

Evaluating Comprehensive Sex Education Curricula for Potential Adaptation in New York City

Compiled for the National Institute for Reproductive Health

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Executive Summary

This report analyzes the comprehensive sex education curricula of four school districts. It evaluates the curricula on several measures and provides recommendations on the specific components of each curriculum that would be best suited for adaptation in a comprehensive sex education program in New York City.

Comprehensive sex education is a controversial subject, and there has been much public policy debate about it over the last 25 years. National policy trends were to encourage “abstinence-only” education, which teaches that abstinence from sexual activity is the recommended choice for adolescents to make. No discussions of contraception, condoms, or other aspects of safer behaviors when having sex are part of the curriculum. Research, however, has shown no positive behavioral impact from abstinence-only programs, and has instead found that comprehensive sex education tends to reduce both teen pregnancy and teen STD/HIV infection rates.

Based on discussions with the National Institute for Reproductive Health, four school districts’ sex education programs were chosen for analysis and comparison against New York City’s program: the Anchorage School District (Anchorage, Alaska), Cleveland Metropolitan School District (Cleveland, Ohio), Seattle Public Schools (Seattle, Washington), and District of Columbia Public Schools (Washington, DC). Each district’s program was analyzed, with attention paid to things such as subjects covered, amount of class time spent on the curriculum, and age-appropriate differences in the curriculum. Programs were evaluated on measures in three basic categories: goals and objectives of the curriculum, activities and teaching methodologies of the curriculum, and implementation of the curriculum.

This research found that no one school district positively met each evaluative criterion. It did, find, however, that New York City’s current curriculum offerings are very strong; their biggest impediment is that they are not a required part of students’ education. Other curricula that measured well were found in Seattle and Cleveland. The Seattle Public School’s comprehensive sex education curriculum, *FLASH*, is also important to note because it was developed by the public health department of Seattle and King County, and has been adopted by other school districts across the country, including a partial adoption by Cleveland. The District of Columbia Public School’s program is not a specific curriculum, but rather a required set of district-developed health- and sexuality-education “Standards” that any curriculum used must meet; these Standards are highly comprehensive and integrate sex education well into larger health and lifestyle issues. The Anchorage School District proved to be the only district in this research that required a graded semester of health education that included comprehensive sexuality education, as well as being the only district that hired separate health teachers to implement district-wide curriculum.

Problem Statement

Summary of Report Focus

I was asked by the National Institute for Reproductive Health (“the Institute,” or “NIRH”) to analyze and evaluate comprehensive sex education programs from four school districts and evaluate them for best practice components that can be adapted for use in a comprehensive New York City program. This report also provides a general overview of New York City’s current sex education policies as a baseline for comparison to the best practice elements. The bulk of analytic work in this report deals with the following school districts: Cleveland, Ohio; Seattle, Washington; Washington, DC; and Anchorage, Alaska¹.

The Institute is conducting its own research on both the current state of New York City’s sex education curriculum and several other school district models. This report is to “fill in the blanks,” and focuses on school districts with whom NIRH does not have strong existing relationships for conducting analyses, or that they will not have the time or staff available to research. The districts were chosen after several meetings with the director of the Sexuality Education Project.

Important Terms and Definitions

This research was conducted using two key terms that form the crux of the problem being addressed. Although the terms are used frequently by practitioners in the field, they are nevertheless heavy with implications and assigned value judgments. For clarification purposes and to avoid misrepresenting either term, they are both defined here.

- **Comprehensive sex education:** this form of sex education teaches about ways of preventing pregnancy or sexually transmitted disease (STD) transmission/contraction beyond abstaining from sexual activity^{1,2}. Program and curriculum components beyond this vary, but teaching both abstinence and contraception use is critical.
- **Abstinence-only education:** this form of sex education emphasizes no other form of avoiding pregnancy or STD transmission/contraction except for abstaining from sexual activity. It teaches that sex should be delayed until marriage, and discussions of birth control are usually limited to statements about their ineffectiveness³.

Context and Justification for this Research

There has been a shift in recent years away from the abstinence-only policies that have dominated the sex education debate for the last fifteen years. Prior to President Obama’s election, federal funding was only available to school districts promoting abstinence-only education. Abstinence-only is still the policy of many state and local governments, but this pattern, too, is shifting towards more comprehensive education standards. The current federal budget makes available funds for a wider variety of sex education programs, but the request for proposals has not yet been made available.

¹ A fifth district, in Palm Beach County, Florida, was originally part of the research design, but publicly available information proved impossible to come by. After discussions with the Institute, they reached out to their own sources for this information. Based on the Institute’s feedback on the matter, it was determined that Palm Beach Country would not be included in the research findings.

School districts that operate sex education programs do so at range of levels, both academic and intensive. Districts have sex education curricula at all or only some levels of schooling – elementary, middle, or high school – and these curricula cover all or only some aspects of comprehensive sex education – health, contraception, and agency. The combinations of these components, as well as the larger policy environment, set up the context in which best practices research on comprehensive sex education is done.

Comprehensive sex education has been shown to be more effective in lowering teen pregnancy and sexually transmitted disease (“STD”) rates than abstinence-only education. The only federal funding available for over ten years, however, has been for abstinence-only education. The New York City averages for teen pregnancy, STDs, and age of first sexual experience are above the national averages. New York City does have a variety of sex education components in place, including a purchased curriculum and several health-based initiatives, but no required, district-wide policy or program. A comprehensive sex education program for New York City will likely help lower these rates, which will be good for all City residents.

Literature Review

The Recent History of Sex Education Policy

Abstinence-only sex education has been the dominant policy framework of the last fifteen years. Over the past fifteen years, more than \$1.5 billion in federal funds have been devoted to abstinence-only, and since 1997, zero federal dollars have gone towards other, more comprehensive forms of sex education⁴. Instead, federal money for sex education has been funneled through Title V of the Social Security Act, a restrictive set of eight policy guidelines defining abstinence-only programs that states must follow in order to receive funds from the \$50 million program⁵.

In 2000, the Special Projects of Nationwide Significance Community-Based Abstinence Education Program (SPRANS/CBAE), a competitive grant program from the federal government, was launched. This program was even more restrictive than Title V, as CBAE funding prohibits programs from providing any positive information on how condoms or contraception can protect against pregnancy or sexually transmitted diseases (STDs), even in other settings and with non-CBAE funds⁶. Annual funding for CBAE programs is approximately \$113 million.

The emphasis on abstinence-only came on the heels of almost a decade’s time during the 1990s when teen pregnancy rates in the United States dropped, and reflects political, rather than public, interests; at the time these programs were in use, 92 percent of American adults believed adolescents should learn about contraception in schools⁷. This emphasis on abstinence-only education in schools has not led to different values regarding sexual activity by adolescents who receive abstinence-only education versus not⁸, and in fact, two-thirds of teenagers think that teaching a “just say no” approach to sex education is ineffective⁹. Nevertheless, evaluations by the federal government of sex education programs that proved to be successful did not include abstinence-only programs; politicking is a likely reason why such evaluations were eventually removed from the Centers for Disease Control’s website.

A study of sex education programs commissioned by Congress in 1997 that was supposed to be released in 2002 was pushed back to 2005¹⁰, and then finally released in 2007. The report cast serious

doubt on the success of abstinence-only, as it found that such education does not prevent teenagers from having sex, nor increase or decrease the likelihood that they will use a condom if they do have sex¹¹. The study was conducted by Mathematica Policy Research Inc. and looked at only four of the more than 700 federally funded abstinence-only programs. According to the Sexuality Education and Information Council of the United States (SEICUS), “these programs were handpicked to show results and still failed¹².”

The State of Teen Sexual Activity

Approximately 63 percent of high school students in the United States report having sex by spring semester of senior year¹³. Additionally, over 30 percent of girls in the US become pregnant at least once before they turn twenty. People ages 15-24 account for nearly half of all new cases of sexually transmitted diseases (STDs)¹⁴. Many of these rates are reflected among New York City teenagers: 48 percent of public high school students report having had sex, they are below the national average in the use of the Pill as contraception (8 percent versus 18 percent nationwide), and dual protection – using condoms to protect against STDs and contraception to protect against pregnancy – is half the national average (4 percent versus 8 percent)¹⁵.

Research has shown that abstinence-only programs do not affect sexual activity in US teenagers¹⁶, and can in fact have adverse effects on teen pregnancy and STD rates¹⁷. However, studies have shown that comprehensive sex education delays the start of sexual activity, increases condom and contraception use, and reduces teen pregnancy and STD rates¹⁸. Public opinion is on the side of comprehensive sex education: recent surveys have found that, while the numbers are a bit lower than they were when teen pregnancy rates were at their lowest, upwards of 80 percent of the American public still support teaching comprehensive sex education in middle and high schools¹⁹. This support crosses political and ideological lines, as polls have found that 60 percent of self-identified Republicans support teaching comprehensive sex education in public schools²⁰.

Methodology for Conducting the Research

The methodology for this analysis can be broken down into four main steps, as follows:

- (1) The *initial phase* of this project consisted of becoming familiar with the context of the problem. This was accomplished through information sources provided by the Institute, which then led me to additional sources of information on the state of sex education and teenager outcomes in the country. During this time, specific school districts for were selected for analysis.
- (2) The *second phase* of this project consisted of more fully developing the criteria on which programs and program components will be evaluated. These evaluation criteria, which are discussed in more detail in the next section, are derived from Douglas Kirby’s *Emerging Answers 2007*, which is considered the leading analysis of comprehensive sex education programs’ successes and failures. Although Kirby identifies 17 characteristics that effective comprehensive sex education programs have in common, they are divided into three broad categories. Of these three, only two are used in this research: the contents of the curriculum, and the

implementation of the curriculum. Elements in the third category, the process of developing the curriculum, are discussed when applicable to specific school districts but are not factors I was able to analyze within the time and resource constraints of this research.

- (3) The *third phase* of this project was the analysis of each school district's policies and programs relating to sex education. I researched each district and New York City by studying information available on their websites and consulting studies or evaluations from reputable sources. Interviews were only conducted after consultation with the Institute, if they were unable to help me otherwise obtain the information I needed.
- (4) The *fourth phase* of this project consisted of evaluating programs and components based on the selected criteria. The evaluations were designed to measure their strengths based on Kirby's guidelines, and then extrapolate from those successes the likelihood of success or failure should the component be adapted to or replicated in New York City.
- (5) The fifth and *final phase* of the project was to produce recommendations for the Institute. These recommendations detail which programs or components are best suited for adaptation in New York City.

Evaluation Measures

Notes on the Measures Used

The nature of this research is primarily to identify best practice components from other school districts that might theoretically be adapted to New York City. Any New York-based curriculum changes would require significant political support and Department of Education policy changes, and affecting such actions would require far more knowledge of the intricacies of New York City politics, Department of Education curricula, and education policy than I could obtain in time to complete this report.

Similarly, any cost considerations related to adapting best practice components to New York City would necessarily be predicated on the assumption that City curriculum *would* be changed; this implies far more variables for consideration than I am able to analyze. As such, this report focuses on criteria to measure the *effectiveness* of programs, as well as *political support* given for programs, when such information is publically made available.

As previously stated, much information on program evaluation is drawn from the *Emerging Answers 2007* report, which is considered the leading program evaluation toolkit in the field of sex education. As such, evaluation criteria were influenced heavily, and in some cases taken directly from, *Emerging Answers*. The following criteria reflect a combination of considerations *Emerging Answers* recommends, those in which the Institute expressed an explicit interest, and my own determinations based on research findings.

Evaluation Criterion 1: Goals and Objectives of the Curriculum

- Does the curriculum focus on clear health goals – the prevention of HIV/STDs, pregnancy, or both?

- Does the curriculum focus narrowly on specific types of behaviors leading to these health goals, give clear messages about these types of behaviors, and address situations that might lead to them and how to avoid them?
- Does the curriculum address sexual psychosocial risk and protective factors that affect sexual behavior, and work to change them?
- Does the curriculum include at least one full lesson dedicated to positive teachings about sexual orientation and gender identity?

Evaluation Criterion 2: Activities and Teaching Methodologies of the Curriculum

- Does the curriculum include multiple activities to change each of the targeted risk and protective factors?
- Does the curriculum employ activities, instructional methods, and behavior messages that are appropriate to the adolescents' culture, developmental age, and sexual experience?
- Does the curriculum cover topics in a logical sequence?

Evaluation Criterion 3: Implementation of the Curriculum

This category of curriculum evaluation addresses a variety of potential obstacles school districts must overcome and necessities they require in order to successfully implement their programs. These evaluative measures deal more explicitly with the implementing school district's actions.

- Is the curriculum a required component of students' educational experience?
- Did the school district secure at least minimal support from appropriate political authorities?
- Did the school district select educators with health education backgrounds?
- Did the school district provide specific training, as well as monitoring and support after training was complete?
- Did the school district implement virtually all activities with reasonable faithfulness to the original curriculum as written?

Curriculum Analysis

New York City

Curriculum Overview

New York City's Department of Education (NYCDOE) has several policies and programs in place to address different aspects of health and sex education, but no unified comprehensive curriculum. NYCDOE offers several curricula for different age ranges – a specific program for elementary school children (kindergarten through fifth grade, “k-5”), one for middle school students (sixth through eighth grades, “6-8”), and a combination of two programs for high school students (ninth through twelfth grades, “9-12”). Elementary school curriculum is required, while the curricula offered for middle and high school students is only recommended by NYCDOE:

- K-5: *HealthTeacher*²¹, a skills- and assessment-based curriculum that focuses on specific educational areas and building psychosocial skills to enable children to make healthy life choices

- 6-8: *HealthSmart*²², a recently recommended curriculum that addresses issues facing adolescents of this age, focuses on knowledge- and skills-building, and encourages abstinence
- 9-12: *HealthSmart*²³ and *Reducing the Risk*^{24, 25} are the recommended comprehensive curriculum to address issues facing teenagers using knowledge- and skills-building, encouraging abstinence, and providing information on obtaining and using contraception to prevent pregnancy and STDs

Although comprehensive sex education is not required by NYCDOE, New York State mandates an HIV/AIDS curriculum that is taught in elementary, middle, and high school. This curriculum is designed to be medically accurate and comprehensive, and as such does address sexual activity in some instances, but only as such activity relates directly to HIV/AIDS transmission. Ultimately, the teaching of comprehensive sex education is left to the discretion of individual teachers and principals. There are currently no plans by the New York City government to alter NYCDOE's current policy.

HealthTeacher

HealthTeacher is the only health and sexual education curriculum required by NYCDOE. It focuses on nine knowledge-based areas of education, and supplements this new knowledge the students acquire with psychosocial skills that help students enhance overall health and wellness. Each educational unit is subdivided by grade levels – k-1, 2-3, and 4-5 – to further ensure the age-appropriateness of the material. The k-1 lesson on alcohol and drug use, for example, focuses on what medicine is and why it is used; such a view of drug-related education would be inappropriate for older students, whereas the 4-5 lesson on nutrition focuses on critical viewing or advertisements, which would be inappropriate for younger children:

HealthTeacher Elementary-Age Lessons	
Knowledge Areas	Skills Areas
<ul style="list-style-type: none"> ▪ Alcohol and other drugs ▪ Anatomy ▪ Community and environmental health ▪ Family health and sexuality ▪ Injury prevention ▪ Mental and emotional health ▪ Nutrition ▪ Personal and consumer health ▪ Physical activity ▪ Tobacco prevention 	<ul style="list-style-type: none"> ▪ Advocacy ▪ Communication ▪ Decision making ▪ Planning and goal setting ▪ Relationship management ▪ Self management ▪ Stress management

HealthSmart – Middle School

The *HealthSmart* middle school curriculum is divided into seven subjects that represent a broad range of issues facing adolescents in this age range (grades 6-8 roughly correspond with ages 11-14). Each unit addresses factual information and knowledge-building, as well as skills development to make healthier life choices. Two units deal specifically with sexual behaviors and sexuality, one addresses healthy emotional behaviors and relationships; the others deal with health behaviors that impact sexual activity but are not directly related. The Appendix has more information on key lessons in these three

unit areas. Because this report is focused on curriculum components dealing explicitly with sex education, the related health behaviors are listed but not detailed.

The other related behaviors are:

- Improving Health Behaviors
- Nutrition & Physical Activity
- Tobacco, Alcohol & Other Drug Prevention
- Violence & Injury Prevention

HealthSmart is an optional curriculum. NYCDOE recommends that all middle schools participate in it, and offers the instructional materials for free to teachers who take Office of Fitness and Health Education professional development sessions. Such sessions are offered throughout the school year, and teachers of any subject may register for the sessions and teach the curriculum.

HealthSmart – High School

HealthSmart's high school curriculum covers similar subjects as middle school, with enhancements that reflect the older ages and increased social complexities of the students. Also as with their middle school curriculum, HealthSmart for high school students has two of seven units that deal explicitly with sexual behaviors and one that deals with emotional behaviors, as well as one addressing how to improve risky health behaviors that deals more closely with sexual health than its middle school counterpart. The remaining units are not as closely related to sex education specifically, and so are listed but not detailed.

The other related behaviors are:

- Nutrition & Physical Activity
- Tobacco, Alcohol & Other Drug Prevention
- Violence & Injury Prevention

Reducing the Risk

Reducing the Risk (RTR) is a 16-lesson curriculum that is named as an evidence-based HIV-prevention program by the US Centers for Disease Control and Prevention (CDC). It deals exclusively with pregnancy and STD prevention; it explains that while abstinence is the only certain method for avoiding pregnancy or STD infection, RTR teaches teenagers that factual information about contraception and protection is essential for avoiding pregnancy and STDs. There is an emphasis on communication skills for remaining abstinent and avoiding unprotected sex. The lessons in order of presentation offer an integration of knowledge and skills:

- Abstinence, Sex, and Protection – Pregnancy Prevention Emphasis (alternative Lesson 1 has an HIV prevention emphasis)
- Abstinence: Not Having Sex
- Refusals
- Using Refusal Skills
- Delaying Tactics
- Avoiding High-Risk Situations
- Getting and Using Protection I
- Getting and Using Protection II
- Knowing and Talking About Protection: Skills Integration I

- Skills Integration II
- Skills Integration III
- Preventing HIV and Other STDs
- Risk Behaviors
- Implementing Protection from STDs and Pregnancy
- Sticking with Abstinence and Protection
- Skills Integration IV

RTR’s evidence-based curriculum I heavily influenced by the results of a 1991 pilot study using 13 schools in California to determine whether the lessons worked at reducing pregnancy and STDs among teenagers²⁶. One of the authors of this study was Douglas Kirby, the author of *Emerging Answers 207*, the industry standard evaluation of comprehensive sex education programs and the source of this report’s evaluation criteria. The 1991 study of RTR found that among all participants, parent-child communication and knowledge about abstinence and contraception was significantly increased; it found that participants who had not had sexual intercourse prior to beginning the program were significantly less likely to have engaged in sexual activity 18 months later; and the effects of the program among students not sexually active prior to beginning the lessons were seen across a variety of social and racial subgroups. The study did find, however, that RTR did not significantly affect the frequency of intercourse or contraception use among teenagers sexually active at the time of beginning the lessons.

*HIV/AIDS Curriculum*²⁷

The New York State Department of Education mandates HIV/AIDS education in all school districts, from kindergarten through 12th grade. This is entirely separate from disease education in NYCDOE’s own sex education curriculum. The state HIV/AIDS curriculum was first developed in the 1990s and underwent updates in 2005 to reflect the most current medical knowledge. Lessons in early grades focus on illness generally – what it means to be sick, how to stay healthy, and similar objectives – with HIV introduced as a concept in second grade – HIV as a disease that attacks people’s immune systems and prevents them from fighting off other illnesses, and what it might mean for a child with HIV. The mechanics of HIV are the focus of lessons in fourth grade, and methods of transmission are introduced in fifth grade. All of this information is discussed together and in greater detail by middle school (grades 6-8), with an increasing emphasis placed on open communication in relationships, setting limits on physical intimacy in relationships, condom use, and the sociocultural aspects of sexual activity and HIV infection.

Anchorage, Alaska

Curriculum Overview

The Anchorage School District (ASD) has age-appropriate, required health and sexuality curriculum for k-8 students (elementary and middle school-age), and a physical education requirement for 9-12 students (high school) that can be fulfilled through health courses. In an effort to ensure students received factual, knowledge-based health education, ASD hired Health and Social and Emotional Learning (SEL) teachers on a full-time basis; each teacher works at two-to-three schools at a time on a rotating basis²⁸.

ASD uses a combination of purchased curriculum and district-developed health education frameworks to create a comprehensive health and sex education program. Elementary curriculum does

not cover sex education explicitly, though it does begin educating students on HIV using a facts-based approach during grade 3. Sexual behavior education is covered in units dealing with puberty; comprehensive sex education that includes contraception information does not begin until the required semester-long health course in middle school²⁹.

Puberty education, including introductory sex education, is generally known in ASD materials as Human Growth and Development; it occurs during grades 5-6 and is taught coeducationally. ASD emphasizes that coeducation on these matters is critical to helping students make healthier choices later in life because it reduces the stigma associated with puberty and sexuality, encourages open dialogue between boys and girls when encountering related behaviors, reduces treating members of the opposite sex as sexualized objects instead of people, and reinforces the idea that sexual responsibility is shared by both girls and boys³⁰. The emphasis at this age is primarily on changes the body undergoes during puberty and the physical aspect of sex education (e.g.: reproduction and fetal development as opposed to contraception and sexual decision-making), but groundwork is laid for middle school required sex education.

Three textbooks supplement classroom learning at the middle school level, all of which emphasize the goal of teen sexuality as remaining abstinent. One text does not cover sex education beyond the biology of the reproductive system, and the remaining two texts emphasize abstinence for teenagers:

- *Teen Health 2*, published by Glencoe
- *Postponing Sexual Involvement*, published by Grady Health Systems
- *Discover Healthy Sexual Development*, published by AGS

Postponing Sexual Involvement, recently benefitted from an effectiveness study and update by the Jane Fonda Center at Emory University School of Medicine³¹; the assessment was based on information collected from students using the *Postponing Sexual Involvement* text. Though the focus of the text remained on abstinence during teen years, one finding is that it places the emphasis on students postponing sexual activity until they are older and therefore more ready to take responsibility for the physical and emotional commitments that accompany sexual activity.

Elementary School – The Great Body Shop

The curriculum used by ASD for elementary-age students, *The Great Body Shop*, begins discussing HIV as part of the disease-prevention unit during grade 3 lessons, and begins discussing sexual behavior in grade 5. One of the core performance objectives during this unit is to “consider all of the adverse effects sexual activity outside of marriage would have” on students’ lives³², though other objectives include practicing a “healthful” routine with regards to sexual activity and using decision-making skills to engage in age-appropriate behavior. The same title and sequence of units is used for all grade levels, with age-appropriate information taught in each year:

- Injury Prevention and Personal Safety
- Nutrition
- Functions of the Body
- Growth & Development/The Cycle of Family Life
- Disease and Illness prevention (Including HIV)
- Substance Abuse Prevention
- Community Health & Safety (With Violence Prevention)
- Self Worth, Mental and Emotional Health

- Environmental and Consumer Health
- Physical Fitness

Puberty and sexuality education is covered within the Functions of the Body and the Growth & Development units, with an emphasis on biology and hormones on the physical side of knowledge improvement, and building refusal skills and determining the consequences of sexual activity on the psychosocial side of knowledge improvement. HIV/AIDS education is taught as part of a separate unit on illness prevention. This is also the unit where the Human Growth and Development curriculum is used.

“Growth & Development/The Cycle of Family Life” Program Guide^{33, 34}	
Grade 5	Grade 6
<ul style="list-style-type: none"> ▪ Hygiene routines for puberty ▪ Growing up ▪ Endocrine system ▪ Role of hormones ▪ Scientific careers ▪ Hormonal disorders ▪ Biological differences between boys and girls ▪ Responsibilities of maturing adolescents ▪ Decision-making in at-risk situations ▪ Social skills 	<ul style="list-style-type: none"> ▪ Growing up ▪ Puberty ▪ Routine body care ▪ Emotions ▪ Stages of growth from conception to birth ▪ Consequences of sexual activity ▪ Defining emotional maturity ▪ Practicing refusal skills ▪ Setting personal and family goals ▪ Relationships and responsible behavior

The curriculum also includes a parental involvement component. In addition to lessons students learn during school hours, there is material to be taken home and shared with parents. The emphasis is on maintaining healthy communications skills between parents and children as well as facilitating the exchange of factual information by parents in areas where they may not be knowledgeable.

Middle School – ASD Health Framework/Curriculum guide³⁵

ASD requires one semester of health education for middle school students, to be taken during grade 8. This course includes information on comprehensive sex education, mental health and wellbeing, and media literacy as means to make informed and healthy life decisions. The most time during this course is spent on sexuality education:

- Wellness: 5-10 days spent on subject
- Nutrition: 10-15 days spent on subject
- Mental Health: 10-15 days spent on subject
- Disease Prevention: 5-10 days spent on subject
- Media Literacy and Consumer Health: 5-10 days spent on subject
- Nervous System: 3-5 days on subject
- Alcohol, Other Drugs, and Tobacco: 15-20 days on subject
- Sexuality Education: 20-25 days on subject

The core sexuality education lesson continues to be that abstinence is the healthiest lifestyle choice, though now with the caveat that it is the healthiest choice *for teenagers*. One of the key assessment tools teachers use is the development of an “abstinence brochure” by students, and videos to be shown during the course include the title “Postponing Sexual Involvement.”

However, there is an emphasis on the combination of physical and psychosocial expressions of sex, as well as a focus on healthy vs. unhealthy relationships, and how to identify characteristics of each. One of the core elements is full knowledge of the reproductive system, including STD and pregnancy prevention methods that include contraception, in order to make healthier decisions.

Learning objectives of this unit include evaluating the roles of abstinence and contraception in pregnancy and STD prevention and determining if information is valid and appropriate; an overarching theme of ASD curricula is the strong role of critical thinking in health education and building decision-making skills. Among the several guest speakers that each teacher must arrange through the school district are representatives from the Municipality of Anchorage’s Reproductive Health Clinic and Planned Parenthood.

Cleveland, Ohio

Curriculum Overview

The Cleveland Metropolitan School District (CMSD) overhauled its health and sex education curriculum in 2002 to introduce the Comprehensive Health Plan. The Plan included a health indicator for Responsible Sexual Behavior (RSB), and in 2006, with advocacy and support from Cleveland Mayor Frank G. Jackson, k-12 comprehensive sex education curriculum was implemented district-wide. Four RSB curricula were chosen for their age-appropriate, evidence-based approaches to comprehensive sex education:

Cleveland Metropolitan School District: Comprehensive Sex Education Curricula³⁶	
Age Level	Curriculum
Grades K-3	<i>All About Life</i>
Grades 4-6	<i>FLASH</i>
Grades 7-8	<i>Making Proud Choices</i>
Grades 9-12	<i>Safer Choices</i>

For the 2006-07 school year, CMSD trained 14 health and physical education teachers to present the curricula in their respective schools. In 2007-08, curriculum delivery was handled by the 14 already-trained teachers and educators from six community agencies. During the 2008-09 school year, CMSD focused capacity building fully on district health and physical education teachers, with the goal of having at least one trained teacher at each school to present the curriculum. The plan has worked – there are currently only two community agencies acting as curriculum facilitators for ninth and tenth grades.

All curriculum levels have certain learning objectives that CMSD expects students to have mastered upon completion of lessons. CMSD uses National Health Education Performance Indicators to evaluate by grade level. The Indicators were developed by the CDC and are the written expectations of what students should know and be able to do by certain grade levels. The Indicators promote personal, family, and community health and were designed to give instructors a framework for assessing student work.

The State of Ohio does not have a requirement for sex education in schools. It does mandate that the boards of education for all school districts must establish a health curriculum for all schools

under their purview. Included in this curriculum must be education on STDs which emphasizes that abstinence is the only 100 percent-certain way to avoid pregnancy and STD transmission, including AIDS. Among other pro-abstinence lessons, the state policy requires that health education recommend that students abstain from sexual activity outside of marriage, teach about the potential physical and psychosocial effects of having a child outside of marriage, and teach that having a child outside of marriage is “likely to have harmful consequences for the child, the child’s parents, and society³⁷.”

All About Life

The k-3 curriculum introduces body and relationship topics at using age-appropriate lessons. It covers different facets of each lesson as the students’ age progresses, culminating with an introduction to puberty in the third grade, which prepares them for introductory sex education in grades 4-6. *All About Life* covers:

- The difference between family rules and school rules
- Family
- Friendship
- Feelings
- Personal space
- Appropriate touch

FLASH

The Family Life and Sexual Health (FLASH) curriculum, for grades 4-6, uses a combination of knowledge- and skills-building to enable students to make healthier sexuality choices. FLASH was adopted from Public Health – Seattle & King County, who developed it between 1985 and 1992. It covers seven units divided into ten major lessons: family, self-esteem, gender roles, friendship, decision-making, sexual exploitation (abuse), puberty, the reproductive system, pregnancy, and HIV/AIDS.

Making Proud Choices

The *Making Proud Choices* curriculum uses a knowledge- and skills-based approach to encouraging safer sex. It is an adaptation of the *Be Proud! Be Responsible!* curriculum, which focused on HIV/AIDS prevention; *Making Proud Choices* also addresses teen pregnancy reduction³⁸. *Making Proud Choices* is an evidence-based curriculum and has been named as a “program that works” by the CDC³⁹.

Making Proud Choices encourages abstaining from sexual activity or using condoms if an adolescent chooses to be sexually active. The goal of the curriculum is to empower youth to make positive health choices using cognitive-behavior therapies to change attitudes and actions. The program emphasizes condom use to reduce the chances of unintended pregnancy and STD infection, should adolescents choose to engage in sexual activity. The curriculum was designed for groups of about 10 students, but can be adapted for use with larger or smaller groups. Although it was designed with higher-risk African-American adolescents in mind, it can be implemented in various community settings and among various student groups.

Making Proud Choices Curriculum Objectives and Outline
Objectives:
<ul style="list-style-type: none"> ▪ Increase knowledge of HIV, STDs, and pregnancy prevention ▪ Believe in the value of safer sex, including abstinence ▪ Improve ability to negotiate abstinence/safer sex practices

- Increase ability to use condoms correctly
- Have stronger intentions to use condoms if having sex
- Have a lower incidence of STD/HIV sexual risk-taking behavior
- Take pride in choosing responsible sexual behaviors

Outline:

- Module 1: Getting to Know You and Steps to Making Your Dreams Come True
- Module 2: The Consequences of Sex: HIV Infection
- Module 3: Attitudes and Beliefs About HIV/AIDS and Condom Use
- Module 4: Strategies for Preventing HIV/AIDS Infection: Stop, Think, and Act
- Module 5: The Consequences of Sex: STDs and Correct Condom Use
- Module 6: The Consequences of Sex: Pregnancy
- Module 7: Developing Condom Use Skills and Negotiation Skills
- Module 8: Role-Plays: Refusal and Negotiation Skills

The curriculum was built on three theoretical frameworks: Social Cognitive Theory, the Theory of Reasoned Action, and the Theory of Planned Behavior. Using these theoretical guides, *Making Proud Choices* focuses on the concepts of self-efficacy and outcome expectancies. Self-efficacy addresses an individual's confidence to perform a certain action (e.g.: use a condom correctly), and outcome expectancies focus on beliefs about the consequences of choices. The curriculum addresses four areas out outcome expectancies – goals and dreams beliefs, prevention beliefs, and hedonistic beliefs – and incorporates three learning approaches – community and family, the role of sexual responsibility and accountability, and the role of pride.

Safer Choices

The curriculum for grades 9-12, *Safer Choices*, continues the knowledge- and skills-building developed through *Making Proud Choices* with six lessons that teach about HIV/AIDS and other STDs, promotes positive attitudes about choosing not to have sex and using condoms if having sex, and aligns students' perceptions of their risk of contracting STDs with their current sexual behaviors:

- Increase knowledge of HIV and other STDs
- Promote more positive attitudes about choosing not to have sex and using condoms if having sex
- Increase students' belief in their ability to refuse sexual intercourse or unprotected sexual intercourse, use a condom, and communicate about safer sex practices
- Decrease perceived barriers to condom use
- Increase awareness of sexual coercion and acquaintance rape
- Align students' perceptions of HIV and other STD risk based on their risk behavior

Safer Choices takes a holistic approach to sex education – it extends beyond the classroom and incorporates parents, the school, and the community⁴⁰. The goal is to transform comprehensive sex education from a classroom objective into school-wide changes. As an intervention strategy, it contains five basic components:

1. School organization: creates a School Health Promotion Council that consists of teachers, students, parents, administrators, and community representatives;
2. Curriculum and Staff Development: uses 20 sequential classroom sessions as well as staff awareness and training events;

3. Peer Resources and School Environment: establishes a *Safer Choices* peer team or club that hosts school-wide events;
4. Parent Education: features activities for parents such as newsletters, student-parent homework assignments, and other events; and
5. School/Community Linkages: involves activities to enhance students' familiarity with and access to support services outside of school.

The curriculum is designed to be taught over the course of two years, with ten classroom sessions per year. The lessons in Year 2 are structured to build on knowledge and skills attained in Year 1. It assumes that students have had basic puberty and reproductive biology, and as such is not a comprehensive sexuality education program.

Safer Choices is built using a combination of three theoretical frameworks: social cognitive theory, social influences theory, and models of school change. Social cognitive and social influences theories address ways to reduce risk-taking behaviors. The curriculum provides teenagers with information about teen pregnancy, HIV, abstinence, birth control, and the risks and consequences of teen pregnancy and STDs/HIV. It also gives youth opportunities to personalize information in different ways, such as having youth identify their own risks for pregnancy and STDs or identifying their personal values regarding abstinence or using protection. It offers opportunities to recognize social pressures and anticipate risky social situations through examining common lines used to pressure for sex and teaching youth how to anticipate and prepare for situations in which unwanted or unprotected sex may occur. *Safer Choices* reinforces norms for abstinence or protected sex in each of the classes through the information presented and through the skill instruction and practice. It gives teenagers the opportunity to learn and practice these skills, including refusal and protection skills.

Seattle, Washington

Curriculum Overview

The Seattle Public Schools (SPS) use the comprehensive sexuality education curriculum *Family Life and Sexual Health (FLASH)* for grades 4-12. *FLASH* was developed by the Public Health – Seattle & King County, Family Planning Program, and has since been adopted by school districts across the United States and Canada. This is the same curriculum the Cleveland Metropolitan School District uses for grades 4-6.

Sex education is not currently required for SPS students. State guidelines recommend medically accurate, comprehensive sex education be taught, but no mandate is in place. *FLASH* is, however, taught in most elementary and middle school by science teachers; the majority of teachers begin curriculum in the fifth grade. The curriculum is taught primarily by science teachers who have undergone specific training. All elementary school, middle school, and ninth grade teachers, as part of the required Teacher Professional Development Plan, participate in grade-appropriate *FLASH* training. Teachers are required to participate in the Professional Development Plan annually.

FLASH was developed primarily for use in grades 4, 5, and 6, but been expanded to include lessons for middle and high school grade levels since its initial inception. It is currently divided into age-appropriate lessons for grades 4-6, 7-8, 9-10, and 11-12; the curriculum for grades 11-12 is the only one not designed as a stand-alone set of lessons, and explicitly builds on what is taught during grades 9-10.

FLASH has been undergoing revisions since 2002 to update lessons to reflect the most medically accurate information available. The majority of lessons for grades 4-8 were updated in August 2009, with some as recently as February 2010; most lessons for grades 9-12 were last updated in 2006.

The goals of *FLASH* are not explicitly to encourage teenagers from remaining abstinent until marriage or even until there are no longer teens. Rather, stated goals of the curricula include “discourage[ing] premature sexual involvement,” and to “prepare students for life-long sexual health...and to increase the likelihood of their communicating well and experiencing satisfaction in marriage or other long-term adult relationships⁴¹.”

Gender identity and sexual orientation do not get separate lessons until the 11-12 curriculum. However, the possibility that teenagers may discover that they are gay, lesbian, bisexual, transgender, queer, or questioning, is addressed throughout various earlier lessons. It is treated as normal that students might develop feelings for people “of one’s own gender or another gender regardless of one’s eventual sexual orientation⁴².”

Lesson plans and teaching aids for each curriculum include advice on the best way to present the information and handle questions from students. *FLASH* lesson plans lay out a framework for how to handle questions from students that, for example, might contain derogatory slang or frame a question phrased in terms of beliefs or values. The goal of this framework is to help teachers maintain a balance between preserving a safe and open classroom environment with provision of fact-based knowledge. *FLASH* teaching materials also offer guides for creating homework assignments, opening communication about sexuality education with administrators and parents, and setting up field trips or guest speakers to complement the lessons.

FLASH – Grades 4-6

The *FLASH* curriculum for grades 4-6 is the same as described in the section on the Cleveland Metropolitan School District. Please refer there for information on *FLASH* at this grade level.

FLASH – Grades 7-8

The *FLASH* middle school curriculum is divided into three main groups of lessons: basic, communication, and HIV/AIDS. Most lessons require one class period to teach, though some, such as lessons on STDs and HIV/AIDS, require multiple days. The “basic” lessons cover puberty, sexual health and hygiene, STDs, the reproductive system, pregnancy, decision-making and teen parenthood, touch and abstinence, birth control, and resource people. The “communications” lessons teach about passive, aggressive, and manipulative behaviors, honest asking behaviors, taking “no” for an answer, saying “no,” and defending one’s rights. The HIV/AIDS lessons divide are divided into certain areas for grade 7 – basic facts about HIV/AIDS and how alcohol and other drugs affect the risk of transmission – and grade 8 – understanding risk behaviors and rights and responsibilities.

FLASH – Grades 9-10

The curriculum for grades 9-10 continues the knowledge- and skills-based education from previous *FLASH* lessons, but sets additional focus on the psychosocial aspects of adolescence and sexuality. There is also significantly more emphasis placed on contraception, with five days of lessons devoted to the subject. There is also an emphasis on planned parenting, with three lessons addressing issues such as whether students want children and what the qualifications might be to be a good parent.

FLASH – Grades 11-12

The *FLASH* curriculum for grades 11-12 was developed to follow up on lessons and knowledge learned in *FLASH* 9-10. Several lessons depend on prerequisite knowledge. Emphasis continues to be placed on psychosocial development and its relation to sexuality education. Additionally, there are now lessons dealing exclusively with sexual orientation and gender identity. Abortion is introduced in its own lesson during the “Unplanned Pregnancy” unit, as are the sexual response systems and sexuality as a lifelong concept and experience.

Washington, D.C.

Curriculum Overview

Washington, DC requires that the District of Columbia Public School (DCPS) teach medically accurate sex and STD/HIV education⁴³. To address teen pregnancy and STD rates that were higher than the national average, DCPS implemented a new set of comprehensive health and sex education standards in 2007. The new standards were adapted from Indiana content standards, the National Health Education Standards, and the District of Columbia Department of Health, and emphasize a knowledge- and skills-based sex education that is required of all DCPS students⁴⁴. The Standards utilize age-appropriate health and sexuality lessons – divided into six “Strands” – for all DCPS students; lessons are integrated into classroom curriculum for grades pre-kindergarten through eight, while high school students have course credit requirements in health studies that must cover all six Strands. Content Standards are grouped into six strands, each of which addresses a different component of health and sexuality.

The goal of the Standards is to increase health literacy among DCPS students. Because of societal changes since many health and sexuality education curricula were first designed, the DCPS Standards take an approach that incorporates the influence popular culture and the media can have on teenagers’ health decisions. To achieve that, the Health Standards definition of *health literacy* is “the ability of students to obtain, interpret, and comprehend basic health information, products, and services in order to enhance personal, family, and community health⁴⁵.” In addition to comprehensive sex education, DCPS also provides students with STD screenings and free school-based condom availability⁴⁶.

The Standards are not, in and of themselves, curricula. However, they provide guidance for schools and educators to develop or use existing curricula. They are a tool to focus what students should learn from any education program dealing with health and sexuality subjects. Most critically, they indicate the information students must know upon completion of any curriculum, so the information required by the Standards indicates the level of comprehensiveness of any sex education curriculum used by schools.

The District of Columbia Health Standards take a holistic approach to health and sexuality education that extends beyond the scope of this research. As such, information on components of each strand at each grade level is only given for areas directly addressing sexuality education. More detailed information on sexuality education-related requirements can be found in the Appendix.

Strand 1: Health Promotion and Disease Prevention

Strand 1 focuses on concepts of health promotion and disease prevention. Students are given age-appropriate lessons in seven subject areas: emotional health; school and community health; human growth and development; sexuality, reproduction, and health; disease prevention and treatment, nutrition; and alcohol, tobacco, and other drugs. Sexuality education begins in the second grade, when students are asked to describe the physical differences and similarities between genders. Puberty and pregnancy are introduced in fourth grade, while STDs and abstinence are introduced in fifth grade. Acknowledgement of and respect for the physical and emotional needs of different gender identities and sexual orientations are introduced in sixth grade. Sexual orientation is taught further in eighth grade with discussion of how some students may be having emotional or sexual feelings for people of the same gender identity as themselves.

Strand 2: Access to and Evaluation of Health Information

Strand 2 teaches students how to access and evaluate health information, products, and services. Pre-k teaches children how to access emergency services and how to demonstrate “appropriate” trust in adults. Lessons do not all explicitly correspond to sexuality education. Information in grade 6, which addresses identifying agencies that specialize in working with and providing services for teenagers, and grade 8, which focuses on knowing how to seek professional help depending on the type of service needed, would likely cover curricula that include sexual health information.

Strand 3: Self-Management Skills

Strand 3 teaches students how to apply self-management skills to enhance personal health and safety. Lessons are divided into two tracks: personal health and hygiene, and safety skills. Safety skills emphasize lessons on inappropriate touch, how to avoid it, and what to do if it occurs. The topic is introduced in kindergarten with refusal skills. Techniques for avoiding compromising situations, including sexual situations, are taught in thirds grade. Teen dating violence is addressed in eighth grade.

Strand 4: Analyzing Influences

In Strand 4, students learn to analyze the influences of family, culture, media, and technology on health and health behaviors. Lessons are divided into two tracks: family and cultural influences, and media and technology influences. The relationship between the media, technology, and adolescent health and sexuality behaviors is specified grades 6 and 7.

Strand 5: Interpersonal Communication

In Strand 5, students learn to utilize interpersonal communication skills to enhance and protect health. Lessons are divided into two tracks: effective and respectful communication, and resolving conflicts. Lessons do not explicitly address sexuality- or sexual health-related matters.

Strand 6: Decision-Making and Goal-Setting

In Strand 6, students learn how to implement decision-making and goal-setting skills to enhance health. Grade 8 addresses how students identify health choices that are consistent with their personal beliefs, and do not involve risking their own or other people’s health or safety. No other lessons relate to sexuality or sexual health.

High School Courses

High school health courses must address all six Strands. Strands cover the same lesson categories as their elementary- and middle-school counterparts, with emphases on responsible sexual

and sexual health behaviors, understanding of the healthcare system, and the importance of communication in sexual relationships.

Comparative Analysis

The curricula in this report fall along a spectrum with two distinct, though obviously related, ends: sexuality-related and health-related. Generally speaking, sexuality-related curricula can be defined as focusing primarily on sexuality education, rather than integrated education within a larger health- and behavior-focused curriculum. Conversely, the health-related end of the spectrum refers to curricula that incorporate lessons or units on sexuality education within the scope of a larger, comprehensive, health-based program.

Closest to the sexuality-related end of the spectrum is the Seattle curriculum, FLASH. FLASH exists as a program devoted solely to sex education-related matters; health aspects of this topic relate to sex education. Closest to the health-related end of the spectrum would be the Washington, DC Health Standards. While these Standards place significant focus on comprehensive sex education, they are nevertheless folded into the broadest-reaching comprehensive health curriculum of the school districts studied in this report.

The other three curricula fall along the spectrum between these two ends. The Cleveland curriculum, which includes a FLASH component, falls closest to Seattle, while the Anchorage curriculum, which folds a significant number of lessons on sex education-related matters into larger health curriculum, falls closest to Washington, DC; New York City's curriculum lies in the middle of the spectrum. It should be noted as a point of comparison that New York City is the only school district mentioned here that does not require its curriculum to be taught in all classrooms; nevertheless, basing the evaluation solely on the what each curriculum offers, New York's is squarely in between the other four in terms of a balance of comprehensive health and comprehensive sex education curricula.

Washington, DC is the only school district that doesn't mandate specific curricula or courses in its classrooms. Rather, it sets out certain educational standards that must be met by whichever curriculum a given school chooses to use. By contrast, the other school districts require specific curricula to be used at the different age levels. Washington, DC also uses self-designed Standards instead of purchased curriculum; Seattle is the only other district that uses sex education curriculum designed in-house. New York City, Anchorage, and Cleveland all purchase curricula from education companies.

Differences also appear in how each school district approaches behavior modification in relation to sex or health education. In this context, it refers not to the strictest definition of comprehensive sex education – encouraging safer sex behaviors – but to broader implications of health-related behaviors. Washington, DC, Seattle, and Cleveland use programs that place a good deal of emphasis on how culture, peers, and the media impact and shape health behaviors, and what students can do to avoid negative outcomes from these influences. Anchorage does so as well, but to a much lesser extent.

Seattle and Washington, DC use programs wholly of their own designs. Although it is possible that individual school in DC purchase curricula that meets the Health Standards, the learning objectives for health and sex education in these two school districts were tailored to the unique needs of their

student populaces. This also allows these districts to evaluate and adapt their programs with more ease than if they were beholden to curricula designed by others; both districts note that their programs have recently undergone revision based on new data, both from their students and from the health community.

Three of the school districts train existing teachers to provide health or sex education instruction. New York, Seattle, and Washington, DC stipulate that a certain amount of district-provided training is necessary before normal classroom teachers may begin teaching the curriculum. Cleveland provided special training to existing health and physical education teachers when it implemented its new comprehensive sex education program. Anchorage hired new health and social and emotional learning (SEL) teachers specifically for the purposes of teaching the district's health curriculum.

One area that deserves special note is the inclusion of sexual orientation and gender identity issues in some districts' sex education curricula. Seattle and Washington, DC, both pay particular attention to the way information on sexual orientation and gender identity is presented to their students. Both districts emphasize that it's possible, around the middle school age when their peers are beginning to feel attraction to members of the opposite sex/gender, that some students will feel attraction to members of their own sex/gender. The curricula in these districts emphasize that people of non-traditional orientations and identities to want, need, and deserve physical and emotional love and affection. This is a critical component to progressive health and sex education curricula, and it is an area of policy evaluation that deserves closer attention. New York City, in its state-mandated HIV/AIDS curriculum, emphasizes *all* forms of sexual contact that place people at risk for infection, as well as noting particularly at-risk populations, but does not take the full step forward and address sexual orientation and gender identity directly. Neither Anchorage nor Cleveland discuss orientation or identity.

Evaluations

The following tables illustrate how each school district compares to the others on the basis of the previously-determined evaluation criteria. The symbols used in evaluation are as follows:

- ✓ indicates that a school district meets the specified criterion
- X indicates that a school district does not meet the specified criterion
- ~ indicates that the information publically available at the time of this research was not enough to conclusively determine the answer one way or the other

Criterion 1: Goals and Objectives					
	New York City	Anchorage	Cleveland	Seattle	Washington, DC
Does the curriculum focus on clear health goals?	✓	✓	✓	✓	✓
Does the curriculum focus narrowly on specific types of behaviors leading to health goals?	✓	✓	✓	✓	✓
Does the curriculum address sexual psychosocial risk factors that affect sexual behavior, and change them?	✓	✓	✓	✓	✓
Does the curriculum include at least one full lesson dedicated to positive teachings about sexual orientation and gender identity?	X	X	X	✓	✓

Criterion 2: Activities and Teaching Methodologies					
	New York City	Anchorage	Cleveland	Seattle	Washington, DC
Does the curriculum include multiple activities to change each of the targeted risk and protection factors?	✓	✓	✓	✓	~
Does the curriculum employ activities, teaching methodologies, and behavior messages that affect sexual behavior, and change them?	✓	✓	✓	✓	~
Does the curriculum cover topics in a logical sequence?	✓	✓	✓	✓	✓

The Process of Implementing the Curriculum					
	New York City	Anchorage	Cleveland	Seattle	Washington, DC
Is the curriculum required for all students?	X	✓	✓	X	✓
Did the school district secure at least minimal support from appropriate authorities?	✓	✓	✓	✓	✓
Did the school district select educators with health education backgrounds?	X	✓	✓	X	X
Did the school district provide specific training, as well as monitoring and support after training was complete?	✓	✓	✓	✓	X
Did the school district implement virtually all activities with reasonable faithfulness to the original curriculum as written?	✓	✓	✓	✓	~

Recommendations

I am offering two different recommendations: one that would be the most practical given the current situation in New York City, and one that answers the main subject of this report – the creation of a set of components drawn from best practices in each school district to formulate an “ideal” comprehensive sex education curriculum.

Recommendation 1: Make the current New York City curriculum required.

The current programs used by NYCDOE measured fairly well on curriculum evaluative measures, and are already being used in schools around the city, and training procedures for teachers are already in place. In order to implement a comprehensive sex education curriculum that is both evidence-based and politically feasible, the National Institute for Reproductive Health should advocate for New York City to make its current curriculum required for all students. While the current curriculum has imperfections, it is a solid, evidence-based set of programs that would provide students with age-appropriate comprehensive sex education at multiple grade levels. Taking this path would also likely minimize political pressures, as the curriculum materials are already in use by NYCDOE.

Recommendation 2: Use a combination of program components from other school districts to design an “ideal” curriculum.

As this research was to determine which best practice components from different comprehensive sex education curricula in other school districts might be adapted for use in New York City, I recommend the following pieces from each of the other four school districts be utilized:

1. Anchorage School District: Adopt Anchorage’s approach of hiring separate health teachers to teach health and sex education curriculum. This helps ensure the highest level of qualification to cover educational material.
2. Cleveland Metropolitan School District: Require comprehensive curriculum at all school levels, elementary through high school. This ensures that health and sexuality information is not missed, summarized, or provided prematurely; in this way, education may be more accurately targeted to appropriate age groups.
3. Seattle Public Schools: Adopt Seattle Public Health’s *FLASH* curriculum in its entirety, some capacity, or follow a similar approach as Seattle Public Schools’ and encourage NYCDOE to design a new curriculum with NYC Department of Health and Mental Hygiene. This helps ensure that the curriculum is tailored specifically to NYCDOE’s unique student needs.
4. District of Columbia Public Schools: Fold comprehensive sex education into a broader form of comprehensive health education. This provides students with the ability to see the connections between sexual health and larger health and behavioral issues, as well as providing NYCDOE with the chance to customize curriculum to their student body’s unique needs.

Appendix: Curriculum Details

New York City

HealthSmart Middle School: Sex Education-Related Curriculum		
Abstinence & Puberty	Emotional & Mental Health	HIV, STD, & Pregnancy Prevention
<ul style="list-style-type: none"> ▪ Reviews changes male and female bodies undergo during puberty, including to their reproductive systems ▪ Informs on the qualities of healthy relationships and “appropriate” ways to express affection ▪ Identifies the benefits of abstinence and teaches students to practice communication skills that will protect their abstinent choice 	<ul style="list-style-type: none"> ▪ Helps students create rules for respect and trust to make their classroom a safe and healthy space for learning ▪ Teaches about self-esteem and ways to improve it ▪ Teaches about the effects of stress and how to develop skills for preventing and managing stressful situations ▪ Teaches how to express feelings in healthy ways and develop healthy relationships, get help for troublesome feelings, and practice communications skills to strengthen relationships 	<ul style="list-style-type: none"> ▪ Encourages abstinence and addresses skills and practices for preventing and reducing the risk of unintended pregnancy and STDs ▪ Teaches students how to develop strategies to build and maintain healthy relationships and reduce sexual stereotyping ▪ Reviews the negative consequences of risky sexual behavior and promotes skills for protecting sexual health by remaining abstinent or reducing their risk of unintended pregnancy and STD transmission

HealthSmart High School: Sex Education-Related Curriculum	
Abstinence & Puberty	Emotional & Mental Health
<ul style="list-style-type: none"> ▪ Reviews essential information and teaches strategies to help students stay abstinent and protect their sexual health ▪ Students identify and analyze influences that can protect or threaten their decision to remain abstinent ▪ Students develop and practice self-control, communication, and goal-setting skills to help enable them to remain abstinent 	<ul style="list-style-type: none"> ▪ Students create rules for respect and trust to make their classrooms a safe space for learning ▪ Teaches about characteristics of good mental health and what can be done to maintain it ▪ Teaches students how to deal with strong emotions, and where and how to get help for troublesome feelings ▪ Teaches strategies for building healthy relationships and dealing with stressful situations

	<ul style="list-style-type: none"> ▪ Encourages students to engage in community service efforts to enhance their emotional and mental health
HIV, STD, & Pregnancy Prevention	Improving Health Behaviors
<ul style="list-style-type: none"> ▪ Students learn about the elements of relationships and how to recognize unhealthy relationships ▪ Teaches students ways to stop sexual stereotyping ▪ Teaches about common birth control methods and STDs ▪ Identifies ways to reduce the risk of unintended pregnancy and STD infection ▪ Gives students the opportunity to practice negotiating condom use ▪ Teaches students skills for planning ahead, assessing risks, and communicating to protect their sexual health ▪ Teaches students to advocate to help friends to avoid pregnancy and STDs 	<ul style="list-style-type: none"> ▪ Teaches how to change risky or unhealthy behaviors ▪ Identifies common risky or unhealthy behaviors in adolescents and gives students the chance to perform a self-assessment of their own risky behaviors ▪ Uses a theoretical model, <i>Stages of Change</i>, to help students identify one risky behavior to change ▪ Teaches students to develop a plan for implementing change strategies ▪ Teaches students to monitor their own progress and modify their actions to achieve the desired changes ▪ Explains how to acquire the necessary support to maintain healthy behaviors

Cleveland

Grades 4-6 FLASH Curriculum – Lessons and Key Learning Objectives¹	
Family	<ul style="list-style-type: none"> ▪ Differences/similarities among families ▪ Communication in families ▪ The importance of family
Self-Esteem	<ul style="list-style-type: none"> ▪ Keys to feeling good about one’s self ▪ Self-empowering statements ▪ Helping others feel self-esteem
Gender Roles	<ul style="list-style-type: none"> ▪ Defining sex and gender roles ▪ Development of sex roles ▪ Recognition of historical figures of both genders
Friendship	<ul style="list-style-type: none"> ▪ Identifying what makes a good friend ▪ Making friends ▪ Keeping and being a good friend
Decision-Making	<ul style="list-style-type: none"> ▪ Active vs. passive decisions ▪ Introduces a theoretical model for decision-making
Sexual Exploitation (Abuse)	<ul style="list-style-type: none"> ▪ Good/bad touch ▪ Children’s rights

	<ul style="list-style-type: none"> ▪ Recognizing abuse ▪ Preventing and reporting abuse ▪ Helping a friend
Puberty	<ul style="list-style-type: none"> ▪ Defining puberty ▪ Changes and timing of puberty ▪ Hygiene ▪ Feelings and myths about puberty
Reproductive System	<ul style="list-style-type: none"> ▪ Correct medical terminology ▪ Ovulation, sperm production, and reproduction
Pregnancy	<ul style="list-style-type: none"> ▪ Normal pregnancy ▪ Genetics ▪ Fetal development ▪ The importance of prenatal care, good nutrition, and avoiding alcohol during pregnancy
HIV/AIDS	<ul style="list-style-type: none"> ▪ “Healthy concern vs. unhealthy fear” ▪ Defines communicable disease ▪ Symptomatic stages of HIV/AIDS ▪ Attitudes, decision-making, and assertiveness

<i>Making Proud Choices Outcome Expectancies and Approaches</i>
Outcome Expectancies
<p>Goals and Dreams Beliefs: The belief that unprotected sex can interfere with one’s goals and dreams. The belief is specifically addresses in Module 1 and woven throughout the rest of the curriculum.</p> <p>Prevention Beliefs: The belief that condoms can reduce the risk of pregnancy and STD infection/transmission. It is incorporated throughout the curriculum. Partner-Reaction Beliefs: The belief that condom use would cause a negative reaction from a boyfriend/girlfriend. This is addressed during lessons on negotiating condom use, specifically in Modules 7 and 8.</p> <p>Hedonistic Beliefs: The belief that condom use interferes with sexual pleasure. This can reduce the likelihood of using condoms during sex, and is specifically in Modules 7 and 8. Youth are taught that condom use can still be “fun and pleasurable” and learn to incorporate this belief through role-plays.</p>
Approaches
<p>Community and Family: The curriculum emphasizes how unintended pregnancy and STD infection can affect teenagers’ communities, and addresses using protecting the family and community as a motive to implement individual changes. This was a conscious effort to move away from the traditional focus of HIV/AIDS education on impacts to the individual only.</p> <p>The Role of Sexual Responsibility and Accountability: The curriculum teaches adolescents to make responsible choices regarding their sexual behavior and health, discuss what constitutes sexual responsibility, and learn the importance of developing a positive self-image. They learn to make responsible sexual decisions, such as abstinence or condom use if they decide to be sexually active.</p> <p>The Role of Pride: The curriculum addresses the conflicting images about self-esteem and sexuality that teenagers see in the media. It emphasizes that one can feel proud and responsible by making safer</p>

sexual choices, and encourages this self-respect growth through role-plays and skills-building activities.

Seattle

FLASH Curriculum – Grades 7-8	
Basic Lessons	Summary of Learning Objectives
1. Introduction	<ul style="list-style-type: none"> ▪ Explain ground rules ▪ Contribute to serious, considerate class climate
2. Puberty	<ul style="list-style-type: none"> ▪ List physical, emotional, and social changes ▪ Explain that variation in normal
3. Sexual Health and Hygiene	<ul style="list-style-type: none"> ▪ Distinguish between helpful and useless hygiene practices
4. Sexually Transmitted Diseases	<ul style="list-style-type: none"> ▪ Name STDs ▪ List symptoms ▪ List health behaviors that should follow suspicion of infection ▪ Name dangers of untreated STDs ▪ List ways of reducing risks
5. Sexually Transmitted Diseases	
6. Reproductive System	<ul style="list-style-type: none"> ▪ Pronounce, spell, and describe the functions of the parts of the reproductive systems ▪ Explain that variation is normal
7. Reproductive System	
8. Pregnancy	<ul style="list-style-type: none"> ▪ Distinguish myths from facts ▪ Pronounce, spell, and define terms
9. Pregnancy	
10. Decision-Making and Teen Parenthood	<ul style="list-style-type: none"> ▪ Explain that people don't always act on feelings ▪ Distinguish passive from active decisions ▪ List reasons to decide to delay parenting
11. Decision-Making and Teen Parenthood	
12. Touch and Abstinence	<ul style="list-style-type: none"> ▪ Explain importance ▪ Distinguish healthy from risky touch ▪ List reasons to abstain from intercourse
13. Touch and Abstinence	
14. Birth Control	<ul style="list-style-type: none"> ▪ List and define methods, including abstinence ▪ List reasons to communicate with parents and loved ones re: birth control
15. Resource People	<ul style="list-style-type: none"> ▪ Recognize resource people, such as school nurse, counselors, etc. ▪ Describe how resource people can help with family life and sexual health concerns
Communications Lessons	
16. The Basics	<ul style="list-style-type: none"> ▪ Distinguish among assertive, aggressive, passive, and manipulative behaviors ▪ Describe the consequences of each
17. Asking Honestly for What You Want	<ul style="list-style-type: none"> ▪ Formulate an assertive request ▪ Describe how it feels to risk rejection
18. Taking "No" for an Answer	<ul style="list-style-type: none"> ▪ Ask for something approximate ▪ Gracefully accept the rejection ▪ Recognize that persisting after two "No's" is aggression
19. Saying "No"	<ul style="list-style-type: none"> ▪ Formulate an assertive refusal
20. Defending Your Rights	<ul style="list-style-type: none"> ▪ Formulate an assertive defense ▪ Protect him/herself aggressively, if necessary

HIV/AIDS Lessons	
21. HIV/AIDS: Basic Facts (Grade 7)	<ul style="list-style-type: none"> ▪ Describe how human immunodeficiency virus (HIV) affects the immune system ▪ Name body fluids that transmit HIV ▪ Cite most common ways that HIV is transmitted ▪ Define abstinence ▪ Understand the role of condoms in the prevention of STDs
22. HIV/AIDS: The Influence of Alcohol and Other Drugs (Grade 7)	<ul style="list-style-type: none"> ▪ Describe physical and emotional effects of alcohol and other drugs on the body ▪ Recognize that drugs (including alcohol) impair a person's ability to make decisions ▪ Explain that poor decisions about drugs and sexual behavior can put a person at increased risk for HIV ▪ List reasons why some teens use drugs and healthier, less dangerous alternatives for meeting needs
23. HIV/AIDS: Understanding Risk Behaviors (Grade 8)	<ul style="list-style-type: none"> ▪ Define and distinguish between HIV and AIDS ▪ Explain that anyone who takes risks with sex or drugs is vulnerable ▪ Describe how and when one can find out if s/he has HIV ▪ Know that there is neither a vaccine nor a cure for HIV ▪ Explain limits of treatment ▪ Distinguish between behaviors that can and cannot transmit HIV and especially explain why
24. HIV/AIDS: Rights and Responsibilities (Grade 8)	<ul style="list-style-type: none"> ▪ Problem-solve scenarios that they or their friends may encounter, using factual information rather than myths or stereotypes ▪ Explore beliefs about rights and responsibilities of people with HIV and listen to the opinions of others ▪ Apply the concept that HIV/AIDS is only spread through certain behaviors ▪ Identify abstinence as the safest protection from HIV and explain the steps for correct condom use

FLASH Curriculum – Grades 9-10
Lessons
1. Unit Introduction & Pre-Test
2. Touch & Abstinence
3. Reproductive System
4. Puberty/Adolescence, Day 1: Overview
5. Puberty/Adolescence, Day 2: Who Am I? Where Am I Going?
6. Puberty/Adolescence, Day 3: Am I Normal?
7. Puberty/Adolescence, Day 4: Will I Fit In?
8. Puberty/Adolescence, Day 5: What Will I Decide About Touch?
9. Sexual Exploitation, Day 1: Communication
10. Sexual Exploitation, Day 2: Consent vs. Exploitation
11. Sexual Exploitation, Day 3: Continuum of Touch

12. Sexual Exploitation, Day 4: Assault Strategies
13. Pregnancy, Day 1: The Developing Baby
14. Pregnancy, Day 2: The Experience
15. Pregnancy, Day 3: Prenatal Health
16. Planning to Parent, Day 1: Infant Health
17. Planning to Parent, Day 2: Do I Want Children? How Many? When?
18. Planning to Parent, Day 3: Am I Qualified?
19. Un-Planned Pregnancy
20. Contraception, Day 1: Overview
21. Contraception, Day 2: A Closer Look
22. Contraception, Day 3: What's the Best Method?
23. Contraception, Day 4: Communication
24. Sexually Transmitted Diseases (STDs), Day 1: Overview
25. STDs, Day 2: HIV/AIDS, Understanding the Disease
26. STDs, Day 3: HIV/AIDS, It's Impact on People
27. STDs, Day 4: Epidemiology
28. STDs, Day 5: Communication
29. Sexual Health Care
30. Review and Post-Test

FLASH Curriculum – Grades 11-12
1. Critical Thinking
2. Child and Adolescent Sexual Development: Infant and Pre-School Sexual Development
3. Child and Adolescent Sexual Development: Gender Identity and Expression
4. Child and Adolescent Sexual Development: Sexual Orientation and the Individual
5. Child and Adolescent Sexual Development: Sexual Orientation and Society
6. Child and Adolescent Sexual Development: Learning to Love
7. Fertility and Infertility
8. Unplanned Pregnancy: Abortion
9. Unplanned Pregnancy: Adoption
10. Unplanned Pregnancy: Parenting
11. Unplanned Pregnancy: Pregnancy Options and Society
12. Contraception, Individuals, and Society
13. HIV/AIDS: Update, Review, and Pre-Test
14. HIV/AIDS: Focus on Testing
15. HIV/AIDS: Friends and Family
16. HIV/AIDS: HIV/AIDS and Society
17. The Sexual Response System
18. Abstinence, Attitude, and Activism
19. Lifelong Sexuality and Unit Closure

Washington, DC

Strand 1, Grades K-8

Students comprehend concepts of health promotion and disease prevention
Standards – Teaching Objectives

Grade 2 – Sexuality, Reproduction, & Health	<ul style="list-style-type: none"> Describe physical differences and similarities of gender
Grade 3 – Sexuality, Reproduction, & Health	<ul style="list-style-type: none"> Describe how individual bodies are different sizes, shapes, abilities, and colors, but are all equally special
Grade 3 – Disease Treatment & Prevention	<ul style="list-style-type: none"> Distinguish between communicable and non-communicable diseases Explain that some diseases and health conditions are preventable and some are not
Grade 4 – Sexuality, Reproduction, & Health	<ul style="list-style-type: none"> Explain that talking to parents or other trusted adults about sexuality can be helpful Describe the physical and psychosocial changes that occur at puberty Explain how the health of the mother affects that of the fetus
Grade 5 – Sexuality, Reproduction, & Health	<ul style="list-style-type: none"> Define STDs and HIV/AIDS; describe behaviors that place one at risk for HIV/AIDS, STDs, or unintended pregnancy; and explain why abstinence is the most effective way to prevent disease or pregnancy Discuss strategies to remain abstinent and resist pressures to become sexually active
Grade 5 – Disease Treatment & Prevention	<ul style="list-style-type: none"> Explain that viruses and bacteria cause infectious diseases that lead to common illnesses, including STDs
Grade 5 – Emotional Health	<ul style="list-style-type: none"> Describe the relationship between physical and emotional health
Grade 6 – Sexuality, Reproduction, & Health	<ul style="list-style-type: none"> Explain that people, regardless of biological sex, gender, gender identity, orientation, ability, and culture, have sexual feelings and the need for love, affection, and physical intimacy Identify sexual feelings common to adolescents Differentiate between having sexual feelings and acting on them Describe the signs and symptoms of pregnancy and the potential challenges faced by adolescent parents Explain that sometimes women become pregnant when they do not want or are unable to care for a child Describe the symptoms, causes, and myths about HIV; describe what it means when someone in the family has HIV, including the fact that persons living with HIV/AIDS can live long and healthy lives Explain the benefits of abstinence, postponing sexual behavior, and setting limits on sexual behavior Explain the negative repercussions of dating violence
Grade 6 – Disease Treatment & Prevention	<ul style="list-style-type: none"> Explain the importance of practicing health-promoting behaviors, such as wellness checkups, breast and testicular self-exams, and early identification of potential problems
Grade 6 – Emotional Health	<ul style="list-style-type: none"> Discuss how mental, emotional, social, and physical health are interrelated, and describe how problems in one area can influence another
Grade 7 – Sexuality, Reproduction, & Health	<ul style="list-style-type: none"> Describe short-term and long-term consequences of adolescent sexual activity, and the benefits of abstinence as the most effective means of contraception

<ul style="list-style-type: none"> ▪ Differentiate healthy sexual behaviors (abstinence) from those that are harmful (date rape, sexual promiscuity), and identify barriers and supports ▪ Analyze the social, cultural, religious, and legal factors that influence the choice and use of contraception, and the choice to remain abstinent ▪ Compare and contrast the major symptoms of most STDs, indicating that many have no symptoms, and explain the serious consequences of going untreated ▪ Describe the symptoms of, prognosis for, and ways to assist family members and friends who suffer from HIV/AIDS, including how to decrease acts of discrimination and stigma
<p>Grade 7 – Emotional Health</p> <ul style="list-style-type: none"> ▪ Assess the effects of peer pressure and offer effective ways to cope with negative influences and bullying
<p>Grade 7 – School & Community Health</p> <ul style="list-style-type: none"> ▪ Analyze how unhealthy social environments can influence personal health
<p>Grade 7 – Human Growth & Development</p> <ul style="list-style-type: none"> ▪ Describe the components, functions, and processes of the reproductive system, and key developmental and body changes during puberty, including menstruation
<p>Grade 7 – Disease Treatment & Prevention</p> <ul style="list-style-type: none"> ▪ Compare and contrast prevention and treatment of diseases and health conditions prevalent in adolescents, including obesity, diabetes, Lyme disease, STDs, and HIV/AIDS ▪ Assess the use of public health strategies to prevent disease and improve health conditions
<p>Grade 8 – Sexuality, Reproduction, & Health</p> <ul style="list-style-type: none"> ▪ Define sexual orientation, using correct terminology, and explain that as people grown and develop they may begin to feel romantically and/or sexually attracted to people of a different gender and/or of the same gender ▪ Explain the importance of testing both partners for STDs and HIV before sexual behavior, and the risks and precautions of birth delivery when STDs and HIV are present ▪ Compare and contrast the theories about what determines sexual orientation, including genetics, prenatal, social, and cultural influences, psychosocial factors, and a combination of all of these ▪ Describe why abstinence and contraception are important ▪ Describe fertilization, embryonic development, and fetal development, and discuss prenatal practices that support a healthy pregnancy ▪ Describe the physical and emotional changes that occur during each stage of pregnancy and the importance of regular prenatal care
<p>Grade 8 – Disease Treatment & Prevention</p> <ul style="list-style-type: none"> ▪ Recognize that proper diet, exercise, rest, and avoidance of risk factors such as smoking, drinking, and other substance use contribute to the health of a pregnant woman and positively impact the development of the fetus
<p>Grade 8 – Alcohol, Tobacco, & Other Drugs</p> <ul style="list-style-type: none"> ▪ Explain the relationship between injected drug use and diseases such as HIV/AIDS and hepatitis ▪ Discuss how the use of alcohol and other drugs impairs decision-making, increases the risk of violence, and places one at risk for sexual assault, STDs, and pregnancy

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