Prevention. Through PWWTW, The National Campaign is translating research on teen pregnancy prevention and related issues into user-friendly materials for practitioners, policymakers, and advocates. As part of this initiative, the *Science Says* series summarizes recent research in short, easy-to-understand briefs. This *Science Says* is based on research conducted by Child Trends.

Author Information

This research brief was written by Child Trends staff members Kate Perper and Jen Manlove.

About The National Campaign to Prevent Teen and Unplanned Pregnancy

The National Campaign to Prevent Teen and Unplanned Pregnancy is a nonprofit, nonpartisan organization supported largely by private donations. The National Campaign's mission is to improve the lives and future prospects of children and families and, in particular, to help ensure that children are born into stable, two-parent families who are committed to and ready for the demanding task of raising the next generation. Our specific strategy is to prevent teen pregnancy and unplanned pregnancy among single, young adults. We support a combination of responsible values and behavior by both men and women and responsible policies in both the public and private sectors.

About Child Trends

Child Trends is a nonprofit, nonpartisan research organization dedicated to improving the lives of children by conducting research and providing science-based information to improve the decisions, programs, and policies that affect children. Child Trends conducted the analysis used in this fact sheet.

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Data Sources

Data for this brief came from the National Longitudinal Study of Adolescent Health (Add Health), a nationally representative federally-funded school-based survey of U.S. students in grades 7-12 in 1995. Add Health data collection included three waves of in-home interviews, in 1995 (Wave I), 1996 (Wave II), and 2002 (Wave III). Nearly 15,200 respondents participated in the Wave III follow-up. Our analytic sample consisted of 14,322 respondents who participated in Waves I and III and had valid sample weights. Vulnerable youth were identified based on retrospective questions in the Wave III interview. All socio-demographic data was based on the Wave I interview. Reproductive health measures were drawn from Wave III when respondents were aged 18 to 26.

Notes

a. Youth who were ever arrested before the age of 18, because they were mostly male, were dissimilar on several outcomes. As compared to youth in other risk groups, a smaller percentage of youth who were ever arrested experienced forced sex or reported a teen or unintended birth.

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Effective Teaching Methods for Sexuality Education[1]

This handout is a snapshot of many methods available to you. This is *not* intended to prepare you to use all of these methods. Some of them require considerable training, preparation, and practice.

In order to effectively use a method, you should

- Observe experienced educators/trainers using the method;
- Assess your own comfort level, expertise, values, and skills required;
- Think through for yourself when, where, how, and why you would use the method;
- Practice using the method with colleagues;
- Co-lead a session using the method with an experienced colleague.

Method	How It Works	Examples
Arts & Crafts	Creative, hands-on projects.	Learners… build 3-dimensional models of male & female reproductive anatomy out of… clay, fruit, yarn, balloons, pipe cleaners, etc. Create a spider web on paper, and organize info about a specific STD into each web section, such as symptoms, long-term effects, myths, slang names, etc.
Body sculpting	Used to trigger discussion about specific situations or relationships. Caution: can be emotionally powerful; trainer should be experienced and comfortable addressing feelings that may emerge.	Ask several students to come up to the front of the room. Have two others come up and physically move the actors into a scene they want to portray regarding your topic. Example: a dating situation, or an abusive family relationship. Ask actors to hold the scene for a few moments, and instruct the rest of the group to jot down some reactions. Release the actors for full group discussion.
Brainstorm[2]	Quick listing of responses to a question. Rules: no criticism, be creative, have fun, piggyback on each other's ideas. Caution: same students tend to always answer.	To stimulate creative thinking, hold up a box of baking soda and ask learners to quickly come up with as many uses for this product as they can. Acknowledge the creativity of the group; move directly into another brainstorm on the topic, or another activity requiring creative thought. Ask all students to write down three responses to the question, go around the room and elicit one from each before going into full group brainstorming.

Method	How It Works	Examples
Cartoon scripting	A low-risk way for learners to practice communication skills, or rehearsal for dealing with difficult situations	Learners provide dialogue for cartoon characters of their own making or provided for them. Cut pictures from a magazine and have learners develop dialogue that reflects the lessons. Example: after a class on assertiveness, have them write assertive lines for characters.
Case studies[3]	Using stories to help learners relate to the topic and/or solve a hypothetical problem.	Have learners in small groups create a story about the topic and tell their story to the other groups. Create ethical dilemmas (with characters similar to the learners) for the learners to discuss and resolve.
Charts & graphs	Visual display of factual information. Statistics can be important, but are usually boring. Visual representations of statistics and other facts can help learners absorb new info.	Educator uses chart during lecturette or discussion to clarify statistical information. Fill a jar with variously colored marbles, with one particular color representing teen pregnancy or frequency of an STD. Have students draw marbles from the jar; ones who draw the special marbles are "pregnant."
Continuum[4]	A physical way to represent a range of beliefs. Learners can represent their own, or can complete an anonymous survey which is then mixed up, and participants represent another's view. It is very important to precede this activity with a discussion on values, and respect for others opinions.	Draw a line (real or symbolic) across the room. At one end is an extreme belief about an issue (ex, parental consent for abortion, abstinence from sex outside of marriage, etc.), and at the other end is the opposite extreme. The space between represents the range of beliefs in between. Learners place themselves at the point along the line that best represents their feelings or beliefs. Place large cards around the room. On each card is a sexual behavior, ranging from "holding hands" to "intercourse." Ask learners to stand at the point where they believe abstinence ends and sexual activity begins. Discuss the range of views and lack of clarity regarding an abstinence definition.[5]
Discussion[6]	Learners talk about the issue, in small groups, or in the full group, with or without the instructor. Tip: establish ground rules first.	Show a part of a video, stopping it at a critical moment. Start discussion by asking open-ended questions: What do you think about the interactions of the characters? Who can you relate to? During a lecturette, ask open-ended questions: What would you do if…? So what?

Method	How It Works	Examples
Field trips[7]	Make a real, or simulated, visit to a relevant location.	Arrange for students to visit a FP or STD clinic, and go through the clinic as a patient would. Assign students to purchase condoms, and report on the experience. How were they treated by store clerks? Where were the condoms kept? How did it feel to go through the checkout?
Fish bowl[8]	A Subgroup of the full group discusses a topic with the full group listening.	Invite a small group of male learners to talk about expectations of men in American society. Then ask a small group of females to talk about expectations of women. Ask the observers to take notes while the small group talks. The full group discusses the entire process—what was said, how it felt to say it, to hear it, etc.
Games[9]	The only rule here is to have fun while learning. The game may be competitive, or not; it may be structured, or not; it may be based on a "real" game, or not.	In small groups, assign learners the task of teaching back a topic to the rest of the group using a game show format. They can choose whatever game they want. Create your own game based on any game or board show: Jeopardy, Bingo, Trivial Pursuit, etc.
Graffiti sheets	Invite anonymous responses from learners on butcher paper posted around the room. This can be used to assess knowledge, determine beliefs or values, or to stimulate discussion.	On butcher paper, write sentence stems such as: People who get STDs are…; Abstinence means…; Birth control methods are… etc. Post the paper around the room and have learners circulate and write their responses.
Learning stations	Work or subject stations that learners can visit are set up around the room.	Invite learners to visit as many stations as they can and ask for oral reports. Assign learners to find something similar (or different) in each station.
Lecture or Presentation[10]	Information is presented to the group, often accompanied by overheads, slides, or other visual displays. Factual information is important, and this is sometimes the best way to cover the information. Keep it brief, and follow with interactive methods.	Liven up the lecture with appropriate humor, anecdotes, or breaks for short discussions in dyads or triads. Replace statements with questions: From "some of the most common STDs are…" to "what are some of the most common STDs you've heard of?" Encourage personal reflection or application of the info.

Method	How It Works	Examples
Music	Use as an attention-getter, discussion-starter, or background mood piece.	Ask learners to bring in a piece of music that represents their view of relationships, or the role of women in American society, or communication between genders. Create a tape of popular music that represents respectful and honest relationships, and another of abusive relationships. Play both, and have students compare them.
Out of class projects[11]	Learning experiences that take place out of the classroom.	Assign students to interview someone of another generation about dating and sexual mores of their time; or assign a critical review of a popular TV show or movie; or have students write a letter to the editor about a current issue.
Panels[12]	A group of guest speakers provide their perspective on an issue.	Select panel members from a variety of experiences and world views. Prep the panel members about the audience and expectations. Set ground rules for Q&A.
Quotes	Application of "words from the wise" to the topic at hand.	Select relevant quotes and write them on 3x5 cards, with the first half of the quote on one, and the second on another. Give each participant a card and instruct them to find their partner. Once they do, they should talk about the quote and its relevance to the topic. Post quotes on newsprint on the walls. Ask learners to go to the one that most appeals to them, and to discuss it with others.
Realplays & roleplays[13]	Practice of new skills through trial and feedback.	Ask learners to describe real scenarios they could find themselves in. Set up dyads or triads, or ask for volunteers to play out the scene using new skills or attitudes.
Reflective Writing[14]	An opportunity for individual reflection and writing on an issue.	Ask a group of professionals to write about a personal experience with behavior change prior to a discussion on behavior change theory. Create a journal—some pages have provocative quotes or drawings, other pages are blank. Give students time to write during class, and assign out-of-class writing.
Rehearsal[15]	Exercises that provide a chance to practice a new skill or to verbalize new information.	Write "one-liners" (for teens, could be pressure lines; for professionals, could be difficult questions from clients) on 3x5 cards and distribute to learners. In pairs, they can practice responding to the one-liners. After learning new information, students practice teaching it to small groups of peers.

Method	How It Works	Examples
Simulation[16]	Not quite real life, but comes as close to it as you can get in the classroom!	Set up an experience that models real life: a clinic exam room, a dating scene, a drugstore. Have learners provide the action: a fully-clothed pelvic exam, a frank discussion of sexual decisions, buying condoms.
Slides & overheads[17]	Visual aids that accompany a lecture/discussion. Tip: Don't overuse; keep in mind that purpose is visual illustration, not simply providing the same info you could get across better in a handout, or verbally.	Choose cartoons to illustrate exaggerated examples of poor communication skills, or ads to illustrate "sex sells." Develop colorful graphs or pie charts to "show" rather than simply tell statistics. Make slide photos of people's faces to humanize HIV, or insert nature slides between factual slides to provide visual relief.
Sorting games	A way to practice using new knowledge by applying it.	Write names of different birth control methods on cards. Students can sort the cards by effectiveness rates, or by "type" (nonprescription vs prescription), etc. From David Vaughn, write sexual topics for discussion (ex., telling police you've been raped, telling a friend you have a crush on her, etc.) on cards. Have students sort cards by difficulty. Then rehearse the difficult ones.
Stem sentences[18]	Use sentence fragments to trigger discussion or ideas. Before discussion or reading aloud, set ground rules, especially no criticism.	Post around room butcher paper with stems such as: I was born ... , My parents are ... , one thing I learned today .... Students move around the room answering those they want to with markers. (See graffiti sheets.) Have learners develop the stems. Write stems on papers. Have students complete the stems, shuffle and redistribute papers, and read aloud some of the responses.
Task groups[19]	Small group within a group that accomplishes a set task. Usually follows acquisition of new knowledge or skills.	Assign a group of teachers to develop a lesson plan for teaching about the menstrual cycle. Have a group of parents develop a definition for sexual health.
Value voting	Exercises to develop awareness of one's own, and of other's values and beliefs. You can allow discussion about the items, or not, but if you do, establish ground rules first. It also helps to have a brief discussion of values first, emphasizing respect for differences.	Develop a list of value statements about the topic, with "Agree/Disagree" next to each. Have learners read the list and agree or not with each statement. Shuffle papers. Either by show of hands, or getting up and standing in different parts of the room, indicate whether the paper they're holding agrees or not.

Method	How It Works	Examples
Videos[20]	Can be used to demonstrate communication skills, trigger discussion, and offer information in a highly visual manner.	Show part of a video. Stop at a critical moment for discussion: what would you do if you were this character? Before showing a video on communication skills, assign some students to count the number of open-ended questions, others to count the reflective listening statements, etc. Have small groups rewrite the "end" of the video, and act out for the other groups.
Worksheets[21]	Guidelines for thinking or working through a complex issue or problem. Can be used by an individual or small group.	Develop a worksheet that allows learners to apply their new information by comparing, categorizing, planning, or reacting. Then in small groups, share their answers and develop action plans. Use a worksheet as a "pre-organizer," building on individual experiences (about making a difficult decision, or taking a risk, etc.) before talking about a topic.
Whip[22]	A simple exercise to provide everyone an opportunity to speak. Always give permission to "pass."	Stop the session mid-way and "whip" around the room, asking everyone to state how they're reacting to the session. Whip before talking about a new topic, asking for one idea about it from everyone.

1. This list is adapted from a NICHE '96 handout developed by Gail Stringer & Beth Reis.
2. Hedgepeth and Helmich, Teaching About Sexuality and HIV: Effective Principles and Methods. NYU Press, 1996, p. 211.
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4. lbid., p. 183.
5. David Vaughn, Staying Out of the Risky Zone,
6. Hedgepeth and Helmich, p. 174-4.
7. Ibid., p. 171-2.
8. Ibid., p. 181.
9. Ibid., p. 223, 229.
10. Ibid., p. 148.
11. Ibid., p. 208.
12. Ibid., p. 215.
13. Ibid., p. 192-5.
14. Ibid., p.145.
15. Ibid., p. 196.
16. Ibid., p. 205.
17. Ibid., p. 152.
18. bid., p. 142.
19. Ibid., p. 167.
20. Ibid., p. 153.
21. Ibid., p. 163-4.
22. Ibid., p. 176.

Answering Difficult Sexuality Questions in the Classroom

Many types of questions come up in the classroom. One of the reasons teachers fear teaching HGD is answering questions they get from students. Find out whether your school district supports you in answering all questions that students ask. Many districts do, as long as questions are answered in age-appropriate ways. This question answering protocol could easily be shared with families so they understand how you will answer questions students may have during content that may generate questions about sexuality. Typically this will quiet everyone's concerns about whether or not the school is contradicting family or community values.

The first step in answering any question is determining what type of question it is. This protocol outlines 6 types of questions. They are: 1) the fact question, 2) the values question, 3) the slang question, 4) the question you don't understand, 5) the question you don't know the answer to, and 6) the personal question.

The Fact Question

These are relatively easy to answer. You are not being asked your opinion—you can answer with basic information. You should use your professional judgment and child development theory to determine how much detail you need to go into. We have all heard the stories of children who ask "where did I come from?" who only wanted to know what hospital or city they were born in.

Examples of fact questions

Question	Possible Answer	Answer based on your grade level
What is an erection?	An erection is the penis or clitoris filling with blood and becoming larger and harder.	
Should you worry if you're 14 and you haven't gotten your period?	No. It's perfectly normal to not have your period when you're 14 years old. If a girl hasn't gotten her period by the time she's 16 years old she should talk to someone in her family or a trusted adult.	
What is sperm?	The cell from a man's body that can start a pregnancy.	

The Value Question

It is not possible, or desirable, to provide value-free education. Questions that have a value component must be answered with care—expressing your own personal values might hurt or offend a child and their family. However with **UNIVERSAL** values, it is appropriate and important for you to state your opinion. Universal values are those shared by 95 percent of families that the teacher should feel comfortable, and is in fact OBLIGATED, to teach.

Examples of Relatively **UNIVERSAL** Values

- Forcing someone to have sex with you is wrong
- Knowingly spreading disease is wrong
- It's safest and healthiest for school-age kids not to have sex (this is NOT controversial, what IS controversial is when it's fine to have sex)
- Taking care of your reproductive health is important
- Sex between children and adults is wrong
- Adultery is wrong

However, there are some values that are controversial. These are values that are often hotly debated and have a clear range of beliefs associated with them. Examples of potential **CONTROVERSIAL** values:

- Abortion
- Birth control
- Masturbation
- Homosexuality
- Sex outside of marriage
- Cohabitation
- What age/under what circumstances it's okay to start having sex

If you are sharing this question answering protocol with parents, let them know that, unlike teachers, parents **should** ask their children about their beliefs and share theirs/their families. In fact, this sort of dialogue within families is very important. Employees of public schools and other public agencies have an ethical obligation ***not*** to side with one family or one religious perspective or one child over another. But children absolutely need a chance—at home—to explore feelings and beliefs with adults they love, just as they need a chance to learn factual information and to have universal, community values reinforced at school.

However, just because it's inappropriate in a public school setting to teach **particular values** on controversial issues, that does ***not*** mean one can't teach ***about*** the issues. It just means that it must be done with respect for the diversity of opinion within your community. For example, you can discuss abortion—what it is, the fact that it is legal in this country, where abortions are performed, etc., but it is not appropriate to share your beliefs about whether or not abortion is a correct choice.

When you determine a question is a values question, use the following protocol for answering:
F.L.A.S.H. Values Question Protocol

1. Read (or listen to the question).
2. Legitimize the question.
3. Identify it as a belief/values question.

4. Answer the factual part, if there is one.
5. Help the class describe the community's range of beliefs.
6. Refer to family, clergy, and other trusted adults.
7. Check to see if you answered the question.
8. Leave the door open.

You will eventually tailor your use of the protocol, only using ***every*** step the first time a controversial value comes up. For now, you should practice the protocol step by step—until it becomes a natural part of your teaching. In addition, the first three steps of the protocol can provide you valuable time to think clearly about your answer.

1. **Read the question**. Verbatim, if you can. Use your judgment, of course, but even reading aloud relatively crude language—as long as you do it with a serious tone and facial expression—conveys your respect for the child who asked the question. It is likely to promote respect in return. If the language is too crude to repeat, even with a red face and an explanation *("Someone used slang, but let me read it for you as they wrote it before I translate it."*), then don't read it directly. But when you paraphrase it, make sure you are clear enough that the author of the question will recognize it as his or hers.

2. **Legitimize the question:**

   "I am glad someone asked this one."
   "That's an interesting question."
   "People ask me this one every year."
   "This one is really thoughtful/compassionate/imaginative/respectful."

   This will encourage your students to keep asking even as it discourages snide remarks about whoever asked that particular question.

3. **Identify it as a belief question:**

   "Most of the questions you've been asking have been "fact questions" where I could look up an answer that all the experts agree upon. This one is more of a "value question" where every person, every family, every religion has a different belief."

   Teaching your students to distinguish facts from opinions (and from feelings) is at least as important as any content you will convey.

Answer the factual part, if there is one. Thus, for instance, if the question is about the rightness or wrongness of masturbation, you need to make sure that your class understands that—values notwithstanding—no physical harm results from masturbating:

> *"Before we get to differing beliefs about masturbation, let me just make sure you know it doesn't cause people to go blind or mentally ill or to grow hair on their palms or anything like that."*

Even questions that are apparently fact questions may need a discussion of the underlying values, but always start by answering them:

> *"Can you get birth control without your boyfriend or husband knowing? Yes, legally in our state, you can. Now let's talk about the different beliefs people might have about couple's communicating about birth control."*

4. **Help the class describe the community's range of beliefs, not their own.** On sensitive issues such as sex and religion, it can be really unfair to ask individual students their own beliefs. But it is very appropriate to generalize:

   "Tell me some of the things you've heard that people believe about that."
   Prompt the group with a stem sentence:

   "Some people believe ___?"
   "Um, hmm, and some people believe ___?"

   In a class that is used to thinking about the range of community values, you will be able to draw a full assortment of answers from the students. In other groups, especially younger ones, you may draw only a dichotomy ("Some people believe abortion is wrong." and "Some people believe it is right."). In any case, your role is two-fold: (1) to make sure that every belief gets expressed—or paraphrased—respectfully, hopefully just as the person who believed it might express it; and (2) to make sure that a complete a range of beliefs gets expressed, even if you have to supplement the few values the group can think of:

   "That's right; some people believe that it is wrong under any circumstances. And some believe it is right under any circumstances, as long as the woman and her doctor think its best. Some believe it is OK to have an abortion if you have been raped or if your life is in danger, but not otherwise. Some believe, it is OK to have an abortion if there's something seriously wrong with the fetus and it is doomed to a life of pain. Some think it is best for teens to have abortions, than to raise babies when they are still growing up themselves. Others disagree. Some feel it is better to have an abortion if you already have as many children as you can afford or take proper care of. Again, others disagree. They may feel that abortion is the same as murder. Whereas, some people think it is not really a separate human being with rights until it is developed enough to have feelings or until it is actually born."

5. **Refer to family, clergy, and other trusted adults.**

   "Because people have such different beliefs about this, I really want to encourage you to talk with your families—your parent or guardian, grandparent, auntie, uncle, stepparent, mom's or dad's partner—or with somebody at your community of worship, if you attend a church or synagogue or temple—or with some other adult you love and whose opinions matter to you. That could be your babysitter, your best friend's parent, a counselor, or whoever will listen to your opinions and honestly share theirs. Have a conversation within the next week if you can."

   Notice that this encouragement didn't assume that every child has a parent they can talk with. Some may be newly in a new foster home and don't yet have that kind of relationship with their new "parents." Also, notice that we shouldn't assume that every child goes to church.

   What if the family is likely to convey values that the child will feel hurt by (a teen who has come out to you as gay, for instance, but whose family is strongly opposed to homosexuality)? Still, knowing one's family's beliefs is developmentally important for young people. But help them think of other trusted adults, as well.

6. **Check to see if you answered the question.**

   "Is that what you were asking?"
   "Do y'all think that was what the person who wrote this question was asking?"

7. **Leave the door open.**

   "If that isn't what you really wanted to know, you can drop another question in the box. Or come talk with me in private. You can also get a friend to ask it aloud for you or to explain to me what you meant. Just keep asking until I understand and tell you what you need to know."

   Finally, if you can do it sincerely, thank the class—or in a one-on-one situation, the student—for their maturity or curiosity or compassion or whatever positive qualities the Q & A session has helped them to demonstrate. That will not only increase their retention, it will improve the odds of their repeating the positive behavior on the next occasion.

An Example

Q: I masturbate, is that ok?

A: That's a great question, a lot of kids wonder about masturbation. Masturbation is when a person strokes or touches their genitals for pleasure. I can't share my own beliefs about whether or not it's ok to masturbate because families have really different beliefs about masturbation. Some families believe its ok, as long as you're in a private place. Other families believe it's never ok. You need to check with your families, or another trusted adult to find out how they feel about it. Have I answered your question? If I didn't, you can leave another question in the box or you can talk to me after class.

The Slang Question

You have an obligation to convey, through tone and willingness to read most questions verbatim. This conveys your respect for the person asking the question and faith in his/her motives for asking the question. Slang questions may also be other types of questions. For example, someone may use slang terms but be asking a fact question (see example below). Trust your professional judgment and personal comfort as guides on whether or not you will read the question exactly as it was written.

1. Read the question verbatim (unless it makes you too, too uncomfortable? in which case, own your discomfort and reword the question, making sure it's still identifiable to its author).
2. Identify the slang as such, in a non-judgmental sort of way (unless it is derogatory, demeaning slang in which case identify it as a put-down whether it was meant to be or not).
3. Translate into medical/standard (or, in the case of demeaning slang, "more respectful/sensitive") language.
4. Write the medical/standard/respectful/sensitive term on the board.
5. Answer the question—if it's also a value question (for example, "Is it ok to jack off?"), use the value question protocol in addition to substituting the medically correct term.
6. Check to see if you answered the question.

Remember, language, including slang, isn't necessarily good or bad. It's important to have medical language as well as a soft, playful language. The advantages of reading the question verbatim, if at all possible (given boundaries of one's own discretion and comfort) include:

- Not confusing the author of the question
- Communicating your respect for the students and your trust in their sincerity and maturity
- Communicating that you are relatively unflappable and accepting
- Diffusing the need to try and shock you as the teacher.

Slang Question Examples

Q: How does a dick get big?

A: A lot of people wonder that. "Dick" is a slang term for penis (write "penis" on the board). The penis is full of blood vessels and veins. When the blood vessels and veins fill with blood, the penis gets harder and larger. That's called an erection. Another way a penis gets bigger is by slowly growing bigger as a boy's body grows to the size of a man's body. I hope I answered the question—if I didn't, please let me know or put another question in the box.

And an example of a slang question that can also be answered as a value question:

Q: What if you're a boy and you really like boys, does that make you a faggot?

A: That's a really interesting question. "Faggot" is a put-down word for a person that's a homosexual (write "homosexual" on the board). Other terms are "gay" if it's a man, or "lesbian" if it's a woman. A homosexual is someone who is attracted to and falls in love with people of the same sex. Many boys have really close friendships with other boys, and it doesn't mean they are gay. Families have really different beliefs about homosexuality. Some families believe you're born that way and that it's normal that some people are homosexuals. Other families believe that it's very wrong and not at all normal. You need to talk to your families about what they believe about homosexuality. Whatever your family believes, it's never acceptable to hurt or tease someone because you think they might be gay or lesbian.

The Question You Don't Understand

It's important to own your responsibility for not understanding (as opposed to blaming the author of the question). You have several options for these types of questions. Listed below are some of your options—they are in no particular order:

- Guess at the author's intended question and answer it using the appropriate protocol (value or slang). You may need to answer more than one possible question.
  or,
- Ask if anyone in the class knows what the person might have meant,
  or,
- Invite the author to drop another question in the question box, rephrasing what she/he meant.

Example of a question you don't understand (from a middle school ESL class):

Q: If you got zix do you fell sick?

A: I'm not sure I understand this student's question—I'm not always up to date on words students like to use! Does anyone know what this student might have meant? No? OK, I'll guess at what they might have meant. There are some illnesses that people can get where they don't feel sick. Some sexually transmitted diseases are that way—you might have one and not feel sick at all. If a person is having sex, they should get checked for sexually transmitted diseases at a clinic, even if they don't feel sick. I hope I answered this question—if I didn't, I hope whoever wrote it will try to reword it and put it in the box again.

The Question You Don't Know the Answer to

It's important to acknowledge your limits—admit you don't know! Remember to share with your class that even adults (teachers, doctors, journalists, etc.) don't know all there is to know about human sexuality. The "admission" you don't know is not a failure but a vital opportunity to model this concept. The skill of finding answers is more crucial than the answer itself, and one of the skills in the Health Education Standards. Depending on the amount of time you have, or technology resources available in your classroom, you could look the answer up together, assign it to a student who would like extra credit, or look it up on your own and report back to the class. Always follow through on a promise to bring the answer back to the class.

An example of a question you might not know the answer to:

Q: What causes PMS?

A: That's a great question, but I'm not sure I know the answer. PMS stands for premenstrual syndrome. It's the word for the symptoms some women feel before they get their periods—like being moody or sad. I know some doctors and scientists believe PMS is caused by hormone changes during a woman's menstrual cycle, but I'm not sure if anyone knows for sure. Does anyone in class know the answer? Would anyone be willing to do some research on PMS for extra credit? No? OK, I'll do some research and see what I can find out. I'll get back to you in the next few days.

The Personal Question

Whether to self-disclose is a decision that must be based on both professional judgment and professional comfort. You might feel comfortable disclosing that, for example, you have never had an abortion. But if the next day you decline to disclose, for example, whether or not you have ever masturbated, your students may interpret your refusal to answer as a "yes." It's usually safer **NOT** to self-disclose particularly in the area of human growth and development where disclosing can quickly become inappropriate and unprofessional. In addition, many personal questions are also values questions.

You can:

- Decline to self-disclose and explain why and hold this boundary consistently.
- Generalize when you answer the question—speak of what people do, instead of what you have done.

Example of a personal question (that's also a value question)

Q: How old were you when you first had sex?

A: I know a lot of kids wonder about decisions adults have made, but I'm not comfortable answering a personal question like this one in a large group. Remember our ground rule about protecting privacy? I'm going to protect mine on this issue. The decision about when to have sex for the first time is an important one and families have really different beliefs about when it should happen. Some families believe a person shouldn't have sex until they are married. Other families believe that if you're an adult and are done with school that it's OK. You need to talk to your families or another trusted adult to see what they believe.

Adapted by Lori Stern from King County Health Services. Updated April 2011. Downloaded on October 9, 2012 from:
http://www.kingcounty.gov/healthservices/health/personal/famplan/educators/diffques.aspx?print=1.

Chapter 7
Assessment of Curriculum

Assessing and Reviewing Your Human Growth and Development Curriculum

7

Overview

This section provides tools and guidance to utilize with Human Growth and Development Committees in the review and update of district HGD curricula. Although current statute does not require frequent or periodic review of HGD curricula, information typically covered in HGD does change often. To ensure medical accuracy, relevance, and most current information on sexual health, DPI encourages districts to review HGD instructional materials on a schedule similar to other curricular or content areas.

Scope and Sequence

A Scope and Sequence provides a description of the topics taught (scope) and the progression (sequence) for which the topics are introduced or reinforced at various grade levels. Local HGD advisory committee and program planners will determine the level of detail that will be most useful to them.

The content area standards included in Section 6 of this resource guide will help school districts and educators plan developmentally-appropriate HGD instruction.

Once the Human Growth and Development Committee determines the scope and sequence for HGD in the district, the next step is to review and assess current methods and materials utilized across the grade levels to ensure students meet competency at each level.

Review Instruments

A number of resources may serve as useful tools to assist with the review process for curriculum, videos, and websites based on the factors discussed in the previous section. Three assessment tools are provided in this section for the overall review of the entire curriculum.

Resource 7.1: Tools to Assess the Characteristics of Effective Sex and STD/HIV Education Programs

This resource, created in 2007, is based on the 17 characteristics of effective HGD programs. The entire document can be downloaded from: http://recapp.etr.org/recapp/documents/programs/tac.pdf

"The important question is not how assessment is defined, but whether assessment information is used…"
—Palomba and Banta

Resource 7.2: Health Education Curriculum Assessment Tool—HECAT Revised

This analysis tool was developed by the Centers for Disease Control and Prevention. It covers all of the topics typical in comprehensive health education. The module included in this resource is for sexual health.

Resource 7.3 Wisconsin Standards for Health Education Curriculum Checklist

This assessment tool is based on the Wisconsin Standards. The standards are not specific to HGD or evidence-based programs to reduce adolescent sexual risk taking. However schools have found the questions helpful in assessing curricula.

Resource 7.4 Human Growth and Development Instructional Materials Review Form

This form is an assessment tool for individual resources or modules that may be considered for HGD instruction. Often schools are looking for a specific lesson or video to address a topic not already included in the health education text.

Resource 7.5: Human Growth and Development in Wisconsin Schools 118.019

This side-by-side document reflects topics required based on the revision of the HGD law in 2012. HGD committees can use this resource to ensure the scope and sequence contains all the required elements.

Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs

Based on

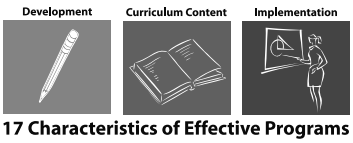
Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics

Developed by

Douglas Kirby, PhD
Lori A. Rolleri, MSW, MPH
Mary Martha Wilson, MA

February 2007

Healthy Teen Network
MAKING A DIFFERENCE IN THE LIVES OF TEENS AND YOUNG FAMILIES

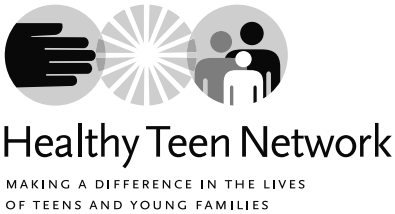


17 Characteristics of Effective Programs

ETR Associates

This document was funded in part by a grant from the Division of Reproductive Health at the Centers for Disease Control and Prevention: #U58/CCU324964.

Healthy Teen Network



Healthy Teen Network (HTN) is a national membership network founded on the belief that youth can make responsible decisions about their sexuality and reproductive health when they have complete, accurate and culturally relevant information, skills, resources and support. Located in Washington, D.C., HTN has been making a difference in the lives of teens and young families since its founding in 1979. HTN is the only national membership network that serves as a leader, a national voice, and a comprehensive educational resource to professionals working in the area of adolescent reproductive health — specifically teen pregnancy prevention, teen pregnancy, teen parenting and related issues. HTN is uniquely able to have an impact on a large number of teens and young families because of its comprehensive approach and its direct and immediate links to a grassroots network of reproductive health care professionals throughout our nation's communities.

For more information about HTN, visit: http://www.healthyteennetwork.org.

ETR Associates

ETR Associates (Education, Training and Research Associates), established in 1981, is a national, nonprofit organization whose mission is to enhance the well-being of individuals, families and communities by providing leadership, educational resources, training and research in health promotion, with an emphasis on sexuality and health education. ETR's Program Services Division offers comprehensive services for the development, implementation, evaluation and dissemination of critical public health initiatives. The division works directly with community-based programs, state and local education agencies, health care providers, health educators and public health organizations. ETR's Publishing Division produces authoritative health education and health promotion resources that empower young people and adults to lead healthier lives. Thousands of ETR pamphlets, books and other materials are used in hundreds of health care settings, schools and workplaces across the United States and around the world.

For more information about ETR, visit: http://www.etr.org.

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ETR Senior Scientist Doug Kirby's steadfast commitment to discovering what works is well known in our field, and has been further demonstrated by the recent publication of the report he wrote with colleagues B.A. Laris and Lori Rolleri, *Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics*, upon which this tool is based. Doug has been readily available as writer, advisor and final editor throughout the production of this tool.

Since 2002, Healthy Teen Network has had the pleasure of working closely with ETR's Senior Program Manager, Lori Rolleri. We thank Lori for sharing her expertise so generously, and her clear vision for delivering research into the hands of practitioners who design, select, implement and evaluate programs. Lori has been the driving force behind the development of this tool.

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Mary Martha Wilson
Director of Training and Technical Assistance
Healthy Teen Network
February 2007

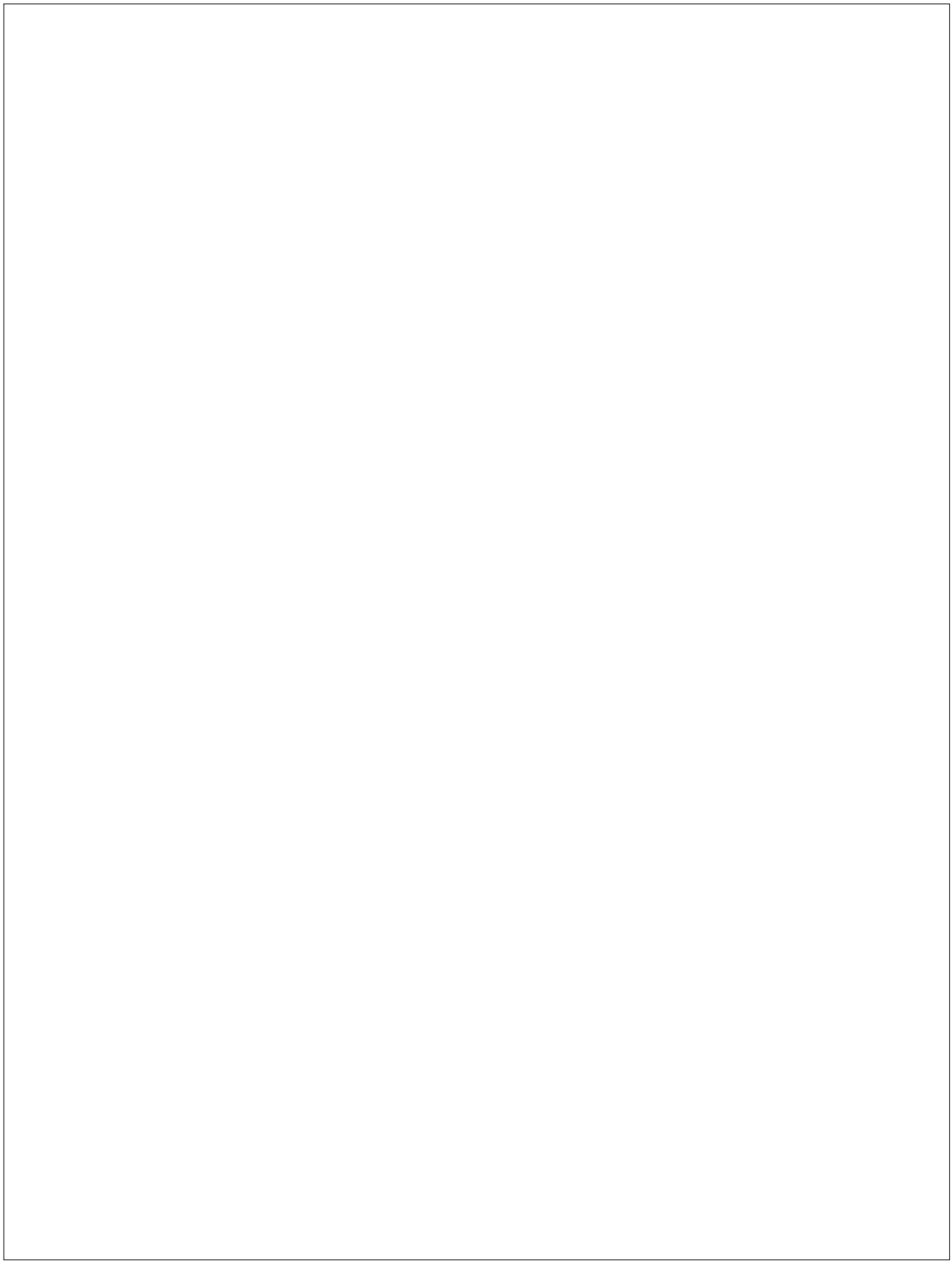

Table of Contents

Introduction

What Is the Rationale Behind the Tool to Assess Characteristics of Effective Sex and STD/HIV Education Programs (TAC)? 1

What Is the TAC? 1

How Were the Common Characteristics Identified? 2

How Is the TAC Organized? 3

Why Would You Use the TAC? 4

What Steps Should You Complete to Assess Existing Curricula? 6

Where Can You Get More Information? 8

17 Characteristics at a Glance 9

Category 1: The Process of Developing the Curriculum 11

Involved Multiple People with Different Backgrounds to Develop the Curriculum 12

Assessed Relevant Needs and Assets of Target Group 14

Used a Logic Model Approach 17

Designed Activities Consistent with Community Values and Available Resources 20

Pilot-Tested the Program 22

Category 2: The Contents of the Curriculum Itself 25

Focused Clearly on at Least One of Three Health Goals 26

Focused Narrowly on Specific Behaviors Leading to the Health Goals 28

Addressed Multiple Sexual Psychosocial Risk and Protective Factors 30

Created a Safe Social Environment for Youth to Participate 32

Included Multiple Activities to Change Targeted Risk and Protective Factors 34

Employed Instructionally Sound Teaching Methods 40

Employed Appropriate Activities, Methods and Messages 42

Covered Topics in a Logical Sequence 43

Category 3: The Implementation of the Curriculum 45

Secured at Least Minimal Support from Appropriate Authorities 46

Selected Educators with Desired Characteristics, Trained Them and Provided Support 47

If Needed, Implemented Activities to Recruit and Retain Youth 48

Implemented Virtually All Activities with Reasonable Fidelity 50

Characteristics Summary Table 51

Resources 57

17 Characteristics of Effective Sex and STD/HIV Education Programs 57

Compendia of Science-Based Programs and Curricula 57

Online Data Resources on Adolescent Reproductive Health 58

Conducting Focus Groups 59

Conducting Surveys 59

Logic Models 60

Risk and Protective Factors Related to Adolescent Sexual Risk-Taking 60

Health Education and Health Behavior Theory 60

Instructional Methods/Pedagogy 61

Program Fidelity and Adaptation 61

Other 61

Glossary 63

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Secured at Least Minimal Support from Appropriate Authorities 46

Selected Educators with Desired Characteristics, Trained Them and Provided Support 47

If Needed, Implemented Activities to Recruit and Retain Youth 48

Implemented Virtually All Activities with Reasonable Fidelity 50

Characteristics Summary Table 51

Resources 57

17 Characteristics of Effective Sex and STD/HIV Education Programs 57

Compendia of Science-Based Programs and Curricula 57

Online Data Resources on Adolescent Reproductive Health 58

Conducting Focus Groups 59

Conducting Surveys 59

Logic Models 60

Risk and Protective Factors Related to Adolescent Sexual Risk-Taking 60

Health Education and Health Behavior Theory 60

Instructional Methods/Pedagogy 61

Program Fidelity and Adaptation 61

Other 61

Glossary 63

How Were the Common Characteristics Identified?

In 2006, ETR's Senior Research Scientist, Douglas Kirby, PhD, and his colleagues, B.A. Laris, MPH, and Lori Rolleri, MSW, MPH, published a report titled *Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics*.[9] That report identified 17 common characteristics of programs found to be effective in changing behaviors that lead to STD, HIV and unintended pregnancy among young people.

To identify those characteristics, Kirby and his colleagues conducted a systematic review of 83 studies of HIV prevention and sex education programs from both the developed and developing world. All of the studies had to meet programmatic criteria (e.g., they had to be curriculum-based programs for young adults) and research criteria (e.g., they had to have a sound experimental or quasi-experimental research design.) Of the 83 studies that were reviewed, about two-thirds of them demonstrated positive behavior change. Thus, some programs were effective at changing behavior in a positive direction while others were not.

Kirby and his team then conducted a more in-depth analysis of the studies and their curricula to try to identify the distinguishing characteristics of effective programs. They first realized that there were important characteristics of effective curriculum-based programs that described the development of the curricula, the content of the curricula, and the implementation of the curricula. To identify the important characteristics of the process of developing the curricula and the important characteristics of implementing the curricula, they carefully reviewed the original studies and any other materials describing the development or implementation of the curricula that were effective. To identify the important characteristics of the content of the effective curricula themselves, Kirby and his colleagues conducted a rigorous in-depth content analysis of a sample of 19 of the effective curricula, especially those with the strongest evidence of positive impact. Across these three categories (development, content and implementation), they identified 17 important common characteristics of effective programs.

The first drafts of the report underwent review by multiple adolescent reproductive health (ARH) practitioners and researchers. During the review process, reviewers suggested that an assessment tool be created that would complement the report. The tool would guide ARH practitioners, program developers and evaluators in operationalizing each of the 17 characteristics as they select, modify, develop, implement and/or evaluate sex and HIV education curricula. This document is that tool.

While feedback from our reviewers was one force behind the creation of this tool, its development was also a natural extension of the work that Healthy Teen Network and ETR Associates had already been conducting. Since 2002, Healthy Teen Network, in partnership with ETR Associates, has received funding from the Centers for Disease Control and Prevention to build the capacity of state adolescent pregnancy prevention (APP) coalitions to implement science-based programs and practices. This tool became part of the training on the 17 characteristics.

In addition to training coalitions on how to apply the 17 characteristics to their work, the team has developed and delivered other capacity-building activities that support science-based practice. Examples of these activities include training on the development of logic models, program evaluation basics, effective pregnancy and HIV prevention programs, program fidelity and adaptation, and using research to improve practice.

9. Through a grant from US AID, Family Health International funded the research and writing of this report. The full report can be downloaded from several websites, including ETR's website at: www.etr.org/recapp and HTN's website at: www.healthyteennetwork.org.

Healthy Teen Network and ETR Associates are pleased to present the *Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs.* Our hope is that it will help you select, improve, develop and implement effective pregnancy and STD prevention programs for the youth you serve in your communities.

How Is the TAC organized?

The *Tool to Assess Characteristics* is divided into six sections. The first three sections describe the three categories of characteristics of effective programs:

Section 1: Category 1 — Characteristics describing the process of developing the effective curricula. Examples include the backgrounds of the program developers, their assessments of their priority groups, their logical approaches to developing activities, and their pilot-testing of the programs.

Section 2: Category 2 — Characteristics describing the contents of effective curricula. Examples include the characteristics of effective programs' goals and objectives, their behavioral messages, their activities and their teaching methods.

Section 3: Category 3 — Characteristics describing the process of implementing the curricula. Examples include securing community support, selecting and training educators, recruiting youth, and implementing the curriculum with fidelity in the settings for which it was designed.

These three categories of characteristics are followed by:

Section 4: A **Characteristics Summary Table** to help you record ideas and action steps for improving the written curriculum.

Section 5: A list of potentially useful **Resources** to help you strengthen some of the characteristics.

Section 6: A **Glossary** to help you better understand some of the concepts in this tool.

Why Would You Use the TAC?

Although the TAC is designed primarily to help you select effective programs, it can also be used to help you do all of the following:

1) To *assess* curricula and to select one that is likely to be effective at changing behavior in your community.
2) To *adapt* a selected curriculum so that it better matches the needs and resources of your own community.
3) To *develop* from scratch a new effective curriculum for your community.
4) To *implement* a curriculum more effectively in your own community.

1 **To assess curricula and to select one that is likely to be effective at changing behavior.** If you are selecting existing curricula to be implemented in your community, your most promising approach is to review those curricula that have previously been demonstrated to be effective with populations of youth similar to your own and that match the needs and resources of your community and then to select one. When you do this, you should make sure that you can implement your selected curriculum as designed and in the settings in which it was originally successfully evaluated.

You may find multiple curricula with evidence of impact that you can implement. When this occurs, you can use the TAC to assess which are most likely to have the greatest impact on behavior, especially with the youth in your own community.

Or you may not find *any* existing curricula that have evidence of impact that match your needs and resources and that you can implement with fidelity in similar settings. Curricula previously demonstrated to be effective may not match the needs of the youth in your community, may not match the setting where you can implement programs, may not fit within your staff capabilities and resource limitations, may not match community values, or may not be appropriate for your youth, your community or your organization for other reasons.

When any of these problems occur, your second most promising approach is to review the larger number of existing curricula that have not been evaluated and found to be effective, but that may incorporate the characteristics of effective curricula and therefore may be very likely to have a positive impact on one or more sexual behaviors.

This TAC is designed to help you select, possibly adapt if necessary, and then implement a curriculum that incorporates the characteristics of effective programs.

In general, the more characteristics in Categories 1 and 2 (development and content) that a curriculum incorporates and the more characteristics in Category 3 (implementation) that you incorporate into your implementation, the more likely it is that your program will reduce adolescent sexual risk-taking. Indeed, programs that incorporate all these characteristics are quite likely to reduce sexual risk-taking.

However, a caution is also in order. The world is complex, and many factors affect the effectiveness of a curriculum. Thus, even if a curriculum incorporates all the characteristics in the first two categories, it may not always change behavior. Therefore, we can only say that a curriculum with

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1 **To assess curricula and to select one that is likely to be effective at changing behavior.** If you are selecting existing curricula to be implemented in your community, your most promising approach is to review those curricula that have previously been demonstrated to be effective with populations of youth similar to your own and that match the needs and resources of your community and then to select one. When you do this, you should make sure that you can implement your selected curriculum as designed and in the settings in which it was originally successfully evaluated.

You may find multiple curricula with evidence of impact that you can implement. When this occurs, you can use the TAC to assess which are most likely to have the greatest impact on behavior, especially with the youth in your own community.

Or you may not find *any* existing curricula that have evidence of impact that match your needs and resources and that you can implement with fidelity in similar settings. Curricula previously demonstrated to be effective may not match the needs of the youth in your community, may not match the setting where you can implement programs, may not fit within your staff capabilities and resource limitations, may not match community values, or may not be appropriate for your youth, your community or your organization for other reasons.

When any of these problems occur, your second most promising approach is to review the larger number of existing curricula that have not been evaluated and found to be effective, but that may incorporate the characteristics of effective curricula and therefore may be very likely to have a positive impact on one or more sexual behaviors.

This TAC is designed to help you select, possibly adapt if necessary, and then implement a curriculum that incorporates the characteristics of effective programs.

In general, the more characteristics in Categories 1 and 2 (development and content) that a curriculum incorporates and the more characteristics in Category 3 (implementation) that you incorporate into your implementation, the more likely it is that your program will reduce adolescent sexual risk-taking. Indeed, programs that incorporate all these characteristics are quite likely to reduce sexual risk-taking.

However, a caution is also in order. The world is complex, and many factors affect the effectiveness of a curriculum. Thus, even if a curriculum incorporates all the characteristics in the first two categories, it may not always change behavior. Therefore, we can only say that a curriculum with

2. Determine which behaviors need to be changed and can be changed. For example, should you focus more on delaying sex (to reduce pregnancy and STD), reducing the number of sexual partners (to reduce STD), increasing condom use (to reduce STD and pregnancy), increasing other contraceptive use (to reduce pregnancy) or increasing STD testing and treatment (to reduce STD), or some combination of the above.
3. Gather data or include people in your assessment who have current information about what percentage of youth are having sex at various ages and grade levels and what percentage of sexually active youth are using condoms and other forms of contraception. (You may use local survey data such as the Youth Risk Behavior Survey to assess these.)
4. Try to determine the factors, pressures, barriers, perceptions of risk, values, attitudes, norms, skills, access to condoms and other contraceptives, etc. that have important effects on sexual behavior and condom or other contraceptive use among youth in your community. (You might conduct surveys, review research and/or conduct focus groups with youth or professionals working with youth to better understand these.)
5. Assess your community's values and support for different types of interventions (e.g., school-based abstinence-only or comprehensive sex education programs).
6. Assess your community's resources that can be devoted to curriculum-based programs (e.g., assess staff time that can be devoted to this; relevant staff knowledge, interest and skills; facility space; available classroom time in schools; supplies; etc.). All of these factors limit which curricula activities can actually be implemented.

Fourth, become thoroughly familiar with each of the curricula you are assessing and, to the extent feasible, the process used to develop each. Gather and read information about:

1. The background of the individuals who developed the curricula.
2. The characteristics of the youth served in the original studies.
3. The goals of the original curricula, the behaviors they focused upon, and the mediating factors they addressed.
4. The processes they used for pilot-testing and revising drafts of the curricula.
5. AND, of course, the activities and other contents of the curricula themselves.

This information may be found in the curricula's introductions, journal articles or progress reports, or may be obtained by speaking directly with the program's developers.

Fifth, become familiar with the TAC. Read through the TAC first so that you are familiar with the three major categories of characteristics, the types of detailed questions asked within each characteristic, the summary table to record ideas and action steps, the resources and the glossary. Have a basic understanding of how it can be used. And be sure to make sufficient copies of the TAC so that you have one for each curriculum you are assessing.

Finally, begin actually using the TAC to assess curricula. Be sure to set aside sufficient time to complete this process. Do not assume that you can complete a TAC assessment in a couple of hours. Sometimes this is possible, but it may also take as long as a day to complete the TAC for a single curriculum. At the very least, it will take as long as it takes to read or scan the entire curriculum and assess it.

For each characteristic, one at a time, read or reread the appropriate sections of the curriculum, as needed, and:

1. **Read** the brief description of the characteristic in the TAC.
2. **Answer** each of the checklist questions in the TAC by checking "yes" or "no." (In general, the more questions under each characteristic you can answer positively, the more likely the curriculum incorporates that characteristic.)
3. **Summarize** your assessment of each characteristic by answering the questions in the shaded box that concludes each set of checklist questions. (The more characteristics incorporated into your program, the more likely it will change behavior.)
4. **Record** your answers to these questions in the **Characteristics Summary Table** on pages 51-55.

Finally, after you have completed assessing the appropriate characteristics for each curriculum, review your TAC summary table for each, consider your community's resources and values and the needs of your youth, and reach a conclusion about the most promising curriculum for your community.

Good luck with your assessment!

Where Can You Get More Information?

For more information about the 17 Characteristics of Effective HIV and Pregnancy Prevention Program or the TAC, contact:

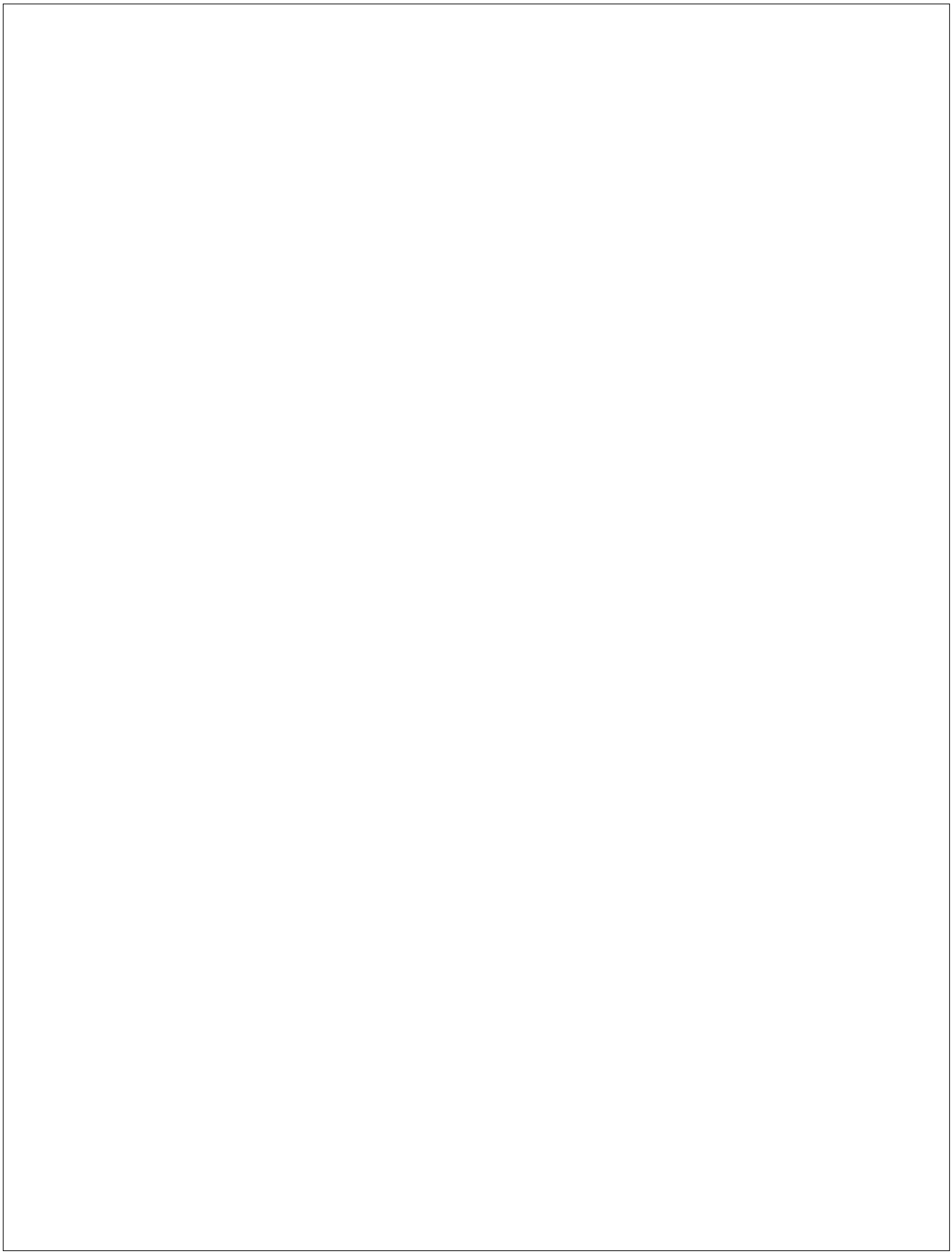
Lori A. Rolleri
ETR Associates
lorir@etr.org

Mary Martha Wilson
Healthy Teen Network
marymartha@healthyteennetwork.org

Douglas Kirby
ETR Associates
dougk@etr.org

The 17 Characteristics At a Glance

The Process of Developing the Curriculum	The Contents of the Curriculum Itself	The Implementation of the Curriculum
1. Involved multiple people with different backgrounds in theory, research and sex and STD/HIV education to develop the curriculum. 2. Assessed relevant needs and assets of target group. 3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors. 4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space and supplies). 5. Pilot-tested the program.	***Curriculum Goals and Objectives*** 6. Focused on clear health goals — the prevention of STD, HIV and/or pregnancy. 7. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them. 8. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms and self-efficacy). ***Activities and Teaching Methodologies*** 9. Created a safe social environment for youth to participate. 10. Included multiple activities to change each of the targeted risk and protective factors. 11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors. 12. Employed activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age and sexual experience. 13. Covered topics in a logical sequence.	14. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations. 15. Selected educators with desired characteristics (whenever possible), trained them, and provided monitoring, supervision and support. 16. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement (e.g., publicized the program, offered food or obtained consent). 17. Implemented virtually all activities with reasonable fidelity.



Category 1: The Process of Developing the Curriculum

Introduction

This category of characteristics is related to the process of developing an adolescent pregnancy or HIV prevention program or curriculum. Program development includes conceptualizing, researching, writing and pilot-testing a program. This category also includes the backgrounds and skills of the people involved in developing the curriculum, the tools they use, and the preparations they make.

Characteristics in Category 1

1. Involved multiple people with different backgrounds in theory, research and sex and STD/HIV education to develop the curriculum.

2. Assessed relevant needs and assets of target group.

3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors.

4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space and supplies).

5. Pilot-tested some or all of the activities.

READ

1. Involved multiple people with different backgrounds in theory, research and sex and STD/HIV education to develop the curriculum.

This characteristic refers to the team involved in conceptualizing, writing and evaluating the curriculum. A curriculum development team should include people with different backgrounds and expertise, especially in the areas of health behavior theory, adolescent sexual behavior and the risk and protective factors affecting that behavior, instructional design, cultural norms and evaluation. Each of these backgrounds typically plays an important role in creating an effective curriculum.

(It should be noted parenthetically that some of the questions asked below appear to be duplicative. However, typically the first question asks about the process of development used to produce the original curriculum, while the second question asks about your process for either assessing a curriculum that matches your community or your process for adapting a selected curriculum.)

ANSWER

Checklist:

YES	NO		
❑	❑	1.	Are you able to identify who was involved in developing the completed version of the program/curriculum and/or their backgrounds? If yes, continue with the following questions.
		2.	Does the curriculum development team have the following areas of expertise or background?

YES	NO	
❑	❑	Knowledge of theories of health behavior and how to change behavior
❑	❑	Knowledge of research on adolescent sexual behavior, and risk and protective factors affecting that behavior
❑	❑	Knowledge of theory of instructional design (e.g., how to increase knowledge, personalize this knowledge, change values and attitudes, change perception of peer norms and increase skills)
❑	❑	Knowledge of elements of good curriculum design
❑	❑	Experience teaching youth about sexual topics
❑	❑	Familiarity with the culture and values of the community for which the curriculum is written
❑	❑	Knowledge and experience pilot-testing curricula and conducting formative evaluation and impact evaluation

ANSWER

3. Does *your* curriculum assessment team have the following areas of expertise or background?

YES	NO	
❑	❑	Knowledge of theories of health behavior and how to change behavior
❑	❑	Knowledge of research on adolescent sexual behavior, and risk and protective factors affecting that behavior
❑	❑	Knowledge of theory of instructional design (e.g., how to increase knowledge, personalize this knowledge, change values and attitudes, change perception of peer norms, and increase skills)
❑	❑	Knowledge of elements of good curriculum design
❑	❑	Experience teaching youth about sexual topics
❑	❑	Familiarity with the culture and values of the community for which the curriculum is written
❑	❑	Knowledge and experience pilot-testing curricula and conducting formative evaluation and impact evaluation

SUMMARIZE

- To what extent did the process of developing the *original* curriculum involve multiple people with different backgrounds in theory, research and sex and STD/HIV education? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent does *your* process of selecting a curriculum involve multiple people with different backgrounds in theory, research and sex and STD/HIV education? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there ways to improve your involvement of multiple people with different back grounds in theory, research and sex and STD/HIV education? If so, what are some concrete steps you can take to involve more people with desired qualities? (Record your ideas on the Characteristics Summary Table.)

READ

2. Assessed relevant needs and assets of target group.

Assessing the population you intend to serve should provide concrete information about prevalent sexual behaviors and the risk and protective factors affecting those behaviors. More specifically, assessment data can help program developers understand what percentage of teens are having sex, at what grade level, and what their characteristics are. It may help them understand the reasons young people do or do not have sex. It may also help them understand what percentage of sexually active teens are using condoms or other contraceptives, the barriers they encounter to using condoms or contraception, and the other reasons young people do or do not use condoms or other forms of contraception.

Curriculum developers typically review quantitative pregnancy, STD and HIV data (e.g., national, state and/or preferably local pregnancy or birth rates), as well as other survey data on young adult sexual behavior (e.g., Youth Risk Behavior Surveillance data). They may also conduct focus groups or interviews with youth and/or the adults working with youth on reproductive health concerns.

Better understanding local behavior and factors affecting that behavior can guide program developers in creating the most effective programs that best "fit" the needs of the youth they want to serve in their own communities. The process of gaining this understanding may also increase the community's perceived legitimacy of the program.

ANSWER

Checklist:

YES	NO	
❑	❑	In general, were the needs and assets of the youth assessed in the original study?

Examples:

YES	NO	
❑	❑	Were data on teen pregnancy, birth or STD rates reviewed? Were these local data that adequately described the targeted youth?
❑	❑	Were survey data on teen sexual behavior and use of condoms and other contraceptives reviewed? Were these local data that adequately described the targeted youth?
❑	❑	Were focus groups conducted with groups of youth?
❑	❑	Were multiple groups conducted?
❑	❑	Were the youth in these focus groups representative of the target groups?
❑	❑	Were challenges in avoiding sex and using condoms or contraceptives discussed openly?

ANSWER

YES	NO	
❑	❑	Were interviews with adults who work with youth conducted?
❑	❑	Were interviews with multiple adults conducted?
❑	❑	Were these adults knowledgeable about the sexual behavior of the target youth and the reasons why they do or do not have sex or use condoms or contraception?
❑	❑	During the interviews, were the factors affecting sexual and condom/contraceptive behavior discussed?

YES **NO**
❑ ❑ In general, have *you* assessed the needs and assets of the youth you intend to serve?

Examples:

YES	NO	
❑	❑	Have you reviewed data on teen pregnancy, birth or STD rates? Were these data local data that adequately described your targeted youth?
❑	❑	Have you reviewed survey data on teen sexual behavior and use of condoms and other contraceptives? Were these data local data that adequately described your targeted youth?
❑	❑	Have you conducted focus groups with youth?
❑	❑	Were multiple groups conducted?
❑	❑	Were the youth in these focus groups representative of your target groups?
❑	❑	Were challenges in avoiding sex and using condoms or contraceptives discussed openly?

YES **NO**
❑ ❑ In general, does the curriculum appear to address the key findings of the *original study's* needs assessment?

Examples:

YES	NO	
❑	❑	Are the health goals (e.g., reducing pregnancy or STD rates) consistent with the data?
❑	❑	Are the behavioral goals consistent with the survey data (e.g., are the appropriate emphases placed on delaying the initiation of sex, reducing the number of sexual partners or increasing condom or other contraceptive use)?

ANSWER

YES	NO	
❑	❑	Do the curriculum activities address the reasons that the targeted youth do or do not have unwanted sex or do or do not use condoms or contraception?

YES	NO	
❑	❑	In general, does the curriculum appear to match the key findings of your needs assessment?

Examples:

YES	NO	
❑	❑	Are the health goals (e.g., reducing pregnancy or STD rates) consistent with the data from your community?
❑	❑	Are the behavioral goals consistent with your survey data (e.g., are the appropriate emphases placed on delaying the initiation of sex, reducing the number of sexual partners or increasing condom or other contraceptive use)?
❑	❑	Do the curriculum activities address the reasons that the youth in your community do or do not have unwanted sex or do or do not use condoms or contraception?

SUMMARIZE

- To what extent was the *original* curriculum based on an assessment of relevant needs and assets of the youth? (Circle your score below and then record it on the Characteristics Summary Table)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent does *your* process of selecting a curriculum lack or include the assessment of relevant needs and assets of your target group? How closely does the assessment information from the original study match your assessment of your priority population? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

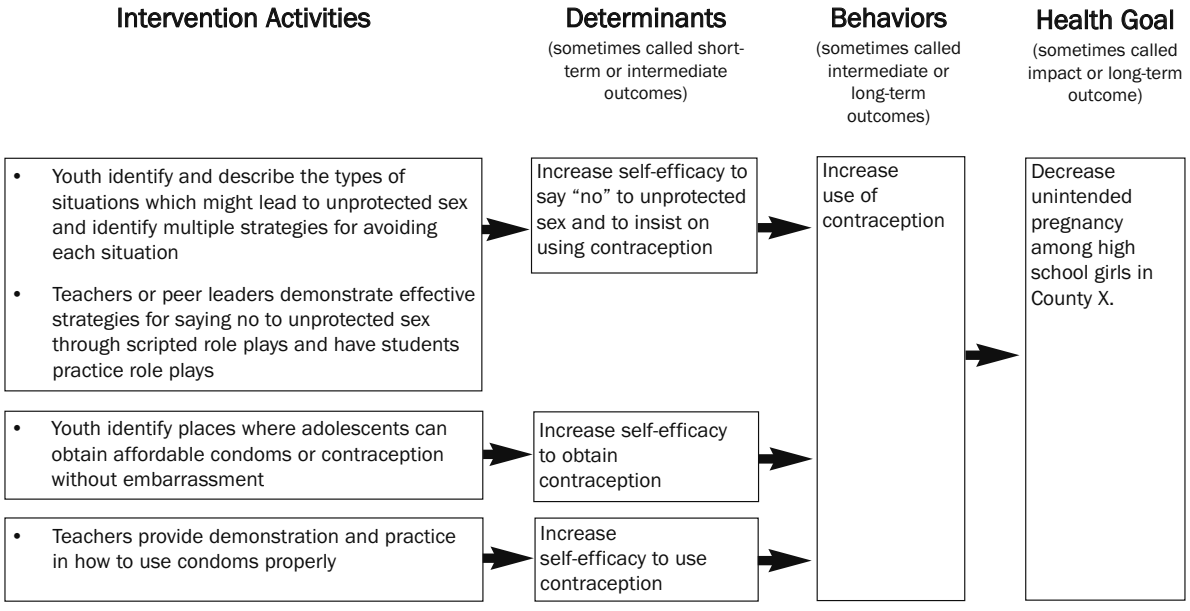
- If you need to find out more information about your own population, what concrete steps can you take? (Record your ideas on the Characteristics Summary Table.)

READ

3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors.

A logic model is a tool used by program developers to plan and design a program. A well-designed logic model will show the clear links between a health goal, the behaviors directly affecting that goal, the determinants of those behaviors, and the intervention activities that will change those determinants. Sometimes effective curriculum developers specify "short-term," "intermediate" and "long-term" effects, instead of determinants and behaviors.

Effective curriculum developers may or may not consciously develop a formal logic model. However, their discussion of the development of the curriculum, their use of theory, and their measurement of both sexual and contraceptive behaviors and the determinants affecting those behaviors all suggest that they identified the four components of a logic model described above. A logic model approach compels program designers to use theory, research and professional experience to identify those risk and protective factors that affect behavior, and to link activities to those factors. Sometimes the program's logic model is clearly described in the introductory pages, other times it may require consulting the published papers on the program/curriculum. Below is an example of *part* of a logic model.



READ

Recommendation:

If you are reviewing a completed curriculum, we strongly recommend that you first complete an assessment of characteristics 6, 7, 8 and 10 before completing an assessment of characteristic 3 below. The assessment for characteristic 3 will be much easier and more obvious after you first think about characteristics 6, 7, 8 and 10.

If you are developing a new curriculum, you will need to develop your logic model in this phase.

ANSWER

Checklist:

YES	NO	
❑	❑	Does the completed curriculum appear to have used a logic model or other program planning framework?
❑	❑	Does that logic model match a plausible logic model for youth in *your* community?
❑	❑	Is the **health goal** of the program (e.g., reducing teen pregnancy or STD rates) clear and easily identifiable?
❑	❑	Does it match *your* health goal?
❑	❑	Are the important **behaviors** that lead to HIV, STD or pregnancy easily identifiable (e.g., using condoms, abstaining from sex, etc.)?
❑	❑	Do they match the behaviors that you should change among youth in *your* community?
❑	❑	Are specific **risk and protective factors** that lead to these behaviors easily identifiable (e.g., knowledge about condoms, attitudes about abstinence, etc.)?
❑	❑	Do they match the risk and protective factors that you should change among youth in *your* community?
❑	❑	Are the **intervention activities** directly linked to the identified risk and protective factors?
❑	❑	Does the curriculum identify a particular theory or theories (e.g., social learning theory) that it uses as a foundation for specifying the determinants (or mediating factors) and changing sexual behavior?

SUMMARIZE

- To what extent was the *original* curriculum based on a logic model with the qualities specified above? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Does the logic model match the needs of your priority population? In what ways could you improve the logic model for your program to better match the needs of your youth? What concrete steps could you take? (Record your ideas on the Characteristics Summary Table.)

READ

4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space and supplies).

This characteristic emphasizes the importance of both community values and organizational resources in the development of programs. Community values may include beliefs and opinions about abstinence and the teaching of contraceptives among young people. Organizational resources may include the expertise of staff, available equipment, funding, etc. While this characteristic may seem obvious, there are numerous examples of curricula that could not be or were not fully implemented because they were not consistent with community values and resources, and consequently were not effective.

ANSWER

Checklist:

YES	NO	
❑	❑	Did you assess values in your community in some way? For example, can you describe local policies and prevailing attitudes about abstinence and the teaching of condom or other contraceptive use among adolescents?
❑	❑	Does the curriculum reflect sexual values consistent with those in your community?
❑	❑	Are the resources required by the curriculum available at your organization? For example, does your organization have the following resources in place?

YES	NO	
❑	❑	Trained and available staff
❑	❑	Adequate staff time
❑	❑	Safe and comfortable facility for implementing the curriculum
❑	❑	Supplies (e.g., videos and video equipment, photocopies, markers, flipchart paper, snacks for youth, etc.)
❑	❑	Transportation for youth (if needed)
❑	❑	Other: _____

SUMMARIZE

- To what extent does *your* process of selecting a curriculum involve an assessment of your community's values and available resources? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent does this curriculum match your community's values and available resources? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Do you need to find out more information about either your community's values or available resources? What concrete steps could you take? (Record your ideas on the Characteristics Summary Table.)

READ

5. Pilot-tested the program.

This characteristic is sometimes overlooked, and yet may be vital to the success of the program. Pilot-testing the program allows for adjustments to be made to any program component before formal implementation. This gives program developers an opportunity to fine-tune the program and discover important and needed changes. For example, they may change a scenario in a role play to make it more appropriate, or change wording in a role play so that it is more familiar or understandable to the program participants. Again, a description of pilot-testing may be in the program manual, or you may have to consult other published documents about the program.

ANSWER

Checklist:

YES	NO	
❑	❑	Was the curriculum pilot-tested with youth in the original study?
❑	❑	Was the curriculum pilot-tested with youth similar to the youth you plan to serve?
❑	❑	Have you or can you pilot-test the curriculum with youth you plan to serve in your community before you implement the curriculum broadly?
❑	❑	Were participating youth in the original study questioned about how well they liked individual activities, how they interpreted those activities, what they got out of activity, and how the activities could be made better?
❑	❑	Were participating youth in your pilot-test questioned about how well they liked individual activities, how they interpreted those activities, what they got out of activity, and how the activities could be made better?
❑	❑	Were modifications and improvements made after the pilot-testing in the original study?
❑	❑	Can modifications and improvements be made after your pilot-testing without significantly changing the curriculum and potentially reducing its impact?

READ

5. Pilot-tested the program.

This characteristic is sometimes overlooked, and yet may be vital to the success of the program. Pilot-testing the program allows for adjustments to be made to any program component before formal implementation. This gives program developers an opportunity to fine-tune the program and discover important and needed changes. For example, they may change a scenario in a role play to make it more appropriate, or change wording in a role play so that it is more familiar or understandable to the program participants. Again, a description of pilot-testing may be in the program manual, or you may have to consult other published documents about the program.

ANSWER

Checklist:

YES	NO	
❑	❑	Was the curriculum pilot-tested with youth in the original study?
❑	❑	Was the curriculum pilot-tested with youth similar to the youth you plan to serve?
❑	❑	Have you or can you pilot-test the curriculum with youth you plan to serve in your community before you implement the curriculum broadly?
❑	❑	Were participating youth in the original study questioned about how well they liked individual activities, how they interpreted those activities, what they got out of activity, and how the activities could be made better?
❑	❑	Were participating youth in your pilot-test questioned about how well they liked individual activities, how they interpreted those activities, what they got out of activity, and how the activities could be made better?
❑	❑	Were modifications and improvements made after the pilot-testing in the original study?
❑	❑	Can modifications and improvements be made after your pilot-testing without significantly changing the curriculum and potentially reducing its impact?

Category 2:
The Contents of the Curriculum Itself

Introduction

The characteristics in this category describe the actual curriculum contents, including the important goals and objectives, actual activities, teaching strategies, etc. This category includes the largest number of characteristics (eight) and several of them have multiple assessment steps.

The eight characteristics are divided into two sections: (1) curriculum goals and objectives, and (2) activities and teaching methods.

Characteristics of Category 2

Curriculum Goals and Objectives

6. Focused on clear health goals — the prevention of STD, HIV and/or pregnancy.
7. Focused narrowly on specific behaviors leading to these health goals, gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them.
8. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy).

Activities and Teaching Methodologies

9. Created a safe social environment for youth to participate.
10. Included multiple activities to change each of the targeted risk and protective factors.
11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors.
12. Employed activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age and sexual experience.
13. Covered topics in a logical sequence.

READ

6. Focused clearly on at least one of three health goals — the prevention of STD, HIV and/or pregnancy.

The most effective programs in reducing pregnancy and or STD/HIV are all clearly focused on at least one of these three health goals. They give clear messages about these health goals, namely that, if young people have unprotected sex, they are more likely to contract HIV or another STD or to become pregnant (or cause a pregnancy) and that there are negative consequences associated with these outcomes. In the process of communicating these messages, they strive to motivate young people to want to avoid STD and unintended pregnancy.

(It should be noted parenthetically that some youth development programs do not focus on any of these goals but have still reduced sexual risk-taking or pregnancy. However, they take a completely different approach to reducing sexual risk-taking, were not the focus of the review by Kirby and his colleagues, and, thus, are not the focus of this tool.)

ANSWER

Checklist:

YES	NO	
❑	❑	Does the program clearly address one or more of the health goals listed above? Which one(s)?
❑	❑	Does it include the health goal(s) for youth in *your* community?
❑	❑	Do the majority of lessons, activities, facts, etc., appear to support this goal(s)?
❑	❑	Does the curriculum clearly inform young people about their chances of contracting STD and/or becoming pregnant (or getting someone pregnant)?
❑	❑	Does the curriculum clearly inform young people about the negative consequences associated with STD, HIV and/or unintended pregnancy?
❑	❑	Does the curriculum include activities that motivate young people to want to avoid STD, HIV and/or unintended pregnancy?

SUMMARIZE

- To what extent does the curriculum focus clearly on one of three reproductive health goals? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent do the goals of the curriculum match the reproductive health goals for youth in *your* community? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there other ways to improve the reproductive health goals of the curriculum? If so, what are some concrete steps you can take to improve them? (Record your ideas on the Characteristics Summary Table.)

READ

7. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them.

As noted above, effective programs focus on at least one of three health goals identified in the previous characteristic. Once a health goal is selected for the program, developers then identify very specific behaviors that led directly to the health goal. For example, specific behaviors that reduce the chances of pregnancy and/or STD include: (1) avoidance of sex (abstinence), (2) reduction in the frequency of sex, (3) reduction in the number of sexual partners and (4) correct and consistent use of condoms and/or other forms of contraception. Changing these behaviors is an effective approach to reaching the health goal.

In contrast, other behaviors, such as substance use, may indirectly affect pregnancy or STD by affecting one or more of these sexual behaviors, which, in turn, affect pregnancy or STD, but they do not directly affect pregnancy or STD.

ANSWER

Checklist:

YES	NO	
❑	❑	Does the curriculum clearly focus on one or more specific behaviors that directly affect pregnancy or STD/HIV?

YES	NO	
		STD/HIV prevention programs:
❑	❑	Abstinence
❑	❑	Frequency of sex
❑	❑	Number of partners
❑	❑	Condom use
❑	❑	STD testing & treatment
❑	❑	HIV testing & treatment
		Pregnancy prevention programs:
❑	❑	Abstinence
❑	❑	Frequency of sex
❑	❑	Contraceptive use

ANSWER

YES	NO	
❑	❑	Do the behaviors that the curriculum focuses on match the behaviors that can and should be changed among youth in *your* community?
❑	❑	Does the curriculum give a clear message about which behaviors to engage in and which not to engage in? For example, if the health goal of a curriculum was to reduce STD/HIV, did it repeatedly emphasize clearly that abstinence is the safest method of avoiding HIV, but that if youth have sex, they should use a condom correctly every time they have sex?
❑	❑	Does the curriculum link this clear message about behavior with other important values among youth? For example, does it emphasize that avoiding sex or always using a condom is the "responsible" thing to do? Or does it state that youth should avoid unwanted sex and "respect themselves"?
❑	❑	Are these messages appropriate to the age, sexual experience, family and community values, and culture of the youth for whom the curriculum is intended?
❑	❑	Are these messages appropriate to the age, sexual experience, family and community values, and culture of the youth in *your* community?
❑	❑	Does the curriculum identify specific situations or specify a process for identifying specific situations that may lead to unwanted sex or unprotected sex and how to avoid them or get out of them?
❑	❑	Is the process for identifying specific situations or actual situations appropriate for youth in *your* community?

SUMMARIZE

- To what extent does the curriculum focus narrowly on the specific behaviors leading toward your reproductive health goals? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent do the specified behaviors of the curriculum match the behaviors that can and should be changed in *your* community to achieve your reproductive health goals? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there other ways to improve the behaviors targeted by the curriculum so that it better matches the behavioral change needed by your population? If so, what are some concrete steps you can take to improve them? (Record your ideas on the Characteristics Summary Table.)

READ

8. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms and self-efficacy).

Effective programs identify and focus on specific psychosocial risk and protective factors and design multiple activities to address those specific factors. The factors included in the checklist below had at least two qualities. First, of those studies that changed one or more sexual behaviors and measured their impact on these factors, at least half successfully changed these factors. Second, multiple studies have demonstrated that these factors are related to one or more sexual behaviors related to pregnancy or STD/HIV.

Few curricula consciously addressed all of these factors, but, logically, the more factors that a curriculum addresses well, the more likely it is that it will change behavior.

ANSWER

Checklist:

YES	NO	
❑	❑	Does the curriculum address multiple sexual psychosocial risk and protective factors affecting sexual behaviors? (While it is ideal if a curriculum addresses all of the factors listed below, not all effective curricula must address all of them.)

YES	NO	
❑	❑	Knowledge, including knowledge of sexual issues, HIV, other STD, and pregnancy (including methods of prevention)
❑	❑	Perception of HIV risk
❑	❑	Personal values about sex and abstinence
❑	❑	Attitudes toward condoms (including perceived barriers to their use)
❑	❑	Perception of peer norms about sex and perception of peer sexual behavior
❑	❑	Self-efficacy to refuse sex and to use condoms
❑	❑	Intention to abstain from sex or to restrict frequency of sex or number of sexual partners
❑	❑	Communication with parents or other adults about sex, condoms or contraception

ANSWER

YES	NO	
❑	❑	Self-efficacy to avoid STD/HIV risk and risk behaviors
❑	❑	Actual avoidance of places and situations that might lead to sex
❑	❑	Intention to use a condom
❑	❑	Other?_____
❑	❑	Other?_____

YES	NO	
❑	❑	Are these risk and protective factors important factors affecting sexual behavior among youth in *your* community?
❑	❑	Was the curriculum effective at positively affecting these factors?

SUMMARIZE

- To what extent does the curriculum address multiple sexual psychosocial risk and protective factors? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent do the risk and protective factors targeted in the curriculum match the risk and protective factors of youth that can and should be targeted in *your* community? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there other ways to improve the risk and protective factors addressed by the curriculum so that it better matches your population? If so, what are some concrete steps you can take to improve them? (Record your ideas on the Characteristics Summary Table.)

READ

9. Created a safe social environment for youth to participate.

Creating a safe social environment allows youth to participate more fully in program activities in a respectful and open manner, allowing for individual differences and preferences. If the social environment does not feel safe to participants, they are much less likely to actively participate, to express their views, to ask questions or to internalize some of the important programmatic messages.

To create a safe social environment, a program may need to spend sufficient time at the beginning for introductions and for the establishment of groundrules for participation, and throughout the curriculum for positive reinforcement and feedback.

ANSWER

Checklist:

YES	NO	
❑	❑	Does the curriculum establish group groundrules at its beginning (e.g., one person talks at a time, no put-downs, what is said in the room stays in the room, etc.)?
❑	❑	If necessary, does the curriculum use icebreakers or other activities to ease students into discussion/involvement?
❑	❑	Does the curriculum provide adequate opportunities for all youth to participate?
❑	❑	Does the curriculum encourage facilitators to praise youth and provide positive reinforcement when appropriate?
❑	❑	Does the curriculum provide tips or recommendations for classroom management?
❑	❑	If needed and appropriate, does the curriculum divide students by gender so that they are more comfortable discussing some topics?
❑	❑	Will these groundrules and activities be sufficient to assure comfort among youth in *your* community?

SUMMARIZE

- To what extent do the curriculum activities create a safe social environment? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent will these groundrules and activities be sufficient to create a safe social environment for youth in *your* community? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there other ways to improve the social environment of the students? If so, what are some concrete steps you can take to improve it? (Record your ideas on the Characteristics Summary Table.)

READ

10. Included multiple activities to change each of the targeted risk and protective factors.

In order to change the selected risk and protective factors that influence the participants' behavior, effective programs incorporate multiple activities to change each factor. Often individual activities are linked to specific factors; other times they address multiple factors.

The checklist below is organized into six sections (A-F), with each section representing an important category of risk or protective factors. Each section guides you in thinking about specific activities related to changing these risk and protective factors.

ANSWER

Checklist:

A. Basic information about risks of having sex and methods to avoid sex or use protection

Does the curriculum provide information about:

YES	NO	
❑	❑	STD transmission (including HIV)?
❑	❑	Susceptibility to contracting STD?
❑	❑	Symptoms of STD?
❑	❑	Consequences of STD
❑	❑	Ways to prevent STD (including effectiveness of abstinence and condoms and correct use of condoms)
❑	❑	Testing and treatment of STD
❑	❑	Common myths about STD
❑	❑	The probability of becoming pregnant or causing a pregnancy if sexually active
❑	❑	Consequences of unintended pregnancy?
❑	❑	Contraceptive methods, their effectiveness, and how they work?
❑	❑	Local resources for obtaining condoms, contraceptives and HIV/STD testing
❑	❑	Common myths about pregnancy?
❑	❑	Is the information medically accurate?

ANSWER

YES	NO	
❑	❑	Do curriculum activities help participants apply this information to their own lives?
❑	❑	Does this information match the knowledge needed by youth in *your* community?
❑	❑	Are there ways to improve the curriculum regarding this section? How? _____

B. Perceptions of risk, including susceptibility of risk and severity of risk

YES	NO	
❑	❑	Does the curriculum focus on the chances of contracting HIV, STD and/or pregnancy?
❑	❑	Does the curriculum focus on the consequences of contracting HIV, STD and/or pregnancy?
❑	❑	Does the curriculum provide prevalence data on youth similar to the youth being served?
❑	❑	Does the curriculum include videos with true stories of young people like themselves contracting STD or HIV or becoming pregnant?
❑	❑	Does the curriculum include simulations demonstrating how STD spreads easily or how easily people become pregnant over time if they have unprotected sex?
❑	❑	Does the curriculum provide opportunities to assess personal risk and how HIV, STD and/or unintended pregnancy would affect them?
❑	❑	Does the curriculum focus on the risks that are particularly important among youth in *your* community?
❑	❑	Are there ways to improve the curriculum regarding this section? How? _____

C. Personal values about having sex or premarital sex and perceptions of peer norms about having sex

❑	❑	Does the curriculum repeatedly emphasize that abstinence is the safest method of avoiding pregnancy or STD?
❑	❑	Is this an appropriate message for the youth you are reaching in *your* community?
❑	❑	Does the curriculum discuss the advantages of abstaining from sex?

ANSWER

YES	NO	
❑	❑	Does the curriculum discuss ways to show someone you care about him/her without having sex?
❑	❑	Does the curriculum include activities, such as surveys of their peers, demonstrating that their peers believe that abstinence is their best choice
❑	❑	Do youth in *your* community believe abstinence is their best choice? Will activities like these be effective in *your* community?
❑	❑	Does the curriculum include activities in which youth reinforce peer norms about not having sex (e.g., by identifying lines that peers use to get someone to have sex and then generate responses to those lines to avoid unwanted sex)?
❑	❑	Does the curriculum discuss common situations that might lead to sex and how to avoid these situations?
❑	❑	Does the curriculum discuss common situations that might lead to sex in *your* community?
❑	❑	Does the curriculum address pressures and other reasons that youth give for having unwanted or unintended sex?
❑	❑	Does the curriculum address the pressures and other reasons that youth in your community give for having unwanted or unintended sex?
❑	❑	Are there ways to improve the curriculum regarding this section? How?_____

D. Individual attitudes and peer norms toward condoms and contraception

YES	NO	
❑	❑	Does the curriculum give a clear message about using condoms or contraception if having sex?
❑	❑	Is this an appropriate message for the youth you are reaching in *your* community?
❑	❑	Does the curriculum provide medically accurate information about the effectiveness of condoms and different methods of contraception?
❑	❑	Does the curriculum include activities, such as surveys of their peers, demonstrating that their peers believe they should use condoms or contraception if they do have sex?

ANSWER

YES	NO	
❑	❑	Do youth in *your* community actually support the use of condoms or contraception if they do have sex? Will activities like these be effective in *your* community?
❑	❑	Does the curriculum address the following attitudes towards condoms and contraception and perceived barriers to using condoms?

YES	NO	
❑	❑	Perceived effectiveness in preventing STD and pregnancy?
❑	❑	Difficulties obtaining and carrying condoms?
❑	❑	Embarrassment asking one's partner to use a condom?
❑	❑	The hassle of using a condom?
❑	❑	The loss of sensation while using a condom?

YES	NO	
❑	❑	Does the curriculum include activities in which youth reinforce peer norms about using condoms or contraception (e.g., by conducting roleplays in which participants insist on using condoms if having sex)?
❑	❑	Do these activities address the factors and reasons that youth in *your* community give for having sex without condoms or other contraceptives?
❑	❑	Are there ways to improve the curriculum regarding this section? How?_____

E. Both skills and self-efficacy to use those skills

Does the curriculum use role playing to teach the following skills:

YES	NO	
❑	❑	To refuse unwanted, unintended or unprotected sex?
❑	❑	To insist on using condoms or contraception?

Do these role playing activities:

YES	NO	
❑	❑	Describe the components of the skill?
❑	❑	Model the skill?
❑	❑	Provide multiple opportunities for individual practice of the skill?

ANSWER

YES	NO	
❑	❑	Provide feedback on the performance of the skill?
❑	❑	Start with easier scenarios that are fully scripted and move to more difficult scenarios that are not scripted?
❑	❑	Does the curriculum include activities to teach how to use condoms correctly and consistently?

Do these activities:

YES	NO	
❑	❑	Describe the components of the skill?
❑	❑	Model the skill?
❑	❑	Provide an opportunity to practice the skill?

YES	NO	
❑	❑	Did the curriculum discuss places where condoms or contraceptives could be obtained most easily and comfortably or include actual visits to sources of condoms or contraceptives?
❑	❑	Do these activities address the skills that youth in *your* community need to avoid unintended, unwanted or unprotected sex or to use condoms or other contraceptives?
❑	❑	Are there ways to improve the curriculum regarding this section? How? _____

F. Communication with parents or other adults

YES	NO	
❑	❑	Does the curriculum provide students with activities (e.g., home work assignments) that encourage them to communicate with their parents or other trusted adults about a topic related to the program?
❑	❑	Does the curriculum or broader program provide parents or other adults with information about adolescent sexual behavior, pregnancy, STD, including HIV, in their region, or other relevant information to help them communicate with their adolescents?
❑	❑	Do these activities match the needs and values of youth and parents in *your* community?
❑	❑	Are there ways to improve the curriculum regarding this section? How? _____

SUMMARIZE

- To what extent does the curriculum include multiple activities to change each of the targeted risk and protective factors? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent do these activities address the needed knowledge, values, attitudes, perceptions of peer norms and skills of youth in your community? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- If these activities do not address the risk and protective factors of the youth in your community, are there ways to strengthen the activities? Are there other ways to improve knowledge, values, attitudes, perceptions of peer norms and skills of the youth and their communication with parents? If so, what are some concrete steps you can take to improve them? (Record your ideas on the Characteristics Summary Table.)

READ

11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors.

Effective programs use learning activities and instructional methods that are interactive and engage youth. Some programs use learning activities that directly encourage youth to apply new concepts to their own lives. The interactive quality of many of these teaching methods is part of what makes them effective at changing the risk and protective factors described above. Consistent with educational theory, effective programs select teaching strategies that are appropriate for changing their respective risk and protective factors. For example, to overcome various barriers to using condoms or contraceptives, students can brainstorm solutions, and to learn various refusal skills, students can practice role playing. Brainstorming and role playing are two interactive learning activities that are appropriate for addressing different kinds of risk and protective factors.

ANSWER

Checklist:

YES	NO	
❑	❑	Does the curriculum incorporate a variety of teaching methods? Check all that apply:

YES	NO	
❑	❑	short lectures
❑	❑	class discussion
❑	❑	small group work
❑	❑	brainstorming sessions
❑	❑	role plays
❑	❑	video presentation
❑	❑	stories
❑	❑	live skits
❑	❑	simulations of risk
❑	❑	competitive game
❑	❑	forced-choice activities
❑	❑	surveys of attitudes and intentions

ANSWER

YES	NO	
❑	❑	problem-solving activities
❑	❑	worksheets
❑	❑	homework assignments to talk with partners or other adults
❑	❑	drug store visits
❑	❑	clinic visits
❑	❑	question boxes
❑	❑	hotlines
❑	❑	condom demonstrations
❑	❑	quizzes
❑	❑	other:_____

YES	NO	
❑	❑	Do most of the curriculum activities actively involve the participants?
❑	❑	Do most of the curriculum activities help youth personalize the information they are learning?
❑	❑	Are these teaching methods appropriate for the youth you are serving in *your* community?

SUMMARIZE

- To what extent does the curriculum include instructionally sound teaching methods? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- To what extent do these activities include instructionally sound teaching methods that will be effective with youth in *your* community? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there other instructional methods that would be more effective with your youth? If so, what are some concrete steps you can take to include them? (Record your ideas on the Characteristics Summary Table.)

READ

12. Employed activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age and sexual experience.

Obviously, all programs are not appropriate for all youth regardless of their culture, age and sexual experience. Thus, effective curricula are adapted to the culture, age and sexual experience of the youth. These adaptations include values, norms or concerns of particular racial or ethnic groups, different behavioral messages, and different teaching strategies appropriate to the developmental stage of the youth.

ANSWER

Checklist:

YES	NO	
❑	❑	Are the behavioral goals of the curriculum and its messages about behavior appropriate for the participants' age and sexual experience of youth in *your* community?
❑	❑	Do activities reflect the culture, age and level of sexual activity of youth you are serving in your community (e.g., are role playing scenarios realistic and meaningful to them)?
❑	❑	Are the teaching strategies consistent with the developmental age and academic skills of the youth you are serving in your community (e.g., language, cognitive development and literacy levels)?

SUMMARIZE

- To what extent are the health goals, behaviors, teaching strategies, and activities consistent with the culture, age and sexual experience of youth in *your* community? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there ways to strengthen those activities that are consistent with your priority population? If so, what are some concrete steps you can take to improve them? (Record your ideas on the Characteristics Summary Table.)

READ

13. Covered topics in a logical sequence.

Part of a program's effectiveness involves its organization and presentation of activities and materials. In many, but not all, effective curricula, the risk and protective factors and the activities addressing them were presented in an internally logical sequence. Often the curricula first enhanced the motivation to avoid HIV, other STD and pregnancy by emphasizing susceptibility and severity of these events, then gave a clear message about behaviors to reduce those risks, and, finally, addressed the knowledge, attitudes and skills needed to change those behaviors.

ANSWER

Checklist:

YES	NO	
❑	❑	Do the curriculum's topics follow a logical sequence such as described below? (This is only an example of typical logical sequence.)

- Basic information about HIV, other STD or pregnancy, including susceptibility and severity of HIV, other STD and pregnancy
- Discussion of behaviors to reduce vulnerability
- Knowledge, values, attitudes and barriers related to these behaviors
- Skills needed to perform these behaviors

SUMMARIZE

- To what extent were the topics covered in a logical sequence? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there ways to improve the sequence of the topics? If so, what are some concrete steps you can take to improve them? (Record your ideas on the Characteristics Summary Table.)

Category 3
The Implementation of the Curriculum

Introduction

The program characteristics in this category should be applied to your implementation of the curriculum you have selected or designed. They do not involve the contents of the curriculum. Regardless of the scale of implementation of a curriculum, each of the four characteristics below apply to effective programs.

Characteristics in Category 3

14. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations.

15. Selected educators with desired characteristics (whenever possible), trained them, and provided monitoring, supervision and support.

16. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement (e.g., publicized the program, offered food, or obtained consent).

17. Implemented virtually all activities with reasonable fidelity.

READ

14. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations.

Program buy-in is essential to the long-term success of the program. Partners could include school districts, departments of health or education, school principals, administrators of local organizations, funders and board members. Local partners should be informed about the potential success of the program and its intended outcomes so that they can support implementation efforts.

ANSWER

Checklist:

YES	NO	
❑	❑	Have you obtained support for your program from appropriate organizations or individuals needed to fully implement the curriculum? (e.g., School Board, Principal, Board of Directors, Youth Chaplain, etc.)?

SUMMARIZE

- To what extent have you obtained at least minimal support from appropriate authorities? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there ways to improve your support from appropriate authorities? If so, what are some concrete steps you can take to improve it? (Record your ideas on the Characteristics Summary Table.)

READ

15. Selected educators with desired characteristics (whenever possible), trained them, and provided monitoring, supervision and support.

Most effective programs employ staff who can relate to youth and who also have a background in health education, especially sex or HIV education. Qualitative evaluations of multiple programs have found that what is most important to young people is whether the educator can relate to them, not the age, race/ethnicity or gender of the educator.

ANSWER

Checklist:

YES	NO	
❑	❑	Are the educators you selected to implement this curriculum comfortable talking about sexuality with youth?
❑	❑	Do the educators have background in health education or sex or HIV education?
❑	❑	Have the educators been trained to implement this curriculum or similar curricula?
❑	❑	Do you have procedures in place to monitor, supervise and support the educators?

SUMMARIZE

- To what extent have you selected educators with desired characteristics, trained them and supervised them? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there ways to improve your selection, training and supervision of your educators? If so, what are some concrete steps you can take to improve them? (Record your ideas on the Characteristics Summary Table.)

READ

16. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement (e.g., publicized the program, offered food or obtained consent).

Some programs, such as those implemented in schools, may have a captive audience and do not need to recruit and retain youth. Other programs do not have a captive audience and must recruit and retain youth. If needed, effective programs implement activities necessary to recruit and retain youth and avoid or overcome obstacles to their attendance. For example, if appropriate, effective programs will obtain parental notification, provide transportation, implement activities at convenient times, and assure safety. Although this characteristic may be obvious, there are many reported examples in the field in which too few youth chose to participate in voluntary sex or HIV education programs and, thus, the programs were not effective.

ANSWER

Checklist:

YES	NO	
❑	❑	How many youth do you want to recruit for your program? Is there a minimal number?
❑	❑	If youth must be recruited, do you have procedures in place that will enable you to recruit the desired number?
❑	❑	Do you have adequate staffing and resources to conduct recruitment and retention acitivities (e.g., flyers, home visits, phone calls, etc.)
❑	❑	Will your program provide youth with transportation?
❑	❑	Will your program obtain consent from parents?
❑	❑	Will your program offer incentives to youth to attend the program?
❑	❑	Will your program implement the curriculum at a convenient, safe and comfortable location?
❑	❑	Will your program implement the curriculum at a convenient time for youth?

SUMMARIZE

- To what extent have you or can you recruit your desired number of youth and to what extent have you surmounted any barriers to youth participating? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there ways to improve your recruitment of youth? If so, what are some concrete steps you can take to improve it? (Record your ideas on the Characteristics Summary Table.)

READ

17. Implemented virtually all activities with reasonable fidelity.

Implementing a curriculum with "fidelity" means implementing the curriculum as designed, in the setting for which it was designed. Either failing to implement nearly all the activities as designed or implementing the curriculum in a different type of setting (e.g., during school instead of after school) may reduce effectiveness.

ANSWER

Checklist:

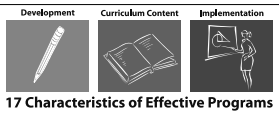
YES	NO	
❑	❑	Was the curriculum implemented in the setting for which it was designed?
❑	❑	Were nearly all the activities implemented?
❑	❑	Was the actual implementation of the activities observed or monitored, and were the activities implemented as designed?
❑	❑	Are there activities that you are expecting not to implement? Why?
❑	❑	Will not implementing these activities compromise the curriculum's fidelity and thus compromise effectiveness?

SUMMARIZE

- To what extent have you or can you implement all activities with fidelity? (Circle your score below and then record it on the Characteristics Summary Table.)

1	2	3	4
Not at all	Slightly	Somewhat	Completely

- Are there ways to improve the fidelity of your implementation? If so, what are some concrete steps you can take to improve it? (Record your ideas on the Characteristics Summary Table.)



Characteristics Summary Table

The table below is designed to help you summarize your review of curricula.

In general, the higher the score below for each characteristic, the more likely it will change behavior.

On the other hand, there is a word of caution about totaling and averaging your 17 scores — the scores in the TAC are really designed to guide you in determining which characteristics need improvement and how effective different curricula may be. Not all the questions under each characteristic are equally important, and not all characteristics are equally important. Thus, total or average scores represent only a rough guide to the probable effectiveness of curriculum. There is no particular score that means that either a curriculum will be effective or ineffective.

Name of Curriculum:
Name of Reviewers:

Characteristic	Score(s) (1-4)	Ideas/Action Steps for Improvement
Category 1		
1. Involved multiple people with different backgrounds in theory, research and sex and STD/HIV education to develop the curriculum.		

Characteristic	Score(s) (1-4)	Ideas/Action Steps for Improvement
Category 1 (continued)		
2. Assessed relevant needs and assets of target group.		
3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors.		
4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space and supplies).		
5. Pilot-tested the program.		

Characteristic	Score(s) (1-4)	Ideas/Action Steps for Improvement
Category 2		
6. Focused on clear health goals — the prevention of STD/HIV and/or pregnancy.		
7. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them.		
8. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms and self-efficacy).		
9. Created a safe social environment for youth to participate.		

Characteristic	Score(s) (1-4)	Ideas/Action Steps for Improvement
Category 2 (continued)		
10. Included multiple activities to change each of the targeted risk and protective factors.		
11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors.		
12. Employed activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age and sexual experience.		
13. Covered topics in a logical sequence.		

Characteristic	Score(s) (1-4)	Ideas/Action Steps for Improvement
Category 3		
14. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations.		
15. Selected educators with desired characteristics (whenever possible), trained them and provided monitoring, supervision and support.		
16. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement (e.g., publicized the program, offered food or obtained consent).		
17. Implemented virtually all activities with reasonable fidelity.		

Resources

The resources listed in this section of the Tool to Assess Characteristics were selected to support you in the assessment, adaptation and/or development of your prevention program with regard to the 17 characteristics. This is not meant to be an exhaustive list. Rather, these are resources that are readily available from the internet, free and relatively easy to use.

17 Characteristics of Effective Sex and STD/HIV Education Programs

Kirby, D, Laris, B.A., & Rolleri, L. (2006). *Sex and HIV Programs for Youth: Their Impact and Important Characteristics.* Washington, DC: Healthy Teen Network. www.healthyteennetwork.org

Compendia of Science-Based Programs and Curricula

Child Trends guide to effective programs for children and youth: Teen pregnancy and reproductive health: http://www.childtrends.org/Lifecourse/programs_ages_teenpregreprohealth.htm

Child Trends "What Works" program table for reproductive health: http://www.childtrends.org/what_works/youth_development/table_adrehealth.asp

Diffusion of Evidence-Based Intervention (DEBI) found on CDC Division of HIV and AIDS Prevention website: http://www.effectiveinterventions.org/about/index.cfm

Innovative Approaches to Increase Parent-Child Communication About Sexuality: Their Impact and Examples from the Field. (2002). New York, NY: Sexuality Information and Education Council of the United States (SIECUS). http://www.siecus.org/pubs/families/innovative_approaches.pdf

It's a Guy Thing: Boys, Young Men, and Teen Pregnancy Prevention. (2006). Washington, DC: National Campaign to Prevent Teen Pregnancy. http:// www.teenpregnancy.org

Kirby, D. (2001). *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy.* Washington, DC: National Campaign to Prevent Teen Pregnancy. http://www.teenpregnancy.org/resources/data/report_summaries/emerging_answers/default.asp

Klerman, K. (2004). *Another Chance: Preventing Additional Births to Teen Mothers.* Washington, DC: National Campaign to Prevent Teen Pregnancy https://www.teenpregnancy.org/store/item.asp?productId=281

Manlove, J., Franzetta, K., McKinney, K., Romano Papillo, A., & Terry-Humen, E. (2004). *A Good Time: After-School Programs to Reduce Teen Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy. http://www.teenpregnancy.org/works/pdf/goodtime.pdf

Manlove, J., Franzetta, K., McKinney, K., Romano Papillo, A., & Terry-Humen, E. (2004). *No Time to Waste: Programs to Reduce Teen Pregnancy Among Middle School-Aged Youth.* Washington, DC: National Campaign to Prevent Teen Pregnancy. http://www.teenpregnancy.org/works/pdf/NotimetoWaste.pdf

Manlove, J., Papillo, A. R., & Ikramullah, E. (2004). *Not Yet: Programs to Delay First Sex Among Teens.* Washington, DC: National Campaign to Prevent Teen Pregnancy. http://www.teenpregnancy.org/works/pdf/NotYet.pdf

Manlove, J., Terry-Humen, E., Papillo, A. R., Franzetta, K., Williams, S., & Ryan, S. (2002). *Preventing Teenage Pregnancy, Childbearing, and Sexually Transmitted Diseases: What the Research Shows* (research brief). Washington, DC: Child Trends and the Knight Foundation. http://www.childtrends.org/files/K1Brief.pdf

Papillo, A. R., & Manlove, J. (2004). S*cience Says: Early Childhood Programs.* Washington, DC: The National Campaign to Prevent Teen Pregnancy. http://www.teenpregnancy.org/works/pdf/ScienceSaysEarlyChildhood.pdf

Science and Success: Sex Education and Other Programs That Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections. (2003). Washington, DC: Advocates for Youth. http://www.advocatesforyouth.org/programsthatwork

Science-Based Practices: A Guide for State Teen Pregnancy Prevention Organizations. (2004). Washington, DC: Advocates for Youth. http://www.advocatesforyouth.org/publications/frtp/guide.htm

Solomon, J., & Card, J. J. (2004). *Making the List: Understanding, Selecting, and Replicating Effective Teen Pregnancy Prevention Programs.* Washington, DC: The National Campaign to Prevent Teen Pregnancy. http://www.socio.com/pasha.htm#overview

Online Data Resources on Adolescent Reproductive Health

Centers for Disease Control and Prevention, Division of Adolescent and School Health
http://www.cdc.gov/healthyyouth

Centers for Disease Control and Prevention, Division of HIV and AIDS
http://www.cdc.gov/hiv/topics/research/index.htm

Centers for Disease Control and Prevention, Division of Reproductive Health
http://www.cdc.gov/reproductivehealth/index.htm

Centers for Disease Control and Prevention: HIV/AIDS Surveillance
http://www.cdc.gov/hiv

Centers for Disease Control and Prevention: Reproductive Health Atlas
http://www.cdc.gov/reproductivehealth/GISAtlas/index.htm

Centers for Disease Control and Prevention: Sexually Transmitted Disease Surveillance
http://www.cdc.gov/std

Child Trends
http://www.childtrends.org

Child Trends Data Bank
http://www.childtrendsdatabank.org

Guttmacher Institute
http://www.guttmacher.org

Healthy People 2010
http://www.healthypeople.gov

Kaiser Family Foundation
http://www.kff.org

Kids Count
http://www.aecf.org/kidscount

National Campaign to Prevent Teen Pregnancy
http://www.teenpregnancy.org/resources

National Center for Health Statistics
http://www.cdc.gov/nchs

National Longitudinal Study of Adolescent Health (Add Health)
http://www.cpc.unc.edu/projects/addhealth

National Mental Health Information Center
http://www.mentalhealth.samhsa.gov

National Survey of Family Growth (NSFG)
http://www.cdc.gov/nchs/nsfg.htm

State Health Facts On-Line
http://www.statehealthfacts.kff.org

Youth Behavior Risk Surveillance Data
http://www.cdc.gov/HealthyYouth/yrbs/index.htm

Conducting Focus Groups

American Statistical Association
http://www.amstat.org

ETR Associates — Focus Groups Basics: From Development to Analysis
http://www.ccfc.ca.gov/ffn/FGcourse/focusGroupCourse.html

Krueger, R.A. Focus Group Interviewing
http://www.tc.umn.edu/~rkrueger/focus.html

Management Assistance Program for Nonprofits
http://www.mapfornonprofits.org

Conducting Surveys

American Statistical Association
http://www.amstat.org/sections/srms/whatsurvey.html

Survey Monkey
http://www.surveymonkey.com

Survey Research — Cornell University: William M.K. Trochim
http://www.socialresearchmethods.net/kb/survey.htm

Logic Models

BDI Logic Model Online Course found on ETR's ReCAPP website
http:// www.etr.org/recapp

Community Tool Box
http://ctb.ku.edu/

Kellogg Foundation — Logic Model Development Guide
http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf

Kirby, D. (2004). *BDI Logic Models: A Useful Tool for Designing, Strengthening and Evaluating Programs to Reduce Adolescent Sexual Risk-taking, Pregnancy, HIV and other STDs.* Santa Cruz, CA: ETR Associates. http://www.etr.org/recapp/BDILOGICMODEL20030924.pdf

Logic Model Resources (CDC Evaluation Working Group)
http://www.cdc.gov/eval/resources

Risk and Protective Factors Related Adolescent Sexual Risk-Taking

Kirby, D., LePore, G., & Ryan, J. (2005). F*actors Affecting Teen Sexual Behavior, Pregnancy, Childbearing and Sexually Transmitted Disease: Which Are Important? Which Can You Change?* Washington, DC: National Campaign to Prevent Teen Pregnancy.
http://www.etr.org/recapp/theories/RiskProtectiveFactors/RiskProtectivefactorPaper.pdf

Health Education and Health Behavior Theory

Ecological Systems Theory
http://pt3.nl.edu/paquetteryanwebquest.pdf

Health Belief Model
http://www.etr.org/recapp/theories/hbm/index.htm

Motivational Interviewing
http://www.health.nsw.gov.au/public-health/dpb/supplements/supp6.pdf

Social Learning (Cognitive) Theory
http://www.etr.org/recapp/theories/slt/Index.htm

Stages of Change
http://www.etr.org/recapp/theories/StagesofChange/index.htm

Theory at a Glance: A Guide for Health Promotion Practice
http://www.nci.nih.gov/theory/pdf

Theory of Reasoned Action/Planned Behavior
http://www.etr.org/recapp/theories/tra/index.htm

Instructional Methods/Pedagogy

Changing Social Norms
http://www.etr.org/recapp/column/column200404.htm

Classroom Management to Promote Learning
http://www.etr.org/recapp/practice/edskills200109.htm

Cooperative Learning
http://edtech.kennesaw.edu/intech/cooperativelearning.htm

Constructivist Theory
http://www.exploratorium.edu/ifi/resources/constructivistlearning.html

Guiding Large Group Discussions
http://www.etr.org/recapp/practice/glgd.htm

Instructional Design Models — University of Colorado at Denver
http://carbon.cudenver.edu/~mryder/itc_data/idmodels.html

Managing Small Groups
http://www.etr.org/recapp/practice/sm_groups.htm

Principles of Adult Learning
http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/adults-2.htm

Role Play for Behavioral Practice
http://www.etr.org/recapp/practice/rpbp.htm

Program Fidelity and Adaptation

Finding the Balance: Program Fidelity and Adaptation in Substance Abuse Prevention, published by the Substance Abuse and Mental Health Services Administration in 2002
http://www.modelprograms.samhsa.gov

Practice Profiles for Get Real About AIDS and Reducing the Risk, published by ETR Associates
http://www.etr.org/recapp/theories/usingResearch/practiceProfiles.pdf

Other

Office for Human Research Protections (OHRP)
http://www.hhs.gov/ohrp/

Glossary

Adaptation: In this context, adaptation is the process of making changes to an existing curriculum in order to make it more suitable for a new group or situation. Adaptations might include deletions or enhancements to the program's core components and activities or changes in the way the program is taught or delivered. They might involve changes to make the program more appropriate with regard to culture or age or gender.[10]

Attitude: An attitude is a state of mind, feeling or disposition. Attitudes are often expressed in the way we act, feel and think. They demonstrate our opinions, dispositions, perspectives or positions on a particular issue or topic. Attitudes are somewhat different from values. Values are principles or beliefs that serve as guidelines in helping us make decisions about behaviors or life choices. They reflect what we believe about the "rightness" or the "wrongness" of things. Our values tell us what we believe about something.[11]

Curriculum: A curriculum is an integrated course of multiple lessons, activities or modules used to guide instruction.

Determinant: Determinants are the factors that have a causal influence on some outcome. For example, "being in love" or "going steady with someone" are determinants or factors that often affect the initiation of sex among people. The availability of alcohol and perceived peer norms about alcohol use are determinants or factors that affect adolescent drinking. Determinants can include both risk and protective factors. Determinants differ slightly from antecedents. Antecedents must be related to some outcome and must logically precede that outcome, but they do not necessarily cause the outcome. In contrast, determinants imply causality.[12]

Fidelity: In this context, fidelity is the faithfulness with which a curriculum or program is implemented. This includes implementing the program in its entirety without compromising the core components or the essential elements of the program that make it work. Program fidelity is also sometimes referred to as compliance or adherence.[13]

10. Finding the Balance: Program Fidelity and Adaptation in Substance Abuse Prevention. (2002). Rockville, MD: Substance Abuse and Mental Health Services Administration.
11. Plain Talk Walker and Talker Training. (2006). Philadelphia, PA: Public/Private Ventures.
12. ReCAPP Research Glossary: http://www.etr.org/recapp/research/researchglossary.htm
13. Finding the Balance: Program Fidelity and Adaptation in Substance Abuse Prevention. (2002). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Focus Group: Focus groups are a qualitative research technique in which an experienced moderator leads a group of respondents (usually 8–12 persons) through an informal discussion of a selected problem or issue, allowing group members to talk freely about their thoughts, opinions, feelings, attitudes and misconceptions about the issue.[14]

Intention: An intention is a plan or a likelihood that someone will behave in a particular way in specific situations — whether or not they actually do so. For example, a person who is thinking about quitting smoking intends or plans to quit, but may or may not actually follow through on that intent.[15]

Intervention: An intervention is a set of activities that is packaged in a purposeful way with the goal of preventing a problem, treating a problem, and/or supporting an individual or a group. An intervention is generally seen as either a *program* (e.g., Women, Infants and Children (WIC) program or *Reducing the Risk* curriculum, etc.), or a *policy* (e.g. Abstinence-Only-Until-Marriage legislation or a local clinic that makes changes to become more youth-friendly).

Logic Model: A logic model is a tool used by program developers to strategically and scientifically link a health goal to the behaviors directly related to that goal, the determinants of those behaviors, and the intervention activities that are designed to change those determinants.

Mediating Factor: A mediating factor is an intermediate factor in a causal pathway, typically between a program and a behavior. That is, it is affected by a program and, in turn has an impact on a behavior. For example, a program may increase a person's "self-efficacy to say no to unprotected sex" which in turn increases that person's chances of actually saying no to unprotected sex. In some logic models, mediating factors are the risk and protective factors (or determinants) that are affected by a program and, in turn, affect behavior.

Prevalence: The prevalence of a condition (e.g., a disease) is the total number of cases of a defined condition present in a specific population at a given time. Prevalence is different than incidence. Incidence is the total number of *new* cases of a defined condition that occur during a specified period of time in a defined population.[16] People sometimes express prevalence as a rate rather than as a total number.

14. ReCAPP Research Glossary: http://www.etr.org/recapp/research/researchglossary.htm
15. ReCAPP Theories and Approaches: http://www.etr.org/recapp/theories/tra/index.htm
16. ReCAPP Research Glossary: http://www.etr.org/recapp/research/researchglossary.htm

Program: A program is a set of activities packaged in a purposeful way with the goal of preventing a problem, treating a problem, and/or supporting an individual or a group. Examples of adolescent reproductive health programs include: *Reducing the Risk* curriculum and the *Teen Outreach Program*.

Protective Factor: A protective factor is any factor or quality whose presence is associated with increased protection from a disease or condition. For example, self-efficacy to use condoms is a protective factor for actual use of condoms.[17]

Psychosocial Factors:

Psychosocial factors are factors or qualities that pertain to the psychological development of the individual in relation to his/her social environment. In the area of sexuality, psychosocial factors often refer to internal cognitive factors that relate to the environment (e.g., knowledge about different aspects of sexuality, values about different topics in sexuality, perception of peer norms, attitudes, or self-efficacy to engage in or refrain from various sexual behaviors).

Rate: A rate is the quantity, amount or degree of something being measured in a specific period of time. An example is the teen pregnancy rate, which is usually expressed in the number of pregnant teens per 1,000 teens (or sometimes 100 teens) within one year's time.[18]

Risk Factor: A risk factor is any factor whose presence is associated with an increased risk of a disease or condition. For example, social norms that support sex are a risk factor for adolescent pregnancy.[19]

Role Play: Role play for behavioral practice is a teaching strategy that allows youth to practice a variety of communication skills by acting out real life situations in a safe environment such as a classroom or youth group. In order to assure that youth learn the skill effectively, the behavioral practice should include several phases: preparation, reviewing the skill, preparing small groups, enactment in small groups, small-group discussion and large-group discussion.[20]

[17]ReCAPP Research Glossary: http://www.etr.org/recapp/research/researchglossary.htm
[18]ReCAPP Research Glossary: http://www.etr.org/recapp/research/researchglossary.htm
[19]ReCAPP Research Glossary: http://www.etr.org/recapp/research/researchglossary.htm
[20]ReCAPP Research Glossary: http://www.etr.org/recapp/research/researchglossary.htm

Self-Efficacy: Self-efficacy is a person's confidence in his/her ability to perform particular behaviors well enough to control events that affect his/her life. If someone has high self-efficacy, she believes she can perform behaviors well enough to change her environment and achieve a goal. As a result, she has more confidence and is more likely to try to perform the behavior or achieve a goal again. Conversely, if she has low self-efficacy, she believes she can't achieve that goal, has less confidence, and is less likely to try.

Social Norms: Social norms are standards of acceptable behavior or attitudes within a community or peer group. Social norms come in two varieties — actual norms and perceived norms. Actual norms are the true social norms for a particular attitude or behavior. For example, if the majority of a group of sexually active individuals use some form of birth control, the actual norm for the group is to use birth control. Going without birth control is "non-normative" in that group. Perceived norms are what someone *believes* to be the social norm for a group. For example, if a young man believes that most of his peers do not use condoms, for that young man the perceived norm is non-use of condoms.[21]

Susceptibility: Susceptibility is the likelihood of getting a disease or condition.

Youth Risk Behavior Surveillance:

The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health risk behaviors among young adults in grades 9–12. These six behaviors include: behaviors that contribute to unintentional injury and violence; tobacco use; alcohol and other drug use; sexual behaviors that lead to unintentional pregnancy and sexually transmitted disease including HIV; unhealthy dietary behaviors; and physical inactivity. YRBSS includes a national school-based survey conducted by CDC, as well as state and local school-based surveys conducted by education and health agencies. National surveys have been collected biannually since 1991.[22]

21. ReCAPP Topic in Brief: http://www.etr.org/recapp/column/column200404.htm#definition
22. Centers for Disease Control and Prevention. (May 2004). *Surveillance Summaries. MMWR* 2004:53 (SS02).

HECAT: Module SH

SEXUAL HEALTH CURRICULUM

Description: This module contains the tools to analyze and score curricula that are intended to promote sexual health and prevent risk-related health problems, including teen pregnancy, Human Immunodeficiency Virus (HIV) infection, and other sexually transmitted diseases (STD). This module can be used to analyze curricula emphasizing sexual risk avoidance (abstinence) and sexual risk reduction. Risk-reduction outcomes that would not be addressed in a risk-avoidance curriculum are identified with an asterisk (*).

Healthy Behavior Outcomes

A pre-K–12 sexual health curriculum should enable students to

- *Establish and maintain healthy relationships.*
- *Practice and maintain sexual abstinence.*
- *Seek support to be sexually abstinent.*
- *Avoid pressuring others to engage in sexual behaviors.*
- *Return to sexual abstinence if sexually active.*
- *Support others to avoid sexual risk behaviors.*
- *Seek health care professionals to promote sexual health.*

Additional risk-reduction outcomes not addressed in a risk-avoidance curriculum are:

- *Limit the number of sexual partners if sexually active.**
- *Use condoms consistently and correctly if sexually active.**
- *Use birth control consistently and correctly if sexually active.**

This module uses the *National Health Education Standards* as the framework for determining the extent to which the curriculum will enable students to master the essential concepts (Standard 1) and skills (Standards 2–8) to promote sexual health.

The concepts, sub-skills, and skill examples included in this module were developed through a rigorous process guided by research evidence and expert opinion on the types of knowledge, skills, and learning experiences that help students in grades pre-K–12 adopt and maintain behaviors that promote sexual health. Appendix 5 also includes suggested concepts and skills for children ages 3-4, who might be enrolled in a school-based early childhood program.

Because school curricula must meet local community needs and conform to the curriculum requirements of the state or school district, users are encouraged to review the analysis items before analyzing curricula and add, delete, or revise them to meet local needs and requirements.

Some concepts and skill examples are relevant to more than one health topic. Look in other topic modules to see if there are any related concepts or skill examples that might be added for the review of sexual health curricula.

If a curriculum focuses on additional topics, such as violence prevention or mental and emotional health, use the chapters that address those topics as well.

Overall Instructions

- Determine the desired Healthy Behavior Outcomes (box on left) that you expect a curriculum to address.
- Review the HECAT items in this module. Add, delete, or revise items to meet the selected healthy behavior outcomes, the curriculum requirements of the state or school district, and community needs.
- Review the completed *General Curriculum Information* (Chapter 2) for the curriculum under consideration.
- Read the curriculum to become familiar with its content and how it is organized.
- Complete the analysis of the curriculum for each standard in this module.
- Score the curriculum based on the analysis: There will be **one** rating score for functional knowledge or concepts (Standard 1) and **two** rating scores for each of the essential skills (Standards 2–8).
- Transfer scores from the analysis of each standard to the *Overall Summary Form* (Chapter 3).
- Complete a separate analysis for each curriculum being reviewed. Make additional copies of any analysis pages.
- Keep all written notes and comments to justify scores and to inform group discussions and curriculum decisions.

Standard 1

The Standard 1 curriculum analysis will result in a single score that reflects the extent to which the curriculum addresses the knowledge required to achieve the selected sexual health behavior outcomes (page SH-1). This module lists the essential concepts to be completed by grades 2, 5, 8, and 12. These are listed by grade groups: pre-K–2; 3–5; 6–8; and 9–12, starting on page SH-3.

Terms related to growth and development, healthy relationships, and making responsible decisions are more commonly used than "sexual health" in curricula for elementary school students. The list of concepts in the HECAT for grades Pre-K–2 and 3–5 reflects this understanding.

Directions for Standard 1

- Review the applicable grade level concepts (pages SH-3 through SH-9).
- Decide if any of the concepts need to be deleted or modified or if any additional concepts should be added to meet the needs of the community or to conform to the curriculum requirements of the state or school district. Sexual risk-reduction concepts, not addressed in a sexual risk-avoidance curriculum, are identified with an asterisk (*). Some concepts may be reflected in the skill examples in Standards 2–8. Review all other standards before making changes to the concepts in Standard 1. Some relevant concepts might be found in other health topic modules. Look in other related topic modules for concepts that might be edited and added to the list of concepts for this topic.
- Read the curriculum to become familiar with its content, the information provided for students, and the methods used to convey information and knowledge content.
- Place a check in the box next to each concept that is addressed by the curriculum and complete the *Concept Coverage Score*. **Important** — a concept is "addressed" if there is sufficient information provided in the curriculum for students to be able to demonstrate competency in this concept. Some concepts might require more evidence than others.
- Transfer the *Concept Coverage Score* to the appropriate line on the *Overall Summary Form* (Chapter 3).
- Record notes to justify scores and to inform group discussions and curriculum decisions.
- Analyze Standard 1 for each curriculum being reviewed. If the curriculum addresses more than one grade group, complete a separate analysis of Standard 1 for each group.
- Complete a separate *Overall Summary Form* for each curriculum and grade group.

Directions for Standards 2–8 are provided on page SH-11.

Standard 1 Students will comprehend concepts related to health promotion and disease prevention.

After implementation of this curriculum, by grade 2, students will be able to:

SEXUAL HEALTH (Check all that are given attention in the curriculum)

☐ Identify qualities of a healthy relationship.

☐ Describe ways to prevent the spread of germs that cause common infectious diseases.

Additional Concepts

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

CONCEPT COVERAGE SCORING: Complete the score based on the criteria listed below.

The curriculum addresses:
4 = all of the concepts. (100%)
3 = most of the concepts. (67-99%)
2 = some of the concepts. (34-66%)
1 = a few of the concepts. (1-33%)
0 = none of the concepts. (0)

CONCEPT COVERAGE SCORE ☐

TRANSFER THIS SCORE TO THE HEALTH INFORMATION/CONCEPTS LINE OF THE *OVERALL SUMMARY FORM* (CHAP. 3).

Notes:

Reminder: The HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise concepts to reflect community needs and to meet the curriculum requirements of the school district.

Standard 1

The Standard 1 curriculum analysis will result in a single score that reflects the extent to which the curriculum addresses the knowledge required to achieve the selected sexual health behavior outcomes (page SH-1). This module lists the essential concepts to be completed by grades 2, 5, 8, and 12. These are listed by grade groups: pre-K–2; 3–5; 6–8; and 9–12, starting on page SH-3.

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☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

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CONCEPT COVERAGE SCORE ☐

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- Decide if any of the concepts need to be deleted or modified or if any additional concepts should be added to meet the needs of the community or to conform to the curriculum requirements of the state or school district. Sexual risk-reduction concepts, not addressed in a sexual risk-avoidance curriculum, are identified with an asterisk (*). Some concepts may be reflected in the skill examples in Standards 2–8. Review all other standards before making changes to the concepts in Standard 1. Some relevant concepts might be found in other health topic modules. Look in other related topic modules for concepts that might be edited and added to the list of concepts for this topic.
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SEXUAL HEALTH (Check all that are given attention in the curriculum)

☐ Identify qualities of a healthy relationship.

☐ Describe ways to prevent the spread of germs that cause common infectious diseases.

Additional Concepts

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

CONCEPT COVERAGE SCORING: Complete the score based on the criteria listed below.

The curriculum addresses:
4 = all of the concepts. (100%)
3 = most of the concepts. (67-99%)
2 = some of the concepts. (34-66%)
1 = a few of the concepts. (1-33%)
0 = none of the concepts. (0)

CONCEPT COVERAGE SCORE ☐

TRANSFER THIS SCORE TO THE HEALTH INFORMATION/CONCEPTS LINE OF THE *OVERALL SUMMARY FORM* (CHAP. 3).

Notes:

Reminder: The HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise concepts to reflect community needs and to meet the curriculum requirements of the school district.

Standard 1 Students will comprehend concepts related to health promotion and disease prevention.

After implementation of this curriculum, by grade 12, students will be able to:

SEXUAL HEALTH (Check all that are given attention in the curriculum)

- ☐ Summarize the importance of setting personal limits to avoid risky sexual behavior.
- ☐ Justify why sexual abstinence is the safest, most effective risk avoidance method of protection from HIV, other STDs, and pregnancy.
- ☐ Analyze the factors that contribute to one engaging in sexual risk behaviors.
- ☐ Analyze the factors that protect one against engaging in sexual risk behaviors.
- ☐ Describe the importance of shared responsibilities for avoiding sexual activity and preventing sexual risk behaviors.
- ☐ Analyze the effectiveness of perfect use vs. typical use of common contraceptive methods in reducing the risk of pregnancy.
- ☐ Analyze the effectiveness of perfect use vs. typical use of condoms in reducing the risk of pregnancy, HIV, and other STD infection, including Human Papillomavirus (HPV).
- ☐ Describe the increased risks associated with having multiple sexual partners including serial monogamy.
- ☐ Explain the importance of using contraceptives correctly and consistently to reduce risk of pregnancy and infection of HIV and most STDs.*
- ☐ Summarize ways to prevent pregnancy and the sexual transmission of HIV and other STDs.*
- ☐ Explain the effects of alcohol and other drug use during pregnancy.
- ☐ Explain important health screenings, immunizations, and checkups, including screenings and examinations that are necessary to maintain reproductive health such as testicular self-examinations and Pap smears.

Sexual Health, Grades 9–12 continued on next page.

* This concept promotes risk-reduction and might not be included in a risk-avoidance curriculum

Reminder: The HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise concepts to reflect community needs and to meet the curriculum requirements of the school district.

Standard 1 Students will comprehend concepts related to health promotion and disease prevention.

After implementation of this curriculum, by grade 12, students will be able to:

SEXUAL HEALTH (Check all that are given attention in the curriculum)

- ☐ Explain the importance of contraceptive counseling and services if sexually active.*
- ☐ Explain the importance of STD and HIV testing and counseling if sexually active.*
- ☐ Clarify why it is safe to be a friend of someone who has HIV infection or AIDS.

Additional Concepts

- ☐ _____
- ☐ _____
- ☐ _____

CONCEPT COVERAGE SCORING: Complete the score based on the criteria listed below.

The curriculum addresses:
4 = all of the concepts. (100%)
3 = most of the concepts. (67-99%)
2 = some of the concepts. (34-66%)
1 = a few of the concepts. (1-33%)
0 = none of the concepts. (0%)

CONCEPT COVERAGE SCORE → ☐

TRANSFER THIS SCORE TO THE HEALTH INFORMATION/CONCEPTS LINE OF THE *OVERALL SUMMARY FORM* (CHAP. 3).

* This concept promotes risk-reduction and might not be included in a risk-avoidance curriculum.

Notes:

Reminder: The HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise concepts to reflect community needs and to meet the curriculum requirements of the school district.

This is the end of Standard 1. Use additional space to record any notes related to the review of standard 1 that can inform discussions and recommendations.

Standards 2–8

The Standards 2–8 analysis will result in **two** ratings for each standard: one rating reflects the extent to which the curriculum addresses important skills and provides the student with the ability to learn and apply the skill; the second reflects the extent to which the curriculum provides the teacher with guidance to instruct and assess the skill.

The *National Health Education Standards* 2–8 describe the key processes and skills that students need to promote personal, family and community health. CDC reviewed these and other state-level standards, analyzed the research findings from effective programs, and used input from experts in health education to develop a list of relevant sub-skills for each standard.

Each standard 2–8 begins with a score page. This is followed by the sub-skills for that standard. The sub-skills are not specific to any one health topic. Skill examples, organized by grade groups, are provided to illustrate how the sub-skills for that standard can be applied to sexual health. Sexual risk-reduction skill examples, not addressed in a sexual risk-avoidance curriculum, are identified with an asterisk (*).

The skill examples are not a complete list of all the ways the sub-skills can be applied to this topic. The examples should be reviewed carefully before the curriculum analysis and revised if necessary. Some skill examples in other health topic modules might be relevant. Review skill examples in other health topic modules for skill examples that could be edited and added to the skill examples for this topic.

Terms related to growth and development, healthy relationships, and making responsible decisions are more commonly used than "sexual health" in curricula for elementary school students. The grades Pre-K–2 and 3–5 skill examples reflect this understanding.

Remember, the HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise items to reflect community needs and meet the curriculum requirements of the school district.

Directions for Standards 2–8

- For each standard, review the list of sub-skills and examples for each grade group. Decide if any of the examples should be deleted or modified to meet the needs of the community or conform to the curriculum requirements of the state or school district. Additional skill examples could be included under other standards. Review all standards before making any changes.
- Read the curriculum to become familiar with the content, the focus on skill learning, and the methods used to convey skill learning.
- Complete the *Student Skill Learning and Application Score* and *Teacher Instruction and Assessment Score* by checking "yes" or "no" for each statement as it applies to the curriculum under review. Use the sub-skills and skill examples to help identify relevant skill outcomes.
- Add the total number of "yes" checks to arrive at an overall score for each scoring area. Transfer the two scores for each standard to the appropriate lines on the *Overall Summary Form* (Chapter 3).
- Record notes to justify scores and inform group discussions and decisions.
- Analyze Standards 2–8 for each curriculum being reviewed. If the curriculum addresses more than one grade group, complete a separate set of skill scores for each standard and each group.
- Complete a separate *Overall Summary Form* for each curriculum and grade group.

Standard 2 Students will analyze the influence of family, peers, culture, media, technology and other factors on health behaviors.

Student Skill Learning/Application Scoring: Complete the skill application score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See pages SH-13 and SH-14 for Standard 2 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide information to the students about the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide one opportunity or activity for students to practice the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide more than one opportunity or activity for students to practice the skills needed to meet this standard? (If yes, also check yes for #2 above.)	❒	❒
4. Does the curriculum provide opportunities for students to assess their own skill progress, such as personal check lists?	❒	❒

Student Skill Learning and Application Score (total number of "yes" checks) ☐

Transfer this score to Standard 2: Analyzing Influences (see Student Learning/Application line) on the *Overall Summary Form* –Chap. 3.

Teacher Instruction and Skill Assessment Scoring: Complete the skill instruction and assessment score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See pages SH-13 and SH-14 for Standard 2 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide guidance to help the teacher understand the steps required to learn and teach the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide guidance for the teacher to model the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide strategies for the teacher to assess the student's ability to perform the skills needed to meet this standard?	❒	❒
4. Are clear assessment standards provided for the teachers, such as a rubric or check sheet that explains the criteria that need to be met to demonstrate the skills needed to meet this standard?	❒	❒

Teacher Instruction and Assessment Score (total number of "yes" checks) ☐

Transfer this score to Standard 2: Analyzing Influences (see Teacher Instruction/Assessment line) on the *Overall Summary Form* - Chap. 3.

Notes:

Standard 2 Skill Examples

After implementing this curriculum, students will be able to analyze the influence of family, peers, culture, media, technology, and other factors on sexual health.

Sub-Skills: As a result of using this curriculum, students will be able to

- Analyze the influence of the media on personal health practices.
- Analyze parent and family influence on personal health practices.
- Analyze peer influence on personal health practices.
- Analyze community influence on personal health practices.
- Analyze the influence of cultural and peer norms on personal health practices.
- Analyze the influence of personal values and beliefs on personal health practices.
- Analyze the influence of alcohol and other drug use on judgment, self-control, and behavior.

Base the curriculum score on its ability to meet the entire standard — not just a few sub-skills for this standard.

Skill Examples: Below are examples that illustrate how a curriculum might address these skills. These examples are not intended to be a complete list of all the ways these skills can be addressed. When considering other examples, it is useful to think about the sub-skills in relation to the content emphasized in the Standard 1 concepts. Remember, the HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise skills or skill examples to reflect community needs and to conform to the curriculum requirements of the school district.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
	• Describe how culture, the media, and people influence what one thinks about attractiveness and relationships. • Describe how culture, the media, and people influence what a person thinks about people who have infectious or chronic diseases, such as HIV infection, AIDS, and cancer.	• Describe how internal influences, such as curiosity, interests, desires, and fears, affect sexual behavior. • Describe how personal and family values influence decisions about sexual behavior and relationships. • Describe a variety of external influences, such as parents, the media, culture, peers, and society that affect sexual decision making and sexual behavior. • Analyze the influence of alcohol and other drugs on sexual behavior. • Explain how sexual exploitation can occur on the internet.	• Examine internal influences, such as hormones, emotions, interests, and curiosity, on sexual feelings and behavior. • Summarize external influences, such as parents, the media, culture, peers, and society, on sexual decision-making. • Examine personal values and how these influence relationships and sexual decision-making. • Evaluate the influence of alcohol and other drugs on sexual behavior.

Additional examples for Standard 2 are listed on the next page.

Standard 2 Skill Examples (continued)

After implementing this curriculum, students will be able to analyze the influence of family, peers, culture, media, technology, and other factors on sexual health.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
		• Examine why stereotypes exist about people with infectious diseases, such as HIV infection. • Explain that most students are not having sex.	• Analyze why stereotypes exist about people with infectious diseases, such as HIV infection. • Analyze the influence of the internet on sexual decision-making. • Explain that most students are not sexually active.

Notes:

Notes:

Standard 3 Students will demonstrate the ability to access valid information and products and services to enhance health.

Student Skill Learning/Application Scoring: Complete the skill application score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See pages SH-17 and SH-18 for Standard 3 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide information to the students about the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide one opportunity or activity for students to practice the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide more than one opportunity or activity for students to practice the skills needed to meet this standard? (If yes, also check yes for #2 above.)	❒	❒
4. Does the curriculum provide opportunities for students to assess their own skill progress, such as personal check lists?	❒	❒

Student Skill Learning and Application Score (total number of "yes" checks) ☐

Transfer this score to Standard 3: Accessing Valid Information (see Student Learning/Application line) on the *Overall Summary Form* - Chap. 3.

Teacher Instruction and Skill Assessment Scoring: Complete the skill instruction and assessment score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See pages SH-17 and SH-18 for Standard 3 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide guidance to help the teacher understand the steps required to learn and teach the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide guidance for the teacher to model the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide strategies for the teacher to assess the student's ability to perform the skills needed to meet this standard?	❒	❒
4. Are clear assessment standards provided for the teachers, such as a rubric or check sheet that explains the criteria that need to be met to demonstrate the skills needed to meet this standard?	❒	❒

Teacher Instruction and Assessment Score (total number of "yes" checks) ☐

Transfer this score to Standard 3: Accessing Valid Information (see Teacher Instruction/Assessment line) on the *Overall Summary Form*- Chap. 3.

Notes:

Standard 3 Skill Examples

After implementing this curriculum, students will be able to demonstrate the ability to access valid information, products, and services to promote sexual health.

Sub-Skills: As a result of using this curriculum, students will be able to

- Differentiate accurate from inaccurate health information.
- Select valid and reliable products and services.
- Access valid and reliable products and services that promote health.
- Access helpful people for accurate information.
- Identify trusted adults and professionals.
- Assess the accuracy and reliability of assistance for health-related problems.

Base the curriculum score on its ability to meet the entire standard — not just a few sub-skills for this standard.

Skill Examples: Below are examples that illustrate how a curriculum might address these skills. These examples are not intended to be a complete list of all the ways these skills can be addressed. When considering other examples, it is useful to think about the sub-skills in relation to the content emphasized in the Standard 1 concepts. Remember, the HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise skills or skill examples to reflect community needs and to conform to the curriculum requirements of the school district.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
		• Identify adults, such as a parent, teacher, or health care provider, who can provide accurate information about puberty, sexual health, relationships, and responsible sexual behavior, including sexual risks. • Demonstrate the ability to access accurate and reliable data on abstinence and sexual risk behaviors among young people. • Demonstrate the ability to access appropriate community resources about puberty, sexual health, and family relationships. • Evaluate accuracy and usefulness of sources of information on sexual health.	• Demonstrate the ability to access a trusted adult such as a parent, teacher, or health care provider, who can provide accurate information about sexual health and responsible sexual behavior, including sexual risks. • Demonstrate the ability to access accurate and reliable information about sexual health. • Demonstrate the ability to access accurate and reliable data on abstinence and sexual risk behaviors among young people. • Evaluate accuracy of sources of information on sexual health.

Additional examples for Standard 3 are listed on the next page.

Standard 3 Skill Examples (continued)

After implementing this curriculum, students will be able to demonstrate the ability to access valid information, products, and services to promote sexual health.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
		• Describe ways to seek help to report sexual harassment, sexual assault, child abuse, and other types to violence. • Demonstrate the ability to access existing laws and policies designed to protect young people from being sexually exploited.	• Evaluate the appropriateness and reliability of reproductive and sexual health information. • Demonstrate the ability to access existing laws and policies designed to protect young people from being sexually exploited. • Demonstrate the ability to access information about where to get counseling, testing, and other health care services related to sexual health issues.*

* This skill example promotes risk-reduction and might not be included in a risk-avoidance curriculum.

Notes:

Notes:

Standard 4 Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

Student Skill Learning/Application Scoring: Complete the skill application score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See pages SH-21 and SH-22 for Standard 4 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide information to the students about the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide one opportunity or activity for students to practice the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide more than one opportunity or activity for students to practice the skills needed to meet this standard? (If yes, also check yes for #2 above.)	❒	❒
4. Does the curriculum provide opportunities for students to assess their own skill progress, such as personal check lists?	❒	❒

Student Skill Learning and Application Score (total number of "yes" checks) ☐

Transfer this score to Standard 4: Communication Skills (see Student Learning/Application line) on the *Overall Summary Form* - Chap. 3.

Teacher Instruction and Skill Assessment Scoring: Complete the skill instruction and assessment score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See pages SH-21 and SH-22 for Standard 4 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide guidance to help the teacher understand the steps required to learn and teach the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide guidance for the teacher to model the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide strategies for the teacher to assess the student's ability to perform the skills needed to meet this standard?	❒	❒
4. Are clear assessment standards provided for the teachers, such as a rubric or check sheet that explains the criteria that need to be met to demonstrate the skills needed to meet this standard?	❒	❒

Teacher Instruction and Assessment Score (total number of "yes" checks) ☐

Transfer this score to Standard 4: Communication Skills (see Teacher Instruction/Assessment line) on the *Overall Summary Form* - Chap. 3.

Notes:

Standard 4 Skill Examples

After implementing this curriculum, students will be able to use interpersonal communication skills to promote sexual health.

Sub-Skills: As a result of using this curriculum, students will be able to

- Use effective interpersonal skills with family, friends, and others.
- Resist pressure from peers to engage in unhealthy behaviors.
- Use effective negotiation to avoid or reduce personal health risks.
- Communicate empathy and support for others.
- Effectively manage interpersonal conflicts.
- Ask for assistance to enhance personal health and health of others.

Base the curriculum score on its ability to meet the entire standard — not just a few sub-skills for this standard.

Skill Examples: Below are examples that illustrate how a curriculum might address these skills. These examples are not intended to be a complete list of all the ways these skills can be addressed. When considering other examples, it is useful to think about the sub-skills in relation to the content emphasized in the Standard 1 concepts. Remember, the HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise skills or skill examples to reflect community needs and to conform to the curriculum requirements of the school district.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
• Demonstrate effective communication skills to express feelings appropriately.	• Demonstrate effective communication skills to express feelings appropriately. • Demonstrate communication skills necessary to maintain a healthy relationship.	• Demonstrate effective communication skills to express feelings appropriately. • Demonstrate actions that express personal values. • Demonstrate communication skills necessary to maintain a healthy relationship. • Demonstrate effective negotiation and refusal skills to avoid sexual risk behavior. • Demonstrate how to ask for help from a parent, other trusted adult, or friend when pressured to participate in sexual behaviors. • Demonstrate how to communicate clear expectations, boundaries, and personal safety strategies.	• Demonstrate effective communication skills to express feelings. • Demonstrate actions that express personal values. • Demonstrate the communication skills necessary to maintain a healthy relationship. • Demonstrate verbal and non-verbal ways to refuse pressure to engage in sexual risk behavior. • Demonstrate verbal and non-verbal ways to ask for help from a parent, other trusted adult, or friend when pressured to participate in sexual behaviors. • Demonstrate how to communicate clear limits on sexual behaviors.

Additional examples for Standard 4 are listed on the next page.

Standard 4 Skill Examples (continued)

After implementing this curriculum, students will be able to use interpersonal communication skills to promote sexual health.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
		• Demonstrate how to communicate clear limits on sexual behaviors. • Demonstrate assertiveness skills in dealing with sexually aggressive behavior. • Identify verbal and non-verbal communication that constitutes sexual harassment.	• Demonstrate how to set clear expectations, boundaries, and personal safety strategies related to sexual health. • Demonstrate the communication skills necessary to reduce sexual risks, if sexually active, such as effectively negotiating consistent condom use. * • Demonstrate how to discuss HIV and STD risk and status with sexual partners if sexually active or experienced.*

* This skill example promotes risk-reduction and might not be included in a risk-avoidance curriculum.

Notes:

Notes:

Standard 5 Students will demonstrate the ability to use decision-making skills to enhance health.

Student Skill Learning/Application Scoring: Complete the skill application score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See page SH-25 for Standard 5 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide information to the students about the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide one opportunity or activity for students to practice the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide more than one opportunity or activity for students to practice the skills needed to meet this standard? (If yes, also check yes for #2 above.)	❒	❒
4. Does the curriculum provide opportunities for students to assess their own skill progress, such as personal check lists?	❒	❒

Student Skill Learning and Application Score (total number of "yes" checks) ☐

Transfer this score to Standard 5: Decision Making (see Student Learning/Application line) on the *Overall Summary Form* - Chap. 3.

Teacher Instruction and Skill Assessment Scoring: Complete the skill instruction and assessment score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See page SH-25 for Standard 5 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide guidance to help the teacher understand the steps required to learn and teach the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide guidance for the teacher to model the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide strategies for the teacher to assess the student's ability to perform the skills needed to meet this standard?	❒	❒
4. Are clear assessment standards provided for the teachers, such as a rubric or check sheet that explains the criteria that need to be met to demonstrate the skills needed to meet this standard?	❒	❒

Teacher Instruction and Assessment Score (total number of "yes" checks) ☐

Transfer this score to Standard 5: Decision Making (see Teacher Instruction/Assessment line) on the *Overall Summary Form* - Chap. 3.

Notes:

Standard 5 Skill Examples

After implementing this curriculum, students will be able to demonstrate the ability to use decision-making skills to avoid or reduce sexual risk behaviors and promote sexual health.

Sub-Skills: As a result of using this curriculum, students will be able to

- Determine when health-related situations require the application of a thoughtful decision-making process.
- Generate alternatives to health-related issues or problems.
- Determine barriers that can hinder healthy decision making.
- Predict the short and long-term consequences of each alternative on self and others.
- Choose healthy alternatives over unhealthy alternatives.
- Evaluate the outcomes of a health-related decision.

Base the curriculum score on its ability to meet the entire standard — not just a few sub-skills for this standard.

Skill Examples: Below are examples that illustrate how a curriculum might address these skills. These examples are not intended to be a complete list of all the ways these skills can be addressed. When considering other examples, it is useful to think about the sub-skills in relation to the content emphasized in the Standard 1 concepts. Remember, the HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise skills or skill examples to reflect community needs and to conform to the curriculum requirements of the school district.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
		• Describe the benefits of delaying romantic involvement. • Explain the possible consequences of early sexual behavior and the emotional, social, and physical benefits for delaying sexual behavior. • Summarize the benefits of sexual abstinence. • Summarize the benefits of reducing the risk of HIV infection, other STD infection, and pregnancy. * • Summarize the options for reducing the risk of HIV infection, other STD infection, and pregnancy. *	• Analyze the benefits of delaying romantic involvement. • Predict short - and long-term consequences of sexual behavior. • Analyze the possible consequences of early sexual behavior and the emotional, social, and physical benefits for delaying sexual behavior. • Analyze the benefits of reducing the risk of HIV infection, other STD infection, and pregnancy. * • Analyze the options for reducing the risk of HIV infection, other STD infection, and pregnancy. * • Describe the steps for seeking HIV and STD counseling and testing.*

* This skill example promotes risk-reduction and might not be included in a risk-avoidance curriculum.

Standard 6 Students will demonstrate the ability to use goal-setting skills to enhance health.

Student Skill Learning/Application Scoring: Complete the skill application score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See page SH-27 for Standard 6 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide information to the students about the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide one opportunity or activity for students to practice the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide more than one opportunity or activity for students to practice the skills needed to meet this standard? (If yes, also check yes for #2 above.)	❒	❒
4. Does the curriculum provide opportunities for students to assess their own skill progress, such as personal check lists?	❒	❒

Student Skill Learning and Application Score (total number of "yes" checks) ☐

Transfer this score to Standard 6: Goal Setting (see Student Learning/Application line) on the *Overall Summary Form* - Chap. 3.

Teacher Instruction and Skill Assessment Scoring: Complete the skill instruction and assessment score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See page SH-27 for Standard 6 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide guidance to help the teacher understand the steps required to learn and teach the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide guidance for the teacher to model the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide strategies for the teacher to assess the student's ability to perform the skills needed to meet this standard?	❒	❒
4. Are clear assessment standards provided for the teachers, such as a rubric or check sheet that explains the criteria that need to be met to demonstrate the skills needed to meet this standard?	❒	❒

Teacher Instruction and Assessment Score (total number of "yes" checks) ☐

Transfer this score to Standard 6: Goal Setting (see Teacher Instruction/Assessment line) on the *Overall Summary Form* - Chap. 3.

Notes:

HECAT: Promoting Sexual Health

Standard 6 Skill Examples

After implementing this curriculum, students will be able to demonstrate the ability to set personal goals related to sexual health, take steps to achieve these goals, and monitor their progress in achieving them.

Sub-Skills: As a result of using this curriculum, students will be able to

- Assess personal health practices and status.
- Develop a goal to adopt, maintain, or improve a personal health practice.
- Plan strategies for performing health-enhancing practices.
- Make a commitment to improve health.
- Overcome barriers to action.
- Monitor progress in achieving desired health practices and outcomes.
- Measure accomplishment in meeting health outcomes.

Base the curriculum score on its ability to meet the entire standard — not just a few sub-skills for this standard.

Skill Examples: Below are examples that illustrate how a curriculum might address these skills. These examples are not intended to be a complete list of all the ways these skills can be addressed. When considering other examples, it is useful to think about the sub-skills in relation to the content emphasized in the Standard 1 concepts. Remember, the HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise skills or skill examples to reflect community needs and to conform to the curriculum requirements of the school district.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
		• Explain how early sexual behavior can affect achieving long-term goals. • Set a goal to reduce risk of pregnancy and transmission of HIV and other STDs. * • Set personal boundaries and limits related to sexual behavior. • Demonstrate the ability to set goals to prevent and manage unhealthy relationships. • Make a personal commitment to remain sexually abstinent.	• Summarize how early sexual behavior can affect achieving long-term goals. • Set a goal to reduce risk of pregnancy and transmission of HIV and other STDs.* • Confirm personal boundaries and limits related to sexual behavior. • Demonstrate the ability to set goals to prevent and manage unhealthy relationships. • Make or renew a personal commitment to remain sexually abstinent.

* This skill example promotes risk-reduction and might not be included in a risk-avoidance curriculum.

Standard 7 Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Student Skill Learning/Application Scoring: Complete the skill application score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See pages SH-29 and SH-30 for Standard 7 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide information to the students about the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide one opportunity or activity for students to practice the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide more than one opportunity or activity for students to practice the skills needed to meet this standard? (If yes, also check yes for #2 above.)	❒	❒
4. Does the curriculum provide opportunities for students to assess their own skill progress, such as personal check lists?	❒	❒

Student Skill Learning and Application Score (total number of "yes" checks) ☐

Transfer this score to Standard 7: Practicing Healthy Behaviors (see Student Learning/Application line) on the *Overall Summary Form* - Chap. 3.

Teacher Instruction and Skill Assessment Scoring: Complete the skill instruction and assessment score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See pages SH-29 and SH-30 for Standard 7 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide guidance to help the teacher understand the steps required to learn and teach the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide guidance for the teacher to model the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide strategies for the teacher to assess the student's ability to perform the skills needed to meet this standard?	❒	❒
4. Are clear assessment standards provided for the teachers, such as a rubric or check sheet that explains the criteria that need to be met to demonstrate the skills needed to meet this standard?	❒	❒

Teacher Instruction and Assessment Score (total number of "yes" checks) ☐

Transfer this score to Standard 7: Practicing Healthy Behaviors (see Teacher Instruction/Assessment line) on the *Overall Summary Form* - Chap. 3.

Notes:

Standard 7 Skill Examples

After implementing this curriculum, students will be able to demonstrate strategies to improve or maintain sexual health.

Sub-Skills: As a result of using this curriculum, students will be able to

- Express intentions to engage in health-enhancing behaviors.
- Perform healthy practices.
- Avoid health risks.
- Take responsibility for personal health.

Base the curriculum score on its ability to meet the entire standard — not just a few sub-skills for this standard.

Skill Examples: Below are examples that illustrate how a curriculum might address these skills. These examples are not intended to be a complete list of all the ways these skills can be addressed. When considering other examples, it is useful to think about the sub-skills in relation to the content emphasized in the Standard 1 concepts. Remember, the HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise skills or skill examples to reflect community needs and to conform to the curriculum requirements of the school district.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
• Demonstrate how to express feelings in a healthy way.	• Demonstrate how to express feelings appropriately.	• Demonstrate strategies for expressing feelings appropriately. • Demonstrate the ability to use self-control. • Acknowledge personal responsibility for sexual abstinence. • Acknowledge personal responsibility for sexual and reproductive health. • Plan strategies for maintaining sexual abstinence. • Plan strategies for avoiding situations that place one at risk for engaging in sexual behavior. • Demonstrate setting personal limits to avoid sexual risk behavior. • Express intentions to be sexually abstinent.	• Demonstrate the ability to use self-control. • Acknowledge personal responsibility for sexual abstinence. • Acknowledge personal responsibility for sexual and reproductive health. • Plan strategies for maintaining sexual abstinence. • Plan strategies for avoiding situations that place one at risk for engaging in sexual behavior. • Demonstrate setting personal limits to avoid sexual risk behavior. • Plan strategies for avoiding sexual exploitation via the internet. • Express intentions to be sexually abstinent.

Additional examples for Standard 7 are listed on the next page.

Standard 7 Skill Examples (continued)

After implementing this curriculum, students will be able to demonstrate strategies to improve or maintain sexual health.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
		• Identifying behaviors that are perceived as sexually coercive.	• Analyze behaviors that may be perceived as sexually coercive. • Explain the skill steps for correctly and consistently using a condom.* • Explain the skill steps for correctly and consistently using contraceptives.*

* This skill example promotes risk-reduction and might not be included in a risk-avoidance curriculum. Skill acquisition is more effective when skill steps are demonstrated and practiced rather than explained. However, demonstration and practice of these skill steps might not be feasible due to community acceptability standards and school district policies.

Notes:

Notes:

Standard 8 Students will demonstrate the ability to advocate for personal, family, and community health.

Student Skill Learning/Application Scoring: Complete the skill application score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See page SH-33 for Standard 8 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide information to the students about the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide one opportunity or activity for students to practice the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide more than one opportunity or activity for students to practice the skills needed to meet this standard? (If yes, also check yes for #2 above.)	❒	❒
4. Does the curriculum provide opportunities for students to assess their own skill progress, such as personal check lists?	❒	❒

Student Skill Learning and Application Score (total number of "yes" checks) ☐

Transfer this score to Standard 8: Advocating for Health (see Student Learning/Application line) on the *Overall Summary Form* - Chap. 3.

Teacher Instruction and Skill Assessment Scoring: Complete the skill instruction and assessment score by checking the appropriate "yes" or "no" box for each criteria and summing the "yes" checks. See page SH-33 for Standard 8 sub-skills and skill examples.

Criteria	Yes	No
1. Does the curriculum provide guidance to help the teacher understand the steps required to learn and teach the skills needed to meet this standard?	❒	❒
2. Does the curriculum provide guidance for the teacher to model the skills needed to meet this standard?	❒	❒
3. Does the curriculum provide strategies for the teacher to assess the student's ability to perform the skills needed to meet this standard?	❒	❒
4. Are clear assessment standards provided for the teachers, such as a rubric or check sheet that explains the criteria that need to be met to demonstrate the skills needed to meet this standard?	❒	❒

Teacher Instruction and Assessment Score (total number of "yes" checks) ☐

Transfer this score to Standard 8: Advocating for Health (see Teacher Instruction/Assessment line) on the *Overall Summary Form* - Chap. 3.

Notes:

HECAT: Promoting Sexual Health

Standard 8 Skill Examples

After implementing this curriculum, students will be able to demonstrate the ability to influence and support others to make positive choices related to sexual health.

Sub-Skills: As a result of using this curriculum, students will be able to

- Declare positive beliefs about health-enhancing practices.
- Educate others about health-enhancing practices.
- Influence positive health practices of others.
- Promote health-enhancing societal norms.
- Influence and support others to make positive health choices.

Base the curriculum score on its ability to meet the entire standard — not just a few sub-skills for this standard.

Skill Examples: Below are examples that illustrate how a curriculum might address these skills. These examples are not intended to be a complete list of all the ways these skills can be addressed. When considering other examples, it is useful to think about the sub-skills in relation to the content emphasized in the Standard 1 concepts. Remember, the HECAT is designed to guide the analysis of curricula for local use. Users are encouraged to add, delete, or revise skills or skill examples to reflect community needs and to conform to the curriculum requirements of the school district.

Grades Pre-K–2	Grades 3–5	Grades 6–8	Grades 9–12
		• Demonstrate ways to encourage friends to remain sexually abstinent or return to abstinence if sexually active. • Demonstrate ways to communicate the benefits of protecting oneself from pregnancy and infections from HIV and other STDs.* • Express compassion and support for people living with disease, such as cancer and AIDS.	• Demonstrate ways to encourage friends to remain sexually abstinent or return to abstinence if sexually active. • Demonstrate ways to communicate the benefits of protecting oneself from pregnancy and infection from HIV or other STDs.* • Demonstrate ways to encourage friends who are sexually active to use condoms consistently and correctly to reduce risks for pregnancy, HIV, and other STD infections.* • Express compassion and support for people living with disease, such as cancer and AIDS. • Demonstrate how to communicate the importance of HIV and STD testing and counseling to others who are sexually active. • Support the decisions of others who are sexually active or experienced to seek HIV and STD testing and counseling services.

* This skill example promotes risk-reduction and might not be included in a risk-avoidance curriculum.

This concludes the health education curriculum analysis items related to sexual health. Complete the *Overall Summary Form* and use the scores and notes to inform group discussions and curriculum decisions.

Additional Notes:

Wisconsin Standards for Health Education

Curriculum Checklist

Wisconsin Department of Public Instruction
Tony Evers, PhD, State Superintendent
Madison, Wisconsin

Standard 1: Students will comprehend concepts related to health promotion and disease prevention to enhance health.

1. Grades PK-2

Learning Priority Develop age-appropriate cognitive understanding of health promotion concepts to improve health behaviors.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Describe healthy behaviors.	1:1:A1 Identify ways to prevent common childhood accidents and injuries. 1:1:A2 Describe healthy behaviors that impact personal health. 1:1:A3 List ways to prevent communicable disease.	
B. Apply knowledge of healthy behaviors.	1:1:B1 Describe why it is important to seek health care. 1:1:B2 Describe why it is important to participate in healthy behaviors. 1:1:B3 Use multiple dimensions of health (e.g., physical, mental, social, environmental, and emotional) in everyday life.	

Standard 2: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

1. Grades PK-2

Learning Priority Know what an influence is and how it could affect behaviors.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. List influences on health behaviors.	2:1:A1 Identify internal and external factors that may influence health behaviors.	
B. Analyze various influences on health behaviors.	2:1:B1 Describe how family, emotions, peers, and media can influence health behaviors.	

Standard 3: Students will demonstrate the ability to access valid information and products and services to enhance health.

1. Grades PK-2

Learning Priority Identify individuals who provide valid health information to enhance health behaviors.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify where to get help to promote health.	3:1:A1 Identify trusted adults and professionals who can help promote health. 3:1:A2 Describe ways to locate school and community health individuals.	

Standard 4: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

1. Grades PK-2

Learning Priority Identify and apply effective interpersonal communication skills.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify communication skills that can improve health and reduce health risks.	4:1:A1 Identify ways to communicate. 4:1:A2 Identify ways to express needs, wants, and feelings.	
B. Apply communication skills that can improve health and reduce health risks.	4:1:B1 Describe ways to respond when in an unwanted, threatening, or dangerous situation. 4:1:B2 Use refusal skills including firmly saying no and getting away from the situation. 4:1:B3 Explain how to communicate to a trusted adult if threatened or harmed.	

Standard 5: Students will demonstrate the ability to use decision-making skills to enhance health.

1. Grades PK-2

Learning Priority Identify when a decision-making process is needed to choose a healthy option.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. List health situations where a decision-making process could be used.	5:1:A1 Identify steps in the decision-making process. 5:1:A2 Provide an example of a situation when a health-related decision is needed to keep one safe. 5:1:A3 Create a decision-making plan with family members or trusted adult.	
B. Apply a decision-making process to various situations to enhance health.	5:1:B1 Provide an example of when a health-related decision can be made individually. 5:1:B2 Provide an example of when assistance is needed to make a health-related decision.	

Standard 6: Students will demonstrate the ability to use goal-setting skills to enhance health.

1. Grades PK-2

Learning Priority Know the parts of a personal health goal.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. List personal health goals.	6:1:A1 Identify a personal health goal. 6:1:A2 Identify the steps to achieve a goal. 6:1:A3 Discuss a health goal with a family member or trusted adult.	

Standard 7: Students will demonstrate the ability to use health-enhancing behaviors and avoid or reduce health risks.

1. Grades PK-2

Learning Priority Demonstrate health-enhancing behaviors.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Demonstrate health-enhancing behaviors.	7:1:A1 Demonstrate health-enhancing practices and behaviors. These may include but are not limited to: proper hygiene, physical activity, and healthy eating. 7:1:A2 Demonstrate behaviors that avoid or reduce health risk. These may include but are not limited to: looking both ways before crossing the street, wearing a seat belt, wearing a bike helmet, and removing oneself from threatening situations.	

Standard 8: Students will demonstrate the ability to advocate for personal, family, and community health.

1. Grades PK-2

Learning Priority Recognize the differences between health needs and personal wants.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify ways to express health needs and personal wants.	8:1:A1 Define health needs and personal wants. 8:1:A2 Express health needs and personal wants with family members or trusted adults.	
B. Develop strategies to communicate personal differences between health needs and personal wants that affect health.	8:1:B1 Communicate knowledge of healthy and unhealthy behaviors to family members, trusted adults, or friends. 8:1:B2 Identify role models for healthy habits. 8:1:B3 Encourage friends and classmates to make health choices.	

Standard 1: Students will comprehend concepts related to health promotion and disease prevention to enhance health.

2. Grades 3-5

Learning Priority Develop age-appropriate cognitive understanding of health promotion concepts to improve health behaviors and prevent disease.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Describe basic concepts related to health promotion and disease prevention.	1:2:A1 Describe ways to prevent common childhood accidents, injuries, and communicable and chronic diseases. These may include but are not limited to: refraining from alcohol, tobacco, and other drug use; engaging in physical activity; demonstrating healthy eating; applying social behaviors to prevent or reduce violence; safety and related behaviors. 1:2:A2 Describe the relationships among environment, healthy behaviors, and personal health. 1:2:A3 Explain ways to prevent the spread of communicable diseases.	
B. Apply health knowledge to health-related situations.	1:2:B1 Describe when it is important to seek health care. 1:2:B2 Describe personal and environmental barriers to practicing healthy behaviors. 1:2:B3 Compare various dimensions of health (e.g., emotional, mental, physical, social, and environmental).	

Standard 2: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

2. Grades 3-5

Learning Priority Identify how influences can impact health behaviors.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify influences.	2:2:A1 Describe external factors, including family, peers, culture, media, technology, school environments, physical environments, and health care, which can influence health behaviors. 2:2:A2 Give examples of messages from external factors that can influence health behaviors. 2:2:A3 Describe internal factors, such as personal values, beliefs, and emotions, which can influence health behaviors.	
B. Explore possible impacts of influences.	2:2:B1 Describe how various internal and external factors interact to influence health behaviors.	

Standard 3: Students will demonstrate the ability to access valid information and products and services to enhance health.

2. Grades 3-5

Learning Priority Identify valid sources of health information.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. List sources of valid health information.	3:2:A1 Identify characteristics of valid health information, products, and services. 3:2:A2 Discuss ways to locate valid health information.	
B. Identify valid health information to promote health.	3:2:B1 Identify various valid sources of health information.	

Standard 4: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

2. Grades 3-5

Learning Priority Demonstrate interpersonal communication skills.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Demonstrate communication skills that can improve health.	4:2:A1 Demonstrate effective verbal and nonverbal communication skills to enhance health. 4:2:A2 Describe how to ask for assistance.	
B. Demonstrate communication skills that prevent, resolve, or reduce health risks.	4:2:B1 Demonstrate ways to prevent health risks and conflict through communications. 4:2:B2 Identify refusal skills that avoid or reduce health risks. 4:2:B3 Discuss nonviolent strategies to reduce, manage, or resolve conflict.	

Standard 5: Students will demonstrate the ability to use decision-making skills to enhance health.

2. Grades 3-5

Learning Priority Apply a decision-making process to evaluate health options.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Continue to identify health-related situations that require a decision.	5:2:A1 Identify situations that require a thoughtful decision. 5:2:A2 List healthy options to health-related issues or problems. 5:2:A3 Choose the healthiest option when making a decision.	
B. Examine and apply how a decision-making process can enhance health.	5:2:B1 Determine when assistance is needed in making a health-related decision. 5:2:B2 Examine the potential outcomes of each option when making a health-related decision.	

Standard 6: Students will demonstrate the ability to use goal-setting skills to enhance health.

2. Grades 3-5

Learning Priority Apply goal-setting skills to improve health.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify ways to achieve a personal health goal.	6:2:A1 Identify resources to assist in achieving a personal health goal. 6:2:A2 Identify key family, school, and community members that can assist in achieving a personal health goal.	
B. Practice appropriate goal-setting skills to achieve a personal health goal.	6:2:B1 Choose a clear and realistic personal health goal. 6:2:B2 Develop a plan for reaching the goal. 6:2:B3 Track progress toward goal achievement.	

Standard 7: Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

2. Grades 3-5

Learning Priority Demonstrate a variety of health-enhancing behaviors.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify health-enhancing practices.	7:2:A1 Identify responsible personal health behaviors. These may include but are not limited to: proper hygiene, physical activity, healthy eating, and safety-related behaviors.	
B. Demonstrate health-enhancing behaviors.	7:2:B1 Demonstrate behaviors that will maintain or improve personal health. These may include but are not limited to: engaging in regular, age-appropriate physical activity; making complex food choices that constitute healthy eating; and following medical instructions during illness. 7:2:B2 Demonstrate behaviors that avoid or reduce health risks. These may include but are not limited to: looking both ways before crossing the street; wearing a seat belt; wearing a bike helmet; and refraining from alcohol, tobacco, and other drug use.	

Standard 8: Students will demonstrate the ability to advocate for personal, family, and community health.

2. Grades 3-5

Learning Priority Describe advocacy and health-related situations for which it is appropriate.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Define advocacy.	8:2:A1 State opinions about health issues. 8:2:A2 Discuss factual information about health issues with family members or trusted adults. 8:2:A3 Define advocacy.	
B. Describe situations where advocacy is appropriate.	8:2:B1 Discuss situations where advocacy may be used. 8:2:B2 List types of situations in which one could model health-enhancing behaviors. 8:2:B3 Encourage family members to engage in health-enhancing behaviors through actions or suggestions.	

Standard 1: Students will comprehend concepts related to health promotion and disease prevention to enhance health.

3. Grades 6-8

Learning Priority Comprehend and apply concepts related to health promotion and disease prevention.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify the components of health promotion and disease prevention.	1:3:A1 Identify specific behaviors that can reduce or prevent injuries and communicable or chronic diseases. These may include but are not limited to: refraining from alcohol, tobacco, and other drug use; engaging in physical activity; demonstrating healthy eating; sexual behaviors; applying social behaviors to prevent or reduce violence; safety and related behaviors. 1:3:A2 Describe the negative consequences of engaging in unhealthy behaviors. 1:3:A3 Describe how family history can affect personal health. 1:3:A4 Describe how physical and social environments can affect personal health.	
B. Analyze the benefits of and barriers to practicing healthy behaviors.	1:3:B1 Analyze the relationships between healthy behaviors and personal health. 1:3:B2 Examine healthy behaviors and consequences related to a health issue. 1:3:B3 Predict the outcomes of a variety of unhealthy behaviors.	

Standard 2: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

3. Grades 6-8

Learning Priority Examine how internal and external factors influence personal health behaviors.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Examine impact of influences.	2:3:A1 Examine how external and internal factors can influence health behaviors. 2:3:A2 Provide examples of how factors can interact to influence health behaviors. 2:3:A3 Examine how one's family, culture, and peers influence one's own personal health behaviors. 2:3:A4 Examine how media and technology influence one's own personal health behaviors. 2:3:A5 Examine how one's values and beliefs influence one's own personal health behaviors.	

Standard 3: Students will demonstrate the ability to access valid information and products and services to enhance health.

3. Grades 6-8

Learning Priority Demonstrate and apply strategies to access valid sources of health information.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify criteria for choosing accurate sources of information.	3:3:A1 Describe situations that require accurate health information. 3:3:A2 Locate sources of valid health information from home, school, and community. 3:3:A3 Describe criteria for evaluating resources.	
B. Apply models to analyze sources of information for validity and reliability.	3:3:B1 Analyze the validity of information about health issues, products, and services.	

Standard 4: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

3. Grades 6-8

Learning Priority Examine and demonstrate communication skills that enhance health and avoid health risks.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Examine communication strategies in various health-related settings.	4:3:A1 Examine appropriate communication strategies. 4:3:A2 Examine the outcomes of using effective and ineffective strategies of communication.	
B. Apply appropriate communication skills in various health-related settings.	4:3:B1 Demonstrate refusal and limit setting skills that avoid health risks. 4:3:B2 Demonstrate effective conflict resolution skills. 4:3:B3 Demonstrate ways, such as restorative justice practices, to manage or resolve interpersonal conflicts without harming self or others.	

Standard 5: Students will demonstrate the ability to use decision-making skills to enhance health.

3. Grades 6-8

Learning Priority Apply a decision-making process in various health-related situations.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify situations where effective decision-making skills are implemented.	5:3:A1 Determine when individual or collaborative decision making is appropriate.	
B. Assess the impact of a decision-making process on health-related situations.	5:3:B1 Demonstrate decision making in a health-related situation. 5:3:B2 Predict the impact of each decision on self and others. 5:3:B3 Analyze the outcome of a health-related decision.	

Standard 6: Students will demonstrate the ability to use goal-setting skills to enhance health.

3. Grades 6-8

Learning Priority Apply goal-setting skills to health situations.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Identify additional steps to setting and achieving realistic health goals.	6:3:A1 Establish a baseline of personal health behaviors and health status. 6:3:A2 Identify strategies and behaviors needed to maintain or improve health status. 6:3:A3 Identify strategies that might be utilized to overcome barriers or setbacks.	
B. Apply goal-setting skills to various health-related situations.	6:3:B1 Examine how personal health goals can be impacted by various abilities, priorities, and responsibilities that may change throughout the lifespan. 6:3:B2 Develop goals to maintain or improve personal health status. 6:3:B3 Assess the effectiveness of health strategies to reach personal goals.	

Standard 7: Students will demonstrate the ability to use health-enhancing behaviors and avoid or reduce health risks.

3. Grades 6-8

Learning Priority Apply health-enhancing behaviors that maintain or improve the health of self or others.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Explain the importance of self-responsibility for personal health behaviors.	7:3:A1 Evaluate behaviors that maintain or improve the health of self and others. These may include but are not limited to: refraining from risky sexual behaviors; refraining from alcohol, tobacco, and other drug use; engaging in regular and varied physical activity; meal planning that leads to healthy eating; applying social behaviors to prevent or reduce violence; practicing safety-related behaviors in various complex settings; and appropriate use of the health care system.	
B. Demonstrate the role of self-responsibility in enhancing health.	7:3:B1 Demonstrate health-enhancing practices and behaviors that help maintain or improve the health of self and others. 7:3:B2 Demonstrate behaviors that avoid or reduce health risks.	

Standard 8: Students will demonstrate the ability to advocate for personal, family, and community health.

3. Grades 6-8

Learning Priority Develop health-promoting strategies that support family or friends to make positive health choices.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Develop an advocacy plan to promote health.	8:3:A1 Develop an age-appropriate definition of advocacy. 8:3:A2 Plan ways to advocate for healthy individuals, families, and schools. 8:3:A3 Incorporate accurate information as it relates to a health-enhancing position for self and others. 8:3:A4 Discuss the barriers that could be involved in an advocacy effort.	
B. Implement an advocacy plan pertaining to a health issue.	8:3:B1 Predict how an advocacy plan will influence and support the health status of others. 8:3:B2 Apply a plan to advocate a health issue for people that experience health disparities. 8:3:B3 Defend a position relating to a health issue. 8:3:B4 Describe ways to adapt health messages for different audiences.	

Standard 1: Students will comprehend concepts related to health promotion and disease prevention to enhance health.

4. Grades 9-12

Learning Priority Examine and apply health concepts related to health promotion and disease prevention.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Analyze the impact of determinants of health.	1:4:A1 Analyze how genetics and family history can affect personal health. 1:4:A2 Examine the interrelationships of various dimensions of health (e.g., emotional, mental, physical, social, environmental, and occupational). 1:4:A3 Analyze the impact of unhealthy behavior on various dimensions of health (e.g., emotional, mental, physical, social, environmental, and occupational). 1:4:A4 Predict how personal behaviors and access to appropriate health care can affect health. 1:4:A5 Analyze how environment and personal health are interrelated.	
B. Explore factors that impact health status.	1:4:B1 Investigate the relationship between access to health care and health status. 1:4:B2 Compare the benefits of and barriers to practicing a variety of health behaviors. These may include but are not limited to: refraining from alcohol, tobacco, and other drug use; physical activity; healthy eating; social behaviors to prevent or reduce violence; safety and related behaviors. 1:4:B3 Examine susceptibility to and severity of injury and illness if	

	engaging in unhealthy behaviors.	

Standard 2: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

4. Grades 9-12

Learning Priority Evaluate how influences impact health behaviors.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Analyze the impact of external and internal influences on the health behavior of individuals and populations.	2:4:A1 Analyze how external influences, individually and in combination with others, can influence individuals' health behaviors and that of certain populations. 2:4:A2 Analyze how internal influences, including perception of social norms among peers, can influence individuals' health behaviors and that of certain populations. 2:4:A3 Examine how social policies can influence health behaviors. 2:4:A4 Estimate the impact of internal and external influences on one's own personal health behavior. 2:4:A5 Predict how various external and internal influences will interact and impact the health behavior of populations.	

Standard 3: Students will demonstrate the ability to access valid information and products and services to enhance health.

4. Grades 9-12

Learning Priority **Examine strategies to access valid and reliable sources of health information**.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Continue to apply criteria for choosing accurate sources of information.	3:4:A1 Determine the availability of information, products, and services that enhance health. 3:4:A2 Access health information, products, and services that improve health outcomes. 3:4:A3 Determine when professional health services may be needed and how to access them.	
B. Analyze sources of information for validity and reliability.	3:4:B1 Evaluate the validity of sources of health information using key criteria.	

Standard 4: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

4. Grades 9-12

Learning Priority Analyzes various communication skills that enhance health and avoid health risks.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Continue to analyze communication skills in various health-related settings.	4:4:A1 Analyze communication strategies for effective interaction among family, peers, and others to enhance health. 4:4:A2 Reflect on the impact of communication on enhancing health. 4:4:A3 Demonstrate how to ask for and offer assistance to enhance the health of self and others.	
B. Demonstrate communication skills in health-related situations.	4:4:B1 Demonstrate refusal, negotiation, and collaboration skills to enhance health and avoid or reduce health risks. 4:4:B2 Demonstrate strategies to prevent interpersonal conflicts. 4:4:B3 Demonstrate ways, such as restorative justice practices, to manage or resolve interpersonal conflicts without harming self or others.	

Standard 5: Students will demonstrate the ability to use decision-making skills to enhance health.

4. Grades 9-12

Learning Priority Examine the use of a decision-making process in various health-related situations.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Evaluate the impact of a decision-making process on health-related situations.	5:4:A1 Identify situations in which using a thoughtful decision-making process would be health enhancing. 5:4:A2 Justify when individual or collaborative decision making is appropriate.	
B. Apply effective decision-making skills to enhance health.	5:4:B1 Demonstrate effective decision-making processes related to various complex and relevant health-related situations. These may include but are not limited to: decisions about personal behaviors, decisions related to social behaviors, and use of the health care system. 5:4:B2 Generate alternatives to health-related issues or problems. 5:4:B3 Examine barriers that can hinder healthy decision making. 5:4:B4 Predict the potential short-term and long-term impacts of each alternative on self and others. 5:4:B5 Defend the healthy choice when making decisions. 5:4:B6 Evaluate the effectiveness of a health-related decision.	

Standard 6: Students will demonstrate the ability to use goal-setting skills to enhance health.

4. Grades 9-12

Learning Priority Apply goal-setting skills.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Analyze issues that impact setting a goal.	6:4:A1 Assess personal health practices and their impact on overall health status. 6:4:A2 Evaluate potential barriers or setbacks that may impede one's ability to reach his/her health goal. 6:4:A3 Identify strategies that might be utilized to overcome barriers or setbacks.	
B. Apply goal-setting skills to various health-related situations.	6:4:B1 Formulate an effective long-term personal health goal. 6:4:B2 Develop a plan to reach a personal health goal that addresses strengths, needs, and risks. 6:4:B3 Implement a plan and monitor progress in achieving a personal health goal.	

Standard 7: Students will demonstrate the ability to use health-enhancing behaviors and avoid or reduce health risks.

4. Grades 9-12

Learning Priority Demonstrate age-appropriate, health-enhancing behaviors to reduce health risks.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Examine health-enhancing behaviors.	7:4:A1 Determine behaviors that will protect and promote health in high risk situations. These may include but are not limited to: refraining from risky sexual behaviors; refraining from alcohol, tobacco, and other drug use; engaging in various forms of physical activity appropriate to current and future life stages; making complex food choices in various food environments to support healthy eating; applying social behaviors to prevent or reduce violence in settings relevant to one's culture; practicing safety-related behaviors in high risk situations; and appropriately accessing health care services for routine preventive care and for illnesses and injuries. 7:4:A2 Analyze the role of individual responsibility and the health care system in enhancing health.	
B. Apply health-enhancing behaviors.	7:4:B1 Demonstrate a variety of health practices and behaviors that will maintain or improve the health of self and others. These include but are not limited to: personal behaviors such as regular and health-enhancing physical activity, healthy eating, and accessing appropriate preventive health care services. 7:4:B2 Demonstrate a variety of behaviors that avoid or reduce health risks to self and others. These include but are not limited to: various complex safety-related behaviors, appropriately accessing mental and physical health care services, and carefully following medical advice and instructions.	

Standard 8: Students will demonstrate the ability to advocate for personal, family, and community health.

4. Grades 9-12

Learning Priority Apply skills to advocate for a health issue.		
Focus Area	**Learning Continuum**	**Where in the curriculum am I doing this?**
A. Develop strategies to advocate for a health issue.	8:4:A1 Apply societal norms to formulate a health-enhancing message. 8:4:A2 Adapt health-enhancing messages and persuasive communication techniques to a specific target audience. 8:4:A3 Apply accurate information to support a health-enhancing message. 8:4:A4 Develop strategies to overcome barriers or resistance to desired health action or behavior.	
B. Implement an advocacy plan pertaining to a health issue.	8:4:B1 Develop a plan to advocate for a personal, family, or community health issue. 8:4:B2 Implement an advocacy plan for a health issue. 8:4:B3 Demonstrate conviction in encouraging others to make positive health choices.	

Human Growth and Development Instructional Materials

Review Form

Title	
Publisher	Year

Assessment Criteria	Recommendation	Comments
Accuracy of information Provides basic, accurate information about teen sexual health. Information on disease transmission and prevention is complete and accurate, with information on where to access current data.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	Automatic rejection if information is inaccurate, incomplete, or outdated.
Clear outcomes Delivers and consistently reinforces a clear message that is health promoting (e.g., abstinence from sexual intercourse and injectable drug use are promoted as the only 100 percent risk-free behaviors for the majority of HIV transmission). Risk reduction strategies are provided to meet the needs of all learners, including those who continue to engage in a range of high-risk behaviors. Does not directly promote or encourage sexual activity or drug use.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	
Positive approach to human sexuality and relationships Centered on a positive, healthy definition of human sexuality, not solely on the avoidance of negative outcomes. Builds on a basic appreciation of human sexual expression throughout the lifespan, including sexual orientation.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	

Assessment Criteria	Recommendation	Comments
Racially, ethnically, culturally non-biased, gender fair Representation of racially, ethnically, and culturally diverse populations, including LGBT youth in actors and in materials that recognize and respect ranges in cultural/community norms, language, and beliefs. Equal and appropriate representation of males and females. Demonstrates equality in roles/authority, use of referent pronouns, addressing male and female risks of transmission, and responsibility for prevention/protection.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	
Developmentally appropriate for intended age and ability Incorporates language, learning goals, teaching methods, materials, and tone (emotional message) that are appropriate to the age, sexual experience, and culture of audience.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	
Parental involvement Supports involvement of parents and/or other trusted adults in messages and activities to encourage youth to reach out to parents and other trusted adults.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	
Skill-building and personal responsibility Addresses social pressures that influence sexual behavior. Provides examples of and practice with being assertive, using negotiation and refusal skills, making decisions, goal setting, accessing information, self-management, and advocacy. Addresses sexuality within social and cultural contexts and promotes students' power to control personal behaviors.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	
Sound education methodology Employs a variety of skill-based, interactive and creative teaching methods designed to involve participants of different learning styles to help them personalize the information.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	

Assessment Criteria	Recommendation	Comments
Teacher-friendly Materials requiring facilitation (e.g., curricula, videos) are well-organized with clear and thorough instructions or discussion guide. Minimal assembly or preparation time required.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	
Resource quality The narration, packaging, sound, acting, and/or visual quality does not detract from the overall utility of the resource.	❑ 1 - poor ❑ NA ❑ 2 - fair ❑ 3 - OK ❑ 4 - good ❑ 5 - excellent	
Recommended audiences For what audiences would this resource be most appropriate? *Check all that apply*.	Transfer selections to the recommendations form.	❑ Elementary _____ ❑ Middle _____ ❑ High _____ ❑ Communities of color _____ ❑ Urban_____ ❑ Rural_____ ❑ Suburban_____ ❑ At-risk youth _____ ❑ LGBT youth _____ ❑ Parents ❑ Community settings_____
Overall Recommendation	Transfer selection to the recommendations form.	❑ Recommend Highly ❑ Recommend ❑ Reject
Printed Name *First and Last*		
Signature ➢		Date Signed *Mo./Day/Yr.*

Human Growth and Development in Wisconsin Schools 118.019

Human Growth and Development REQUIRED SUBJECTS (2010)	Human Growth and Development REQUIRED SUBJECTS (2012)	Comments
Importance of communication about sexuality & decision making about sexual behavior between pupil and the pupil's parents, guardians, or other family members.		NEW LANGUAGE in *recommended subjects*: The importance of communication about sexuality between the pupil and the pupil's parents or guardians.
Reproductive sexual anatomy & physiology, including biological, psychosocial, and emotional changes that accompany maturation.		Adds intellectual changes in the *recommended* subjects.
Puberty, pregnancy, parenting, body image, and stereotypes.		Repealed from *recommended* subjects.
Skills needed to make responsible decisions about sexuality and sexual behavior throughout the pupil's life, including how to refrain from making inappropriate verbal, physical, and sexual advances and how to recognize, rebuff, and report any unwanted or inappropriate verbal, physical, and sexual behaviors.		Repealed from *recommended* subjects.
The benefits of and reasons for abstaining from sexual activity. Instruction under this subdivision shall stress the value of abstinence as the most reliable way to prevent pregnancy and STI's.	Emphasizes that abstinence from sexual activity before marriage is the only reliable way to prevent pregnancy and STD's, including HIV and AIDS.	Repealed from *recommended* list, but made this language change and inserted it into the new required list of subjects. Is also in the *recommended* subjects.
Health benefits, side effects, and proper use of contraceptives and barrier methods approved by the FDA to prevent pregnancy and barrier methods approved by the FDA to prevent STI's.		Repealed from *recommended* subjects.
Methods for developing healthy life skills, including setting goals, making responsible decisions, communicating, and managing stress.		Remains in the *recommended* subjects.
How alcohol and drug use effect responsible decision making.		Remains in the *recommended* subjects
The impact of media and one's peers on thoughts, feelings, and behaviors related to sexuality.		Remains in the *recommended* subjects
	Provides medically accurate information about HPV, HIV, and AIDS.	NEW REQUIRED SUBJECT
	Explains pregnancy, prenatal development, and childbirth.	NEW REQUIRED SUBJECT

Human Growth and Development REQUIRED SUBJECTS (2010)	Human Growth and Development REQUIRED SUBJECTS (2012)	Comments
DESIGN/APPROACH		
Use instructional methods and materials that do not promote bias against pupils of any race, gender, religion, sexual orientation, or ethnic or cultural background or against sexually active pupils or children with disabilities.	An instructional program shall use methods and materials that do not discriminate against a pupil based upon the pupil's race, gender, religion, sexual orientation, or ethnic or cultural background or against sexually active pupils or children with disabilities.	Slight language change.
Promote self-esteem and positive interpersonal skills, with an emphasis on healthy relationships including friendships, marriage, and romantic and familial relationships.		NEW LANGUAGE: Address self-esteem and personal responsibility, positive interpersonal skills, and healthy relationships. Not in required subjects. (2)(c)
Identify counseling, medical, and legal resources for survivors of sexual abuse and assault, including resources for escaping violent relationships.		Remains in the *recommended* subjects
Instruction in marriage and parental responsibility.	Provides instruction in parental responsibility and the socio-economic benefits of marriage for adults and their children.	Adds socio-economic benefits.
Presents abstinence from sexual activity as the preferred choice of behavior in relationship to all sexual activity for unmarried pupils.	Present abstinence from sexual activity as the preferred choice of behavior for unmarried pupils.	
Emphasizes that abstinence from sexual activity before marriage is the most effective way to prevent pregnancy and STD's, including HIV and AIDS.		
The criminal penalties for engaging in sexual activities involving a child.	Explains criminal penalties for engaging in sexual activities involving a child.	Slight language change.
The sex offender registration requirements. Instruction to include who is required to report and what information must be reported; who has access to the information, and implications of being registered as a sex offender.	Explains the sex offender registration requirements. Instruction to include who is required to report and what information must be reported; who has access to the information, and implications of being registered as a sex offender.	Slight language change.

NEW SUBJECTS LISTED-RECOMMENDED	COMMENTS
Present information about avoiding stereotyping and bullying, including how to refrain from making inappropriate remarks, avoiding engaging in inappropriate physical or sexual behaviors, how to recognize, rebuff, and report any unwanted or inappropriate remarks or physical or sexual behaviors.	
…Identify the skills necessary to remain abstinent.	Part of the teaching of abstinence as the only reliable way to prevent pregnancy and STI's. This skills language is in the recommended subjects but abstinence as the only reliable prevention method is in required subjects.
Adoption resources, prenatal care, and postnatal supports.	
The nature and treatment of STI's.	
Address the positive relationship between marriage and parenting.	

Chapter 8
Resources

Resources

8

State Agencies

Wisconsin state agencies and staff who can provide technical assistance on HGD issues.

Wisconsin Department of Public Instruction

Student Services/Prevention and Wellness Team
PO Box 7841
Madison, WI 53707-7841
http://sspw.dpi.wi.gov/

Lori Stern
HIV/AIDS/STD Prevention Consultant
608-264-9550
lori.stern@dpi.wi.gov

Eileen Hare
Health Education and Physical Activity Consultant
608-267-9234
eileen.hare@dpi.wi.gov

Emily Holder
Coordinated School Health Programs Consultant
608-267-9170
emily.holder@dp.wi.gov

Diane Ryberg
Family and Consumer Sciences Education Consultant
608-267-9088
diane.ryberg@dpi.wi.gov

Wisconsin Department of Health Services

Division of Public Health
1 West Wilson Street
Madison, Wisconsin
www.dhs.wi.gov

Karen M. Johnson
HIV Prevention Consultant
608-266-1808
johnskm@dhs.wisconsin.gov
www.dhs.wisconsin.gov/aids-hiv/

Wisconsin Sexually Transmitted Diseases (STD) Program
www.dhs.wisconsin.gov/communicable/std/index.htm

Federal Agencies

CDC, Division of Adolescent and School Health (DASH). This division seeks to prevent the most serious health risk behaviors among children, adolescents, and young adults. The website contains important information about adolescent health issues and links to related information.
www.cdc.gov/HealthyYouth/index.htm

National Institutes of Health, National Library of Medicine. Medline Plus: Teenage Pregnancy. This informational website has links to the latest news, research, publications, data and research articles relating to teenage pregnancy.
www.nlm.nih.gov/medlineplus/teenagepregnancy.html

CDC, National Center for HIV, STD and TB Prevention, DHAP. This division is responsible for the CDC's HIV/AIDS prevention efforts in the United States. This website contains basic science, surveillance, prevention research, vaccine, prevention tools, treatment, funding, testing, evaluation , and training information about HIV, sexually transmitted diseases (STDs), and tuberculosis.
www.cdc.gov/hiv/dhap.htm

CDC, National Prevention Information Network (NPIN). This section of CDC provides information about HIV/AIDS, STDs, and tuberculosis to people and organizations working in prevention, health care, research, and support services. The website contains information, facts, databases, services, and publications about HIV/AIDS, STDs, and tuberculosis. The CDC MMWRs are also available through NPIN.
www.cdcnpin.org

DHHS, Office of the Surgeon General. Of particular importance for sexuality education is The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior.
www.surgeongeneral.gov/library/sexualhealth/default.htm

Selected National Organizations

Advocates for Youth. Advocates for Youth is dedicated to creating programs and advocating for policies that help young people make informed and responsible decisions about their reproductive and sexual health. Advocates provide information, training, and strategic assistance to youth-serving organizations, policymakers, youth activists, and the media in the United States and the developing world.
www.advocatesforyouth.org

Henry J. Kaiser Family Foundation. The Henry J. Kaiser Family Foundation is a non-profit, private operating foundation focusing on the major health care issues facing the nation. The Foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public. This organization addresses numerous health issues, including adolescent sexuality. www.kff.org/youthhivstds/index.cfm

Sexuality Information and Education Council of the U.S. (SIECUS). SIECUS is a national nonprofit organization that affirms that sexuality is a natural and healthy part of living. It develops, collects, and disseminates information, promotes comprehensive education about sexuality, and advocates for the right of individuals to make responsible sexual choices.
www.siecus.org

National School Boards Association School Health Programs. These programs are committed to helping school policymakers and educators make informed decisions about health issues affecting the academic achievement and healthy development of students and the effective operation of schools.
www.nsba.org/Board-Leadership/SchoolHealth

National Education Association-Health Information Network is the non-profit health and safety arm of the National Education Association (NEA). The NEA Health Information Network (NEA HIN) provides health and safety information, programs, and services for the benefit of the more than 3 million members of the NEA and their 43 million students.
http://www.neahin.org/

Answer at Rutgers University provides professional development opportunities in sexuality education for teachers and other youth-serving professionals through their *Sexuality Education Training Initiative*. In 1994, they began using the power of peer-to-peer communication to offer sexuality education directly to teens through a national *Teen-to-Teen Sexuality Education Project*, which features the award-winning *Sex, Etc.* national magazine and Web site.
http://answer.rutgers.edu/