Comprehensive Sex Education in a Rural School District

By

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ABSTRACT

A rural Pennsylvania school district experienced high rates of teenage pregnancies and was concerned with the impact on its students' lives, as well as the health risks related to early onset of sexual activity. The district wanted to determine the community threshold of sensitivity for topics before implementing a revision to the health curriculum.

A survey was developed which included demographic inquiries and fifteen comprehensive sexuality content questions. Parents and students were asked to indicate the earliest grade level that specific content should be taught. The primary analysis strategy was 2 Groups (students, parents) X 2 Gender (male, female) between-subject ANOVAs. Appropriate sub- analyses were also conducted.

While adult responses for nine of the fifteen questions indicated a parent choice of higher grade levels than student choice, results clearly fell within the elementary to middle school range for the inclusion of comprehensive sex education content in the health curriculum. The mean response rates of 12 of the 15 questions were within the sixth to seventh grade range. The remaining response means varied within the second to fifth grade range.

The results indicated that the parents, teachers, and students are comfortable with the inclusion of sensitive comprehensive sex education content at the middle school levels. Rewriting the curriculum to include comprehensive sex education content will become a priority for the school district. Further exploration into the new National Sexuality Education Standards may also yield additional topics for content consideration.

DEDICATIONS

I dedicate this work to my husband and family. Without their support, I would have not been able to complete my dissertation. My husband graciously accepted the extra responsibilities at home so I could seclude myself while writing and researching for this work. He wouldn't let me quit, even when family and work responsibilities were sometimes overwhelming. When the issues at work seemed to inhibit progress on my dissertation, he found ways to limit access to me so that I could focus on writing. My adult children and sister were great supporters and kept me focused when I found excuses to venture from my study. My grandchildren provided the impetus to keep me progressing so that I could serve as a role model to teach them that learning should be a lifelong venture. I'll love you all, forever.

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Chapter I

Introduction

The Union City Area School District, a conservative, rural, economically impoverished school system in northwestern Pennsylvania, has developed extensive programming to address a myriad of academic and social issues over the past several years. The school district had experienced a dramatic increase in teenage pregnancies that rivaled the larger urban school districts in the county. The district attempted to address the increase in teenage pregnancy rates by offering comprehensive information to assist students in making positive life choices. In 2007, mandatory health education classes in the middle school incorporated *Choosing the Best Way* (Cook, 2009 [3rd ed.]), an abstinence-based program designed for pregnancy prevention by contracting with a local health provider agency. *Choosing the Best Way* a sequential curriculum developed for 6th through 9th grade students, had been reported to show positive results in affecting participants' attitudes, intentions, and behaviors for delaying sexual activity (Weed & Anderson, 2005). The inclusion of parent-child homework, role-playing for resistance training, and realistic video interviews concerning relevant teen issues were elements of the program that were of interest to the school staff and were chosen as the preferred curriculum for those grade levels.

To combat health risks related to early onset of sexual activity for students in grades 9-12, a task force composed of a Modern Living Teacher and administrators developed a curriculum to teach comprehensive, age-appropriate sex education programs within the school district. The program was designed to address abstinence, healthy relationships, and medically accurate information about contraception, decision-making

skills, and assertiveness. An elective class was offered to students who received parent permission prior to scheduling the class. The class was designed to develop Peer Educators who were trained to disseminate relevant, medically accurate health information to their peers and the community. While rates of teen pregnancy have decreased in the school district over the last four years, teen pregnancy and positive life choice issues continue to afflict the school population.

Over the past four years, members of the Peer Educators' class have advised the school administration that comprehensive programming needs to be offered at much younger ages than is currently authorized. To address the problem, it was important to gain insight from students, community agencies and input from parents. Essential feedback regarding specific topics of a comprehensive sex education program and preferred grade levels for dissemination was critical information needed prior to a change in curriculum.

Programs such as *Circles of Sexuality* (Life Planning Education, 2007*)*, *Teen Outreach Program* (Allen & Philliber, 2001), *Making Proud Choices* (Jemmott, Jemmott, & Fong, 1998) and *Safer Choices* (Coyle, et al., 1996) have developed specific curriculum content to deliver information germane to sexuality education and positive youth development. While many of these programs recommend age or grade levels for usage, acceptance of one of these types of programs by the community is a key factor for success. Kirby & Laris (2009) researched "curriculum-based sex and STD/HIV programs and identified "seventeen characteristics of effective programs" (p.21). One of the noted elements in the curriculum development phase included "designing activities consistent with community values" (p. 25). Information received through surveys assist in

structuring future course content for students. Accordingly, the school district polled parents and students.

Schools that have high rates of teenage pregnancy have a responsibility to consider the curriculum used to teach students about sexuality issues. Polling high school students and parents' perspectives is an important step in the change process for developing curricula pertinent to local preference. Providing information to develop the skills necessary to make informed life decisions for specific age populations will help prepare students to meet challenges most will encounter during adolescence and adulthood.

Past research has overwhelmingly shown that parents and students are in favor of comprehensive sexuality education (Constantine, Jerman, & Huang, 2007; Haglund, 2006; Ito, et.al, 2006; Weiser & Miller, 2010). Peer Educators from the school district have repeatedly requested the school administration to offer comprehensive sex education to all students and report that the onset of sexual activity begins in the middle school years. This researcher found no data from surveys conducted for curriculum content comparing student and parent preferences from the same community. The data from such a survey will be very useful when negotiating planned changes to the health curriculum. Student responses will provide an advantage in gaining support for mandating comprehensive sex education in a school district. Determining the grade levels for specific curriculum content is integral to developing the curriculum.

While the Peer Educators have requested that comprehensive sex education be offered in the middle school, polling students with parental permission from grades ten through twelve may reveal that the majority are not in agreement with their peers.

Another possibility is that parents will be less comfortable with the issue of comprehensive sex education and want to have sensitive content presented later in their children's high school years. However, since research has indicated that parents are often in favor of comprehensive sexuality education, the parents in the Union City Area School District may accept a curriculum with sensitive topics in the middle grades. It was important for the school district to determine the threshold of sensitivity for topics from both populations before implementing changes to the curriculum.

Parents may choose for specific sensitive content (e.g., birth control methods) to be taught at higher grade levels than what students would choose. This view would lend support to the following hypothesis:

Hypothesis: Parents will report that (A.) comprehensive sexuality education and (B.) specific sensitive content (e.g., birth control methods) should be taught at higher grade-levels than students report.

Chapter II

Literature Review

Introduction

Sexuality education has received much attention in the last few years. Funding for programs delivers a cost benefit for taxpayers by reducing social costs related to teenage pregnancy such as "increased costs for health care, foster care, incarceration, and lost tax revenue" (National Campaign to Prevent Teen and Unplanned Pregnancy, 2011). It also provides increased health advantages for children, and health and safety information for adolescents.

Teenage pregnancies and sexually transmitted diseases plague American schools and communities. James Wagoner, president of *Advocates for Youth*, reported during a press event in 2001 that "almost 50 young Americans contract HIV, 2500 become pregnant, and nearly 8500 more will contract a sexually transmitted infection daily" (Wagoner, 2001). Over a billion dollars have been invested in abstinence-based programming to address and educate youth on these health related issues, yet recent research notes little effect in decreasing incidences of pregnancy (Stover, 2007). Teenage pregnancy is associated with increased dropout statistics, intergenerational poverty, and life stressors for adolescents, placing them at risk for further social challenges (Hoffman, 2006; Kirby & Laris, 2009; Pogarsky, Thornberry, & Lizotte, 2006; Raphael, 2005).

Of all of the industrialized nations in the world, the United States continues to report the highest number of teenage pregnancy (Bennett & Assefi, 2005; Boonstra, 2002). The investigation of this phenomenon could inform programming and policy in

American schools by identifying the specific skill sets necessary to help adolescents make good decisions that will promote positive outcomes.

History of Sexuality Education in American Schools

National Programs

A review of media and publications indicates that sexuality education was institutionalized by the early decades of the twentieth century (Carter, 2001). Feminist literature, such as women's magazines, provided a vehicle to educate the masses, while the adolescent educational focus strived to provide medically accurate information to prevent sexually transmitted diseases and promote responsible behavior (Bashford & Strange, 2004).

The Social Security Act of 1998 (Section 510) awarded millions of annual grant dollars to promote abstinence-only based curricula in American schools. The effect of this type of programming has been questioned by recent research findings (Eisenberg, Bernat, Bearinger, & Resnick, 2008; Waxman, 2004). Bennett & Assefi (2005) reported that many of the sexuality education curricula they reviewed indicated some change in behavior, but the lasting effects were minimal. Research performed in 2006 with Minnesota parents indicated that parents' preferences for sexuality education content was in conflict with what was offered in most schools (Eisenberg, Bernat, Bearinger, & Resnick, 2008).

The increase in childbearing among adolescents since the 1980s necessitates attention to sexuality education in American schools (Moore, et al., 2008). Abstinence-only curricula have been considered "flawed from scientific and medical ethics viewpoints" (Santelli, Ott, Lyon, Rogers, & Summers, 2006), and merging abstinence-

only education with comprehensive education has been advocated by members of the American Medical Association and the Ambulatory Pediatric Association (Elster & Fleming, 2006; Kittredge, 2006). While recent research has refuted the efficacy of abstinence-only curricula in delaying the onset of sexual activity (Santelli, Ott, Lyon, Rogers, & Summers, 2006) political support for the programs still remains evident through the federal funds allocated for such programming. Healthcare reform legislation in 2010 revealed that comprehensive sex education programs were allocated $75 million, while abstinence-only programs received $50 million (Boonstra, 2010).

Union City Area School District

Five years ago, times were difficult in the Union City Area School District. Poverty rates were the second highest in its county and all but two of the major factories had closed. Truancy, alcohol abuse, illegal drug usage, and the occurrence of teen pregnancy were skyrocketing. After the suicide of a popular teen who had demonstrated no sign of depression or trouble, the administration and staff of the school district knew it had to address these issues and reclaim the once successful culture of the school. In an attempt to understand the problems and to design skill-building remedies, the school district administered a survey in 2004 developed by the *Search Institute*, in Minneapolis, Minnesota (Search Institute, 2012). The survey was designed to identify student risk factors and devise a framework to create a healthy environment for students with *Healthy Youth Development* activities based on the *40 Development Assets Profile* (Search Institute, 2012) in the school and community culture. Concurrently, the teacher of the Modern Living class approached the superintendent with a desire to attend a summer seminar in 2006 that addressed comprehensive sex education, hosted at Rutgers

University. The teacher had noted an increase of pregnancy among her students, despite the basic sex education instruction she had presented in her classes. The teacher had utilized an abstinence-only curriculum.

Upon returning from the seminar, the teacher asked the superintendent if she could develop a new curriculum for her class modeled on the information offered at Rutgers University. The new class was named the Comprehensive Family Life Education class and was offered to students at the beginning of the school year in 2007. Sex education content included elements of the curriculum from *Circles of Sexuality* (Life Planning Education, 2007.) It incorporated units of study for sensuality, intimacy, sexual identity, reproduction, and sexual health. Records reflect that approximately 20 percent of every grade 9-12 have participated in the redesigned Modern Living class from 2007 to 2012.

While the school district continued to provide relevant information for healthy life choices, the teacher soon noted that students were coming to her room before and after school to seek advice regarding very serious issues. Sexual abuse, eating disorders, sexually transmitted infections (STIs), drug and alcohol parties, physical abuse at home, and relationship problems all were issues reported by the students. According to the teens, they sought confidential advice on behalf of their friends, who would not come forth to talk with adults in the school setting. Noting that teens usually respond well to peers, the teacher began a Peer Educators group. The group members began taking classes relevant to HIV/AIDs and STIs through the local County Health Department. Upon completion of the classes, the students were certified to "peer educate" the students in the school who were reluctant to come forth and speak with the school counselors.

Instruction for additional life issues continued, and the Peer Educators became certified to discuss a myriad of issues with students. The Peer Educators annually host a "Making a Difference" (M.A.D.) conference at the school, inviting professionals and community members from the surrounding area to learn about the multitude of issues teens face and the comprehensive life education program. Over 100 professional and community members attend the annual conference. A state senator who represents the locale invited the Peer Educators to address members of the state Senate Education Committee about their program. The students traveled to the state capital and spent a day consulting with various legislators. Legislators requested two further discussions with members of the Peer Educators, and in December 2009, two teen peer educators provided testimony for the House of Representatives' Education Committee about the school programs.

While the school district has made a concerted effort to address teen pregnancy and associated issues within the district, it was essential to make a critical analysis of the current curriculum and gain public input prior to making further changes.

Statistics

Teenage pregnancy in America contributes to social concerns and pervasive health issues with many of our nation's youngest citizens, and often it subjugates young females to substandard living. Risks associated with teenage pregnancy for girls often include the lack of educational success, poor health care, increased probability of dropping out of school, and attainment of careers with low paying wages (Dogan-Ates & Carrion-Basham, 2007).

Studies during the 1990s indicated that more than 70 percent of the births to women under the age of 20 were attributed to single mothers. Of those births documented, “84 percent were unintended” (Moore, et al., 2008).

While studies indicate the number of live births to teen mothers had been decreasing nationally since their peak in the 1990s, the numbers began to increase slightly in 2006 (Tejada-Vera, & Sutton, National Vital Statistics Report 2008; Fast Facts, The National Campaign to Prevent Teen and Unplanned Pregnancy, 2010; Boonstra, 2002; Santelli, Orr, Lindberg, & Diaz, 2009). Due to the lack of abortion data, complete national data are unavailable beyond 2004, leaving many questions as to the reasons for the recent increase in the numbers of teenage pregnancy.

Social program costs are of increased economic concern to many Americans. The cost of teenage pregnancy in 2004 was approximately $9.1 billion dollars (Hoffman, 2006). The *National Vital Statistics Report* of 2008 (Ventura, Abma, Mosher, & Henshaw, 2008) states that these social program expenditures include "public assistance, health care, child welfare, and other expenses"(p. 8). This tax burden limits the available resources for social programming and indicates the need for programs dedicated to reducing the factors associated with teenage pregnancy.

Schools recognize this national concern and have incorporated curricula designed to address issues of teenage pregnancy in many of their health classes. This pervasive issue continues to affect the academic success and the economic future of many teenagers in America's schools. With a plethora of evidence-based programs available for implementation, schools must determine which program delivers the needed components for their school system. The unique cultural environment of a school system may increase

the appeal of one specific program over another. Societal and parental preferences may dictate specific exclusions of relevant information, thus limiting its effectiveness. Teenagers, however, may deem some excluded content important and relevant.

Multiple research studies have provided encouraging statistics regarding successful evidence-based programs, yet few studies draw on teenagers' preferences for relevant content. This information could assist researchers in designing programs to include or improve content pertinent to what teenagers indicate as important knowledge needed to decrease pregnancy or sexually transmitted diseases. Adults working with teens in school systems and members from the community may provide insightful information when determining the appropriate curriculum utilized for sex education courses.

Most studies report pregnancy rates according to age, race, and ethnicity. Statistics illustrate incidents of teen pregnancy are higher for black and Hispanic teens (Tejada-Vera, B & Sutton, P., National Vital Statistics Report, 2008; Fast Facts, National Campaign to Prevent Teen and Unplanned Pregnancy, 2010; Boonstra, 2002). Poverty also has a distinct effect on teenage birthrates. While rates of teenage pregnancy are higher for black and Hispanic teens who live in poverty, communities with high rates of poverty that are predominantly white also need to provide important health and prevention information (Kirby, Coyle, & Gould, 2001). While these factors are important elements to consider regarding programming, Tabi (2002) states that very few studies investigate the essentials needed in programs from the "community perspective of clergy, teens, parents, and school personnel" (p. 276). This suggests that community input is necessary to create a united effort in addressing issues related to teen pregnancy.

The Guttmacher Institute published a fact sheet in 2010 composed of their most recent research regarding teens' sexual activity and reproductive health (Kost, Henshaw, & Carlin, 2010). Forty- six percent of 15 to 19- year-old teens reported they have engaged in sexual activity. The onset of sexual activity is most prevalent for teenagers age 17 or older, yet more than 15% of teens have engaged in sex before 15 years of age. This statistic is problematic because most comprehensive sexuality programming is offered for secondary students during their high school years. An important question becomes what information is relevant to assist students in their middle school years.

Contraceptive usage has increased among teens since the early 1990's. The most popular methods are the pill and condoms. Twenty-five percent of American teenagers use more than one method during sexual intercourse (Kost, Henshaw, & Carlin, 2010). The ability to access contraceptives is problematic for some teens. State laws and insurance regulations can exacerbate confidentiality issues for teens and cause them to avoid contraceptives for less effective means of birth control. These issues should be addressed by public policy aimed at establishing rights for youth to access reproductive health care.

Darroch, Singh, & Frost (2001) conducted research analyzing international data on teenage programming, cultural attitudes, and contraceptive usage. Age of sexual activity onset and the amount of activity did not vary among teens from France, Sweden, Canada, Great Britain/Wales, and America. Marked differences existed in contraceptive methods, number of abortions, socioeconomic class, and cultural perspectives. Boonstra (2009) recommends that the Obama administration overhaul our international policy, moving from the Bush era funding of abstinence-only programs to endorsing programs

that address the distribution of comprehensive information and include reform of policies that inhibit social justice and vital health information.

Types of Sexuality Education

Two divergent ideologies exist when considering programming for adolescents: abstinence-only and comprehensive-based programs. Advocates for Youth's (www.advocatesforyouth.org) describes a comprehensive program as one which addresses

> "Both abstinence and age appropriate, medically accurate information about contraception…it also [introduces] information on relationships, decision making, assertiveness, and skill building to resist social/peer pressure, depending on grade level" (retrieved July 19, 2010 from www.advocatesfor youth.org).

Section 510(b) of Title V of the Social Security Act, P.L. 104-193 describes abstinence education as a program that:

> "Has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
> Teaches abstinence from sexual activity outside of marriage is the expected standard for all school aged children;
> Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases and other health problems;
> Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity;
> Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical side effects;
> Teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society;
> Teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances and
> Teaches the importance of attaining self-sufficiency before engaging in sexual activity" (retrieved July 19, 2010 from

www.advocates for youth.org/abstinenceonly/abonlydefinition.htm).

On the surface, both options offer programming to address issues that impact society. Many opponents of abstinence-only programs cite inaccurate medical information and the use of fear tactics (Jemmott, Jemmott & Fong, 2010) while comprehensive program opponents fear that giving adolescents too much information encourages early onset of sexual activity (Future of Sex Education (FoSE): History of Sex Education, 2010). School districts have much to consider when adopting sex education and positive life choices curricula.

Attitudes toward Sex Education

Survey on California parents' preferences and beliefs regarding school-based sex education policy. This survey was conducted in 2006 using a random-digit telephone survey method. Participants were polled about their preferences for sex education topics, “the importance of teaching selected topics at different grade levels, and the reasons for their preference[s]” (Constantine, Jerman, & Huang, 2007, p.167).

Findings of this study determined that the majority of parents across all categories supported comprehensive sex education and those that preferred abstinence-only did so for "absolutist reasons a moral absolute that abstinence is right" (p.167). Collecting this type of information from parents is a critical step in developing collaboration between parents and schools in delivering sensitive curriculum content. This correlates with other studies that indicate that parents want to be partners with schools in communicating with their children about sexuality issues (Jordan, Price, & Fitzgerald, 2000.) Gathering information about student and parent preferences for sexuality education is important for communities when considering a change in health

curriculum in their local schools. The categories and format from the California survey was used as a reference in developing the survey for the Union City Area School District.

Youth Risk Behavior Survey, 2009. The Youth Risk Behavior Surveillance System (YRBSS) is a national survey conducted every two years by the U.S. Centers for Disease Control and Prevention (CDC) through state and local education and social agencies (Retrieved on July 27, 2010 at http://www.cdc.gov/HealthyYouth/yrbs/index.htm). Students in grades 9 through 12 may choose to participate in the survey. The YRBSS appraises six categories of behaviors that present risk to adolescents. One of the categories monitors sexual behaviors that could lead to teen pregnancy and sexually transmitted infections (STI's).

In the results from the 2009 national survey, "46% of the respondents indicated that they had sexual intercourse, 13.8% with four or more [partners]. [A]mong the sexually active students, 61.1% used a condom during [their most recent] sexual intercourse and 19.8% used birth control pills" (Eaton, et al., 2009, p. 20-21). Pennsylvania results indicate "48% of the students reported having had sexual intercourse. [of that percentage,] 15% with four or more [partners], 35% did not use a condom during [their most recent] sexual intercourse, 73% did not use birth control pills, and 10% were not taught about AIDS or HIV infection in school" (HIV, Other STD, and Teen Pregnancy Prevention and Pennsylvania Students, 2010, p.1)

With One Voice. The National Campaign to Prevent Teen and Unplanned Pregnancy Organization commissioned a survey that polled teenagers and adults on two topics: "(1) parental influence on teens' decisions about sex, abstinence, contraception, and (2) the recent increase in the U.S. teen birth rate" (Albert, 2009, p.1). Findings reveal

that approximately 30 percent of the teenagers surveyed believe that parents maintain the largest influence regarding their decisions to participate in sexual activities, while 43 percent of the adults surveyed maintain that teen peers exert more influence. Sixty-four percent of adults and 75 percent of teens felt the message indicating that abstinence is the optimal method to avoid pregnancy and STIs, does not encourage sexual activity, but if sexual activity is chosen, and then birth control protection should be used. Furthermore, participants indicated that interactions between teens, parents, high quality sex education, and national media campaigns to advertise the facts and effects of teen pregnancy may help to reduce further incidences. This would seem to indicate that a majority of society does not consider that comprehensive sex education encourages sexual activity in teens; rather they feel it is needed to inhibit further adverse effects on teens and society.

Sexual abstinence and the Sexual Abstinence Behavior Scale (SABS).

This four- item scale was developed to survey patients to provide information to medical personnel when teaching sexual abstinence information to young patients (Norris, Clark, & Magnus, 2003). The four items nurses utilized to survey patients were: "How often in the past three month did you:

- Tell yourself you were making the right decision by waiting for sex
- Say "NO" to sex
- Tell him (her) that you wanted to wait to have sex
- Avoid being pressured to have sex by making sure you are out with a group of people." (p. 142)

The scale was developed to help determine consistency in definitions of sexual abstinence and provide pertinent information to medical personnel. Since the definition of abstinence-only usually does not pertain to persons who may have participated in sexual activity, but desire to curtail future activity, the scale helps provide specific information

to personnel to assist them in delivering specific abstinence information. National awareness of the impact of teenage pregnancy and educational curricula that utilize consistent terms and information are important future goals for our country.

Consequences of Teen Sex and Pregnancy

Teenage pregnancy presents many negative consequences for society. Financial support, health factors, labor projects, human capital benefits, and familial effects are ramifications of teenage pregnancy.

Millions of dollars have been allocated to increase programming for prevention of teenage pregnancy, some of which has been ineffective. Increased dependency on the welfare system intensifies with each occurrence of teen pregnancy (Science Says, 2010, p.1). Teenage mothers have reduced employment opportunities, attain lower educational levels, "have more children, higher rates of depression, more marital instability, and increased risk of experiencing violence" (Jaffee, 2002, p. 38). Many of the costs for teen pregnancy are reflected in the following expenditures: "$1.9 billion for increased public sector health care costs, $2.3 billion for increased child welfare costs, $2.1 billion for increased costs for state prison systems, and $2.9 billion in lost tax revenue (due to lower taxes paid by children of teen mothers over their adult lives" (Science Says, 2006, p.1).

Factors such as conduct disorders, depression, low self-esteem and other mental health issues have been noted in many cases of teenage pregnancy (Jaffee, 2002). Mental health issues impact the teen parent and his or her children. This intergenerational effect can subvert the attempts of implemented programs to reduce the impact of teenage pregnancy and to decrease the number of future incidences.

Many adolescents lack high quality parenting skills due to their maturity level and lack of experience and positive role models. The immaturity of some adolescents jeopardizes the ability to provide a nurturing environment for their children, and lack of experience causes unrealistic suppositions about child development. Programming to provide knowledge of child development should be included in educational health classes to counteract this deficit (Johnson-Moore, 1998).

Health factors of concern associated with teenage pregnancy include STIs, prenatal care, and infant health. Teenage mothers comprise a demographic risk category to have premature birth or low birth weights of infants (Suellentrop, 2006, p.3). Premature birth presents an increased risk for "mental retardation, learning and behavioral problems, cerebral palsy, as well as lung, vision, and hearing problems" (Professional & Researchers: Quick Reference Fact Sheet, 2010, p. 3). The lack of prenatal care is also a concern with teenage pregnancy. Lack of access to health care, state regulations requiring parental participation, and deficits of knowledge all contribute to the reasons that teen mothers often do not seek medical care. This represents economic and health risks for our nation.

Positive Life Choices

An important tenet of comprehensive sex education is providing information to students that can assist them in making healthy life choices. Information on how to develop healthy relationships is essential to help adolescents in making positive life choices. Elements of the program may include crucial topics such as (1) sexual abuse and assault, (2) bullying, (3) teen violence, (4) body image, (5) date rape, and (6) the effects of drugs and alcohol on making critical decisions.

Additional important fundamentals of comprehensive sex education include skills that assist adolescents in negotiation, positive decision-making, how to resist pressure from others, and taking responsibility for one's behaviors (AVERT Report, 2010; Guidelines for Comprehensive Sexuality Education, 2004).

While the primary goal for comprehensive sex education may be to delay the onset of sexual activity, provide medically accurate information for birth control, and have students make informed decisions about sexual activity, content for courses needs to encompass information beyond these parameters. Polling parents and students regarding key subject matter for health curriculum regarding comprehensive sexuality education is an important step for communities to take prior to changing existing programming.

Conclusion

Statistics reveal that teenage pregnancy continues to plague our society. The socioeconomic, psychological, and harmful impact on our youth continues to negatively affect our society. Yet, little consensus has been reached as to what a comprehensive curriculum should include beyond sexuality information.

Chapter III

Method

Introduction

The school district in this study is unique because it has offered an elective comprehensive sexuality program to students in grades 9 through 12 for the past five years. While new in programming for the school, the community has not reacted negatively or claimed that it has offended its collective sensibility. Parents must sign a release form indicating their desire for their children to take the class, but the permission rate is almost 100 percent of the students who schedule for the class. While the results of this survey may generalize to other communities, the purpose of this study was to address issues within this small, rural, economically impoverished school district. Future studies would be essential in more than one school district to substantiate generalization beyond the Union City Area School District.

Research Design

The basic design of the study is a 2 (student, parent) X 2 (male, female) between-subjects ANOVA. Both the Group (student, parent) and Gender (male, female) variables are between subjects. ANOVA was used to compare the two groups' responses to the questions on the survey between students and parents. Since both Groups and Gender are naturally occurring, it is not possible to randomly assign participants to groups. Consequently, this will be a quasi-experimental design with nonequivalent groups.

Describing the Sample

Approximately 450 parents have children attending the local school district. All parents were invited to participate in the survey. Due to the sensitive and controversial content of the survey, the researcher felt it was prudent to limit the survey of students to children in grades 10 through 12, which are approximately 225 students. In order to detect a medium-sized treatment effect, a minimum of 150 students and 200 parents were included in this study to establish a reasonable level of statistical power. Institutional approval by the Review Board of the Youngstown State University was obtained prior to conducting the study.

Instrumentation

Survey Monkey®, an electronic survey tool, was employed to solicit responses from participants. Participants responded to questions utilizing an interval scale to determine the appropriate grade level for initial exposure to the sex education content and a Likert scale to determine the strength factor of their choice.

Since the survey is covering a new area, the survey's psychometric properties are unknown. The content for each question was drawn from evidenced-based programs and peer reviewed research articles. Cronbach's α (alpha**)** was used to assess for sexuality questions and relationship questions separately to determine if the questions are cohesive. Prior to conducting the actual study, volunteer teachers in the district who were parents, were asked to complete Informed Consent forms and then pilot tested the survey to evaluate the readability and clarity of the questions.

Survey Content Questions

The survey consisted of 15 questions as presented in Table 1. The range of questions consisted of content considered to be informative to students, yet somewhat benign, to highly sensitive content debated in many communities. Since the purpose of the survey was to determine how early sensitive comprehensive sex education content could be introduced into the school health curriculum, seven questions were created to be reflective of controversial, medically accurate, content. Four of the questions focused on information influencing relationships. Two questions reflected content typically taught at the elementary level, one question involved content related to decision making, and one question targeted self-management. Copies of the surveys are located in Appendices A and B.

Table 1

Survey Questions

		Content Focus	Type of Question	Sensitive Content
"What is the earliest grade…"				
1.	...students should be taught that their personal choices or actions could produce consequences that could hurt themselves or others?	Choices	Decision Making, Typical Elementary Content	No
2.	.. that facts about puberty should be taught?	Puberty	Typical Elementary Content	No
3.	… the benefits of abstinence and self-restraint or self-denial should be taught?	Abstinence	Self-management	No
4.	… that differences between myths and facts about pregnancy should be taught?	Myths	Decision Making	No
5.	.. that negative consequences of teen pregnancy should be taught?	Pregnancy consequences	Medically Accurate, Controversial	Yes
6.	.. that birth control options should be taught?	Birth control	Medically Accurate, Controversial	Yes
7.	.. that information on family planning services should be taught?	Family planning	Medically Accurate, Controversial	Yes
8.	… that methods to avoid unwanted sexual behaviors should be taught?	Avoid sex	Relationship and Communication	No
9.	… that facts about dating violence and sexual abuse should be taught?	Dating violence and sexual abuse	Relationship and Communication	No
10.	… that the difference between love, lust, and infatuation should be taught?	Love, Lust and Infatuation	Relationship and Communication	No
11.	… that information about harmful intimate relationships should be taught?	Harmful relationships	Relationship and Communication	No
12.	… that information on preventative behaviors versus high-risk behaviors for contracting Sexually Transmitted Diseases (STDs) or Human Immunodeficiency Virus (HIV) should be taught?	Prevention of STDs and HIV	Medically Accurate, Controversial	Yes
13.	… that lessons on how to locate medically accurate on-line information regarding pregnancy, birth control, and STDs should be taught?	Location of medically accurate info on pregnancy, birth control, and STD	Medically Accurate, Controversial	Yes
14.	… the signs and symptoms of common STDs should be taught?	Signs of STDs	Medically Accurate, Controversial	Yes
15.	… that medically accurate facts related to symptoms of breast and testicular health problems should be taught?	Facts related to breast and testicular health	Medically Accurate, Controversial	Yes

The National Sex Education Standards were published in January of 2012 (Future of Sex Education Initiative, 2012). While the survey questions for this study were developed prior to the publication of the national standards, the questions regarded as sensitive in this survey echo the classification in the national standards as content to be mastered in grades nine through twelve (Questions 5, 6, 7, 12, 13, and 14). The content of these sensitive questions reflected topics related to medically accurate information regarding consequences of teen pregnancy, birth control options, family planning, and the prevention and signs of STDs and HIV. Table 2 offers a comparison of questions used in this survey to the core content of the National Sexuality Education Standards. While the questions in this survey are not a direct narrative match to the core content, it reflects the recommended grade levels for content as noted in the national standards.

Table 2

Sensitive Questions and National Standard Comparisons

Question on Dissertation-	Union City 's Student and Adult Response Mean Grade Range	National Standards-	National Standards-
The earliest grade level …		6th- 8th grade	9th - 12th grade
# 5- that negative consequences of teen pregnancy should be taught?	6th grade	Examine how alcohol and other substances, peers, media, family and society and culture influence decisions about engaging in sexual behaviors	Analyze influences that may have impact on deciding whether to engage in sexual behaviors
#6- that birth control options should be taught?	6-7th grade	Explain the health benefits, risks and effectiveness rates of various methods of contraception, including abstinence and condoms	Compare and contrast the advantages and disadvantages of abstinence and other contraceptive methods including, condoms
#7- that information on family planning should be taught	7th grade		Identify laws related to reproductive and sexual health care services (i.e., contraception, pregnancy options, safe surrender policies, prenatal care)
#12- that information on preventative behaviors versus high-risk behaviors for contracting Sexually Transmitted Diseases (STDs) or Human Immunodeficiency Virus (HIV) should be taught?	6th grade		Compare and contrast behaviors, including abstinence, to determine the potential risk of STD/HIV transmission from each
#13- that lessons on how to locate medically accurate on-line information regarding pregnancy, birth control and STDs should be taught?	6th-7th grade		Explain how to access local STD and HIV testing and treatment services
#14- the signs and symptoms of common STDs should be taught?	6th- 7th grade		Describe the signs and symptoms of treatments for STDs, including HIV
#15- that medically accurate facts related to symptoms of breast and testicular health problems should be taught?	6th – 7th grade	Not addressed in National Standards	

Question 5, related to when negative consequences of teen pregnancy should be taught and Question 6 related to when birth control options should be taught, seem to be divided into developmental components and span a broad spectrum of grades 6 through 12 as indicated in Table 2.

Question 7, related to when information of family planning; Question 12, when information on preventative behaviors versus high-risk behaviors for contracting Sexually Transmitted Diseases (STDs) or Human Immunodeficiency Virus (HIV) should be taught; Question 13, when lessons on how to locate medically accurate on-line information regarding pregnancy, birth control and STDs should be taught; and Question 14, related to the signs and symptoms of common STDs should be taught are closely mirrored in the National Standards descriptions as viewed in Table 2. The results for these questions suggest a younger grade level choice for Union City's survey questions as opposed to the national standard's core content descriptions.

Question 15, related to facts about breast and testicular health does not appear to be addressed in the national standards. Approximately fifty percent of testicular cancer diagnoses are reported for men in the age group between 20 and 34 and six percent under the age of 20 (Howlader, et al., 2011). Since the high incidence rate of testicular cancer impacts such a young age range, this researcher felt it relevant to survey for inclusion into the health curriculum for students.

Questions related to relationships (Questions 8, 9, 10, and 11) were recommended for mastery in grades six through eight except for question number 8, which had additional development in grades nine through twelve. The questions concerning

abstinence and pregnancy myths vs. facts correlated to content recommended for mastery in grades six through eight.

Procedures

A letter was mailed during the week of May 13, 2012, to all parents within the school district explaining the rationale and specifics of the survey. They were invited to participate in the study utilizing the Dillman Procedure by sending them an introductory letter with the survey link, followed by reminder-automated telephone calls (Dillman, 2000). A paper version of the survey was offered to those families wishing to complete the survey in this manner. They communicated this by calling a telephone number included in the letter. An automated phone call was utilized to remind the families two days prior to the start of the survey. Three separate phones calls were made during May 18 – June 8, 2012, to remind families of the timeline. A link to the survey was posted on the school district's website and a code given for access.

Separate letters were sent to parents of students in grades ten through twelve to obtain permission for participation. Once students returned a signed permission form to the high school office, a card was given to them with the website link and access code for the survey. A proctored computer lab was reserved on a specific date when all students with the card were sent to complete the survey. Copies of all written communication and notices are placed in Appendices C and D.

Statistical Analysis

The primary analysis strategy was 2 Groups (students, parents) X 2 Gender (male, female) between-subject ANOVAs. Additional ANOVAs were conducted to explore

differences in groups based upon other demographic variables. Appropriate sub- analyses were also conducted using between subject t-tests for comparing two levels of a variable, and One-Way ANOVA for comparing more than two levels of a variable. In the latter case, post-hoc comparisons were also conducted to locate the source of the effect.

Chapter IV

Research Findings

Introduction

Demographic inquiries. This chapter contains the results of the responses to the individual survey questions and notes any significance among responses from survey participants. An overview of the type of survey and method for soliciting participation is outlined below and response rates are discussed.

Results will be discussed in a sequential approach. Demographic data will include the frequency of valid responses for adults and students. Age ranges, religious affiliation, ethnicity, highest level of educational attainment will be examined for representation and significance.

Results for the number and ages of male and female children enrolled in the school district were polled to see if age differences impacted the response to what the earliest grade level specific sex education content should be introduced into the school's curriculum.

Student data follows the demographic data collection. Each question required two responses. After each question a respondent was given a range of -never to grade 12- when queried regarding specific content. Then each respondent was asked to indicate how strongly they felt about their choice with a constructed range of 1 as the weakest to 10 as the strongest. Tables are provided to view the response data and significance is noted if evident.

Analysis of Data

Survey Monkey® was utilized to capture responses from both groups of respondents (students, parents). A total of 451 survey notice letters were mailed to parents requesting their participation (Appendix B). Forty-three letters were returned as the addressee unknown. A permission to participate letter for students in grades 10-12 (n= 226) was also included with the parental participation letter for families with students registered in those grade levels. (Appendix C). Sixteen students were absent on the days scheduled for lab access to the link for the survey. There were 206 parent responses and 92 student responses to the survey. The response rate for parents was 50.4 percent and the student response rate was 40.7 percent.

Demographic information was solicited for variables for gender, age, ethnicity, grade level (student), religious preference, number of female and male children in their household, and the ages of female and male children.

Results

Demographic Data

Gender

The participants of each survey were requested to signify their gender. Table 3 provides a summary of their responses. The data indicated that for adults the females were the foremost responders to the survey which is substantially disproportionate to their representation in the overall population (z-ratio for the significance of the difference between two independent proportions $z = -9.47$, *two- tailed* $p < .0002$). Student

responders exhibited a similar trend, but to a lesser extent, z = -2.046, *two-tailed p* < -2.064.

Table 3

Gender of Survey Participants

	Valid Adult Responses		Valid Student Responses	
	Frequency	Percent	Frequency	Percent
Male	50	25.9	39	42.4
Female	143	74.1	53	57.6
Total	193	100.0	92	100.0

Age Range. The participants of each survey were asked their age. Choices of six categories were used to reflect a participant's age. Since students in grades 10-12 were participating in the survey, student age choices began at age 15. The survey question was developed to determine whether the responses differed across age categories. Table 4 reflects the results for adult and student participants.

Table 4

Age of Survey Participants

	Valid Adult Responses		Valid Student Responses	
Ages	Frequency	Percent	Frequency	Percent
15-19	12	6.1	92	100.0
20-25	10	5.1	0	0
26-29	14	7.1	0	0
30-39	52	26.5	0	0
40-49	55	28.1	0	0
50+	53	27.0	0	0
Total	196	100.0	92	100.0

As may be seen in Table 4, all student responses occurred within the 15-19 year old age category. For adult responders, twelve of them indicated their age within the 15-19 year old age category. Since letters were sent to parents with students enrolled within the district, these responses may be from parents who delivered children during their

teenage years. Eighty percent of the adult responders fell within the age ranges of 30 years or older, with almost an equal distribution for the three oldest age categories.

Religious Affiliation. The participants of each survey were requested to signify their religious affiliation. This question was developed to determine whether differences in religious affiliation affected participants' responses. Table 5 provides a summary of their responses.

Table 5

Religious Affiliation of Survey Participants

	Adult		Student	
	Frequency	Percent	Frequency	Percent
Catholic	50	25.5	16	17.4
Protestant	72	36.7	15	16.3
Other Unspecified Christian	28	14.3	18	19.6
Islamic	0	0	0	0.0
Other	25	12.8	16	17.4
None	21	10.7	27	29.3
Total	196	100.0	92	100.0

Approximately 75% of the adult respondents reported a form of Christianity as their religious affiliation while only 50% of the students were reflected in those categories. Only 13% of adults and 17% of students indicated "other" as a religious association. It is interesting to note that nearly one-third of the student participants reported no religious affiliation as opposed to 11% of adults.

No U. S. Census data for religious affiliation for Union City could be located. An Erie County, Pennsylvania membership report cited in the ARDA (Association of Religion Data Archives, 2010) reflected church memberships as 39% Protestant and 61% Catholic.

Tukey HSD post hoc comparisons for adults were nonsignificant and remarkably consistent for all categories of religion across all questions.

The results for the overall ANOVAs for students revealed a significant difference based on religious affiliation for which grade level facts about breast/testicular cancer should be taught, F (4, 83) = 2.508, p = .048, and marginally significant difference for the consequences of choices question, F (4, 82) = 2.096, p = .089. Analyses following up on these findings revealed that for the question about breast/testicular cancer, the Tukey HSD comparison between no religion and unspecified Christian category was marginally significant (p = .068) with the other unspecified Christian reporting that facts about breast/ testicular cancer should be taught later. Additionally, the choices question was marginally significant. A marginally significant Tukey HSD post hoc test suggested that unspecified Christians thought material about consequences of choices should be taught earlier than did Catholic respondents.

Finally, although the overall AVOVA for the question was nonsignificant, a third Tukey post hoc test for the question regarding the prevention of STDs revealed a marginally significant trend (p = .083) suggesting that Catholics thought it should be taught later than those with no religion. However, because of the post hoc nature of these tests we did not explore these results further.

Ethnicity. Survey participants were asked to identify their ethnicity. This question was included to determine if differences existed due to the ethnicity of the survey participants. Table 6 reflects their responses.

Table 6

Ethnicity of Survey Participants

	Valid Adult Responses		Valid Student Responses	
	Frequency	Percent	Frequency	Percent
White	194	99.0	87	94.6
Hispanic	1	0.5	3	3.3
Black	1	0.5	1	1.1
Other	0	0.0	1	1.1
Total	196	100.0	92	100.

Responses obtained in this survey for ethnicity are highly similar to the data percentages in the Union City Area School District student information database. Adult responders of this survey were predominantly white (99%) as compared to the student response of 94.6%. (Appendix D). Overall for Erie County, Pennsylvania the 2010 census data reflects that 88.8% of the total population is white (U. S. Census Bureau, 2010, American Fact Finder, Race). The rural areas of Erie County such as Union City tend to have a higher proportion of white citizens in the outlying regions.

Educational Attainment. Each participant was polled to determine the highest level of their educational attainment. Table 7 reflects the adult responses to this question. One hundred percent of the student responses indicated their attendance in high school.

Table 7

Highest Level of Education for Adult Participants

	Frequency	Percent
Attended High School	11	5.6
High School Graduate	25	12.8
Some College	19	9.7
College Graduate	52	26.5
Graduate School	87	44.4
Doctorate	2	1.0
Total	196	100

Erie County 2010 Census data reflects that 23.6% of the population reported holding a bachelor's degree or higher (U. S. Census Bureau, American Fact Finder, Educational Attainment) as noted in Table 8.

Table 8

Erie County, PA Census Facts

	Erie County	Pennsylvania
High School Graduate or higher	89.5%	87.9%
Bachelor's Degree or higher	23.6%	26.7%

The Census categories " High School Graduates include[d] people whose highest degree was a high school diploma or its equivalent, people who attended college but did not receive a degree, and people who received an associate's, bachelor's master's or professional or doctorate degree. Those who reported completing 12th grade, but didn't receive a diploma, were not included."

The Census category pertaining to the "Bachelor's Degree or Higher was those who [had] received a bachelor's degree from a college or university, or a master's, professional, or doctorate degree".

Union City's survey had categories for *Attended High School, High School Graduate*, *Some College, College Graduate* and *Graduate School*. The *Graduate School* category did not indicate whether it was completion of graduate school or if it just consisted of accumulating some graduate credits. When calculating all of the survey's categories except for the doctorate (n=2), 93.4% had some college coursework, which is very proximate to the Erie County census rate. Union City's *Graduate School* category did not indicate whether a diploma was a qualifier.

The over representation from the *Graduate School* category is noteworthy and may indicate that many of the parents who also teach in the school district responded to the survey. Nonetheless, the respondent population varies from the community at large and a consideration for demographic categories to reflect those as defined by the U.S. Census Bureau should be considered for future surveys.

Number of Male and Female Children in the District. All participants were requested to indicate the number of male and female children they had in the Union City Area School District. Table 9 reflects the number of male and female children as reported by adults.

Table 9

Adult Responses to Number of Female and Male Children in School

	Female			Male		
Number of Children	Frequency	Percent	Percent minus 0 children	Frequency	Percent	Percent minus 0 children
0	119	60.7	0.0	119	60.7	0.0
1	53	27.0	68.8	58	29.6	75.3
2	21	10.7	27.2	15	7.7	19.5
3	2	1.0	2.6	3	1.5	3.9
4	1	0.5	1.2	0	0.0	0.0
5	0	0.0	0.0	0	0.0	0.0
6	0	0.0	0.0	1	0.5	1.3
7	0	0.0	0.0	0	0.0	0.0
8	0	0.0	0.0	0	0.0	0.0
9	0	0.0	0.0	0	0.0	0.0
10_{+}	0	0.0	0.0	0	0.0	0.0
Total	196	100.		0	100	100
Total *	77			77		

Note. * indicates the number of children respondents reported- excluding those that reported no children in household (see below).

A high percentage of respondents indicated that they had no children, yet the survey was sent exclusively to the parents in our school district. To adjust for this apparent anomaly, percentages were recalculated to deduct the response of zero children. This additional calculation reflects a more pertinent representation of the number of children for the adult responders. The purpose of the question was to determine if there was an over representation for either gender. No over-representation was found.

Ages of children enrolled in the school district. Table 10 indicates the adult responses to the ages of their children enrolled in school.

Table 10

Adult Responses to Ages of Female and Male Children In School

	Female		Male	
Age	Frequency	Percentage	Frequency	Percentage
0	125	56.3	120	53.8
6	13	5.9	11	4.9
7	7	3.2	4	1.8
8	5	2.3	8	3.6
9	7	3.2	3	1.3
10	5	2.3	6	2.7
11	8	3.6	6	2.7
12	6	2.7	2	0.9
13	7	3.2	6	2.7
14	6	2.7	13	5.8
15	8	3.6	9	4.0
16	7	3.2	15	6.7
17	7	3.2	10	4.5
18	8	3.6	5	2.2
19	3	1.4	5	2.2
Total	222	100	223	100

Parents responding to the survey reported a higher percentage of male children at the ages of 14, 16, and 17. Female and male children at the age of 6 were also represented at a higher percentage. As was just mentioned for the previous Table 9, many responders claimed 0 children for this survey question for reasons that are unknown.

Student Results

Survey questions were designed to determine what grade level the topics should be presented in the school health curriculum. All question response choices ranged from 0-12 or not taught at all. The results for students' responses for each survey question are presented in Table 11. Cronbach's alpha for all 30 (grade level and strength) questions responded to by the students indicated that the questions were highly inter-correlated, α =.926. Similarly, the grade level only questions were highly inter-correlated, α = .936. Finally, when focusing on the seven most sensitive sexuality questions there is also a substantial correlation of α =.934.

The data presented is for the grade level at which the different topics should be introduced within the curriculum. The means for the student responses are predominantly clustered between grades 4 through 7. The vast majority are grouped around grade 6.

Table 11
Student Responses to Survey Questions

Questions		Valid N	Mean	SD	Skewness	Skewness S.E.	Kurtosis	Kurtosis S.E.
1.	Consequences of Choices	87	5.47	2.230	-.608	.258	2.41	.511
2.	Puberty	88	4.94	1.578	.957	.257	3.891	.508
3.	Abstinence	88	6.31	1.663	-.212	.257	2.393	.508
4.	Myths	88	6.39	1.643	-.772	.257	2.987	.508
5.	Preg. Conseq.	88	6.44	1.515	-.853	.257	2.627	.508
6.	Birth Control Options	87	6.82	1.343	-.894	.258	1.651	.511
7.	Family Planning	88	7.36	1.723	-.901	.257	3.325	.508
8.	Avoid Sex	88	6.43	1.589	-1.236	.257	3.009	.508
9.	Dating Violence & Sex Abuse	88	6.63	1.614	-1.112	.257	2.560	.508
10.	Lust	88	6.53	1.546	-.629	.257	2.622	.508
11.	Harmful Rels	88	6.77	1.499	-.753	.257	1.937	.508
12.	Prevent STD & HIV	88	6.66	1.338	-1.056	.257	3.081	.508
13.	Locate STD & HIV Info	88	6.69	1.359	-.996	.257	3.074	.508
14.	Signs of STDs	88	6.77	1.302	-1.100	.257	4.055	.508
15.	Facts of Breast & Testicular Health	88	6.88	1.388	-.114	.257	-.213	.508

Student Gender Comparisons

For the 92 students gender was distributed with males (n = 39) and females (n = 53). Although the number of males and females who responded was different, I was able to assume equality of variance when comparing males and female responses for all questions. The overall mean scores across all questions pertaining to grade level content introduction were not significantly different for males (M = 6.48) and females (M = 6.46),

t (86) = .105, ns. The mean student male and female responses for individual responses and supporting statistics are reported in Table 12. Males and females were not significantly different in their responses to any of the 15 questions in terms of when content is appropriately introduced into the curriculum.

Table 12

Student Gender t-Test

	Mean			
Questions	Male	Female	t	df
1. Consequences of Choices	5.38	5.54	.332	85
2. Puberty	5.11	4.82	-.838	86
3. Abstinence	6.34	6.28	-.173	86
4. Myths	6.45	6.34	-.302	86
5. Pregnancy Consequences	6.34	6.52	.543	86
6. Birth Control Options	6.97	6.70	-.937	85
7. Family Planning	7.39	7.34	-.147	86
8. Avoid Sex	6.50	6.38	-.349	86
9. Dating Violence & Sex Abuse	6.63	6.62	-.033	86
10. Lust	6.63	6.46	-.514	86
11. Harmful Relationships	6.68	6.84	.481	86
12. Prevent STD & HIV	6.63	6.68	.167	86
13. Locate STD & HIV Info	6.79	6.62	-.577	86
14. Signs of STDs	6.79	6.76	-.105	86
15. Facts of Breast & Testicular Health	6.71	7.00	.969	86

Note. Complete survey questions can be found in Table 1.

Independent sample t-tests revealed that male and female responses were not significantly different; most of the responses were in the sixth grade level with only a few exceptions. Only questions number one and two pertaining to the consequences of choices and puberty (Table 1 in Chapter III) reflected male and female responses in the fourth and fifth grade range. Females and males responded in the seventh grade range for

the family planning (question number 7). Females also chose the seventh grade range for question number 15 pertaining to breast and testicular health.

Student Grade Comparisons

The 92 students were distributed fairly equally across grades 10, 11, and 12, grade 10 (n = 29), grade 11 (n = 35), and grade 12 (n = 28).

The overall mean scores across all questions were not significantly different across grades (Ms = 6.68, 6.59, and 6.09, grades 10, 11, and 12, respectively), F (85, 2) = 1.74, *ns*. The student responses across grades and supporting statistics are reported in Table 13. The number of students were fairly consistent across three grades, with no significant differences in the grade level to which they assigned the introduction of sex education content, χ^2 (2) = .982, *ns*.

Table 13

Student Grade Level Responses

Grade Level	Frequency	Percent
Valid		
10	29	31.5
11	35	38.0
12	28	30.4
Total	92	100.0

Adult Results

The results for adult responses for each question are presented in Table 14.

Table 14

Adult Responses for Survey Questions

Questions	N	Mean	SD	Skewness	Skewness	Kurtosis	Kurtosis
1. Consequences of Choices	193	2.77	2.494	1.393	.175	1.418	.348
2. Puberty	192	4.54	1.414	1.313	.175	3.877	.349
3. Abstinence	191	5.93	1.659	-.232	.176	1.627	.350
4. Myths	189	6.40	1.659	-.305	.177	1.545	.352
5. Pregnancy Consequences	189	6.38	1.449	-.296	.177	1.836	.352
6. Birth Control Options	183	7.29	1.644	-.046	.180	1.246	.357
7. Family Planning	178	7.76	1.780	-.286	.182	.909	.362
8. Avoid Sex	187	6.36	1.955	-.566	.178	.628	.354
9. Dating Violence & Sex Abuse	188	6.89	1.710	-.577	.177	1.406	.353
10. Lust	185	6.89	1.632	-.037	.179	.878	.355
11. Harmful Relationships	186	7.08	1.663	-.315	.178	1.505	.355
12. Prevent STD & HIV	186	6.99	1.558	-.216	.178	1.195	.355
13. Locate STD & HIV Info	183	7.29	1.575	-.148	.180	1.331	.357
14. Signs of STDs	185	7.33	1.537	-.205	.179	1.305	.355
15. Facts of Breast & Testicular Health	186	7.74	1.764	-.360	.178	.783	.355

Mean scores for adult responses were mostly in the grades 6 through 7 ranges, except for the first two questions pertaining to choices and puberty (*M*s= 2.77, 4.54) and to some extent Question 3 pertaining to abstinence (*M*= 5.93), which were lower. The skewness statistics were not particularly high, but they were negative and similar to the students' responses, except for the first two questions which were more extreme and with positive skew.

Adult Responses by Gender

Adult male and female responses for each question are presented in Table 15.

Table 15

Adult Gender t-Test

Questions	Mean Male	Mean Female	t	df
1. Consequences of Choices	2.94	2.71	-.552	191
2. Puberty	5.02	4.37	-2.833*	190
3. Abstinence	6.22	5.82	-1.462	189
4. Myths	6.56	6.34	-.810	187
5. Pregnancy Consequences	6.54	6.32	-.905	187
6. Birth Control Options	7.36	7.26	-.354	181
7. Family Planning	7.73	7.77	.109	176
8. Avoid Sex	6.46	6.32	-.429	185
9. Dating Violence & Sex Abuse	7.00	6.85	-.538	186
10. Lust	7.04	6.84	-.744	183
11. Harmful Relationships	7.08	7.08	.003	184
12. Prevent STD & HIV	7.18	6.93	-.984	184
13. Locate STD & HIV Info	7.24	7.31	.261	181
14. Signs of STDs	7.48	7.27	-.808	183
15. Facts of Breast & Testicular Health	7.82	7.71	-.365	184

Note. Equality of variance was obtained for all questions.
P = .005, * = significance

The adult male and female responses were not significantly different except for question number 2, where females' responses indicated a lower grade level choice than males in terms of introducing the topic of puberty.

Grade Results for All Participants (Adults & Students)

Student and Adult grade results cannot be reported because the student grades are a subset of one value for the adults' grade. Grades 10, 11, and 12 were high school grades, and parents' grade values were elementary, middle, high or none. As a result it was not possible to combine the two measures.

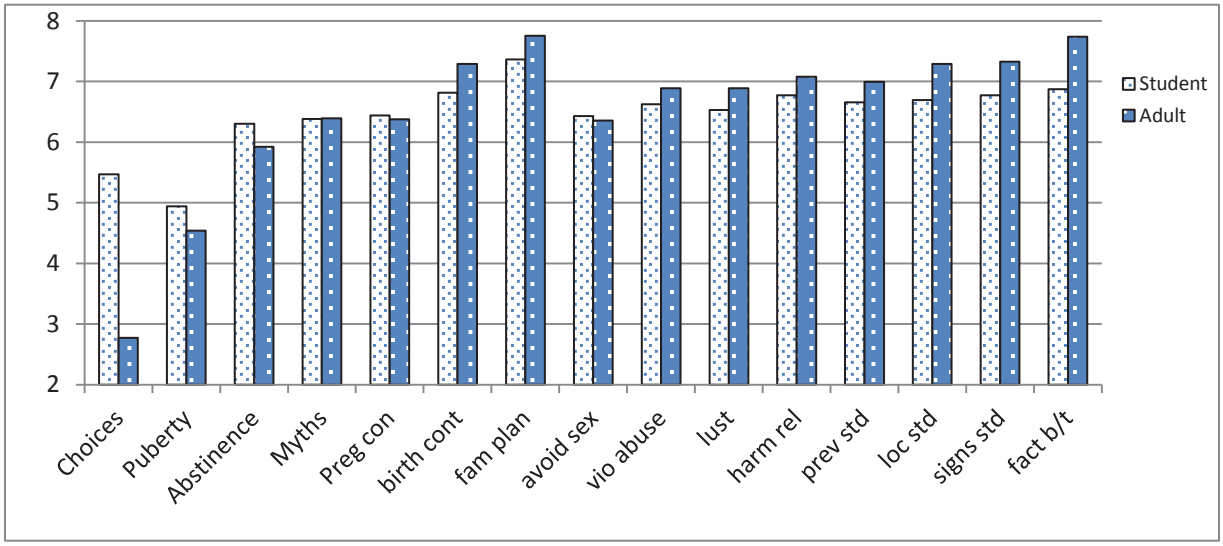
Comparisons of Adult and Student Responses

As indicated in Figure 1, responses for nine of the fifteen questions indicated a trend of parent choice of higher grade levels for comprehensive sex education content than that of students.

Of the seven questions identified to contain sensitive content (Table 1, Questions # 5, 6, 7, 12-15), results indicated that four were significantly different and two were marginally significant. Question # 1 was significantly different, but not in the predicted direction.

Figure 1

	Consequences of Choices	Puberty	Abstinence	Myths	Preg con	birth cont	fam plan	avoid sex	vio abuse	lust	harm rel	prev std	loc std	signs std	fact b/t
Student	5.47	4.94	6.31	6.39	6.44	6.82	7.36	6.43	6.63	6.53	6.77	6.66	6.69	6.77	6.88
Adult	2.77	4.54	5.93	6.40	6.38	7.29	7.76	6.36	6.89	6.89	7.08	6.99	7.29	7.33	7.74
Difference	2.70	0.40	0.38	-0.01	0.06	-0.47	-0.39	0.07	-0.26	-0.36	-0.31	-0.34	-0.60	-0.56	-0.87



Strength Questions

The purpose of the strength questions was to measure how strongly participants felt about their grade level choices. It was important to measure commitment to their grade level choice and determine if ambivalence toward certain curriculum content was present. If the strength factor demonstrated wide variances, the results of the study could indicate a lack of commitment for the content. The strength of the commitment for the content could indicate that the results of this study might make the School Board more confident in making decisions including the comprehensive sex education content in the health curriculum.

Student and adult outcomes were highly similar on strength choices except for the questions pertaining to consequences of choices and puberty (Table 1, Chapter III) as indicated in Figures 2 and 3. Results showed a high ceiling effect and high negative skewness for the strength questions. Due to the ceiling effect and negative skew, the responses were concentrated between numbers eight and ten, leaving little variability to work with and indicating participants felt strongly about their grade level choices. Thus when the factor of strength was added to the analyses, it was clearly not statistically significant, but lent corroboration to participant choices.

Figure 2

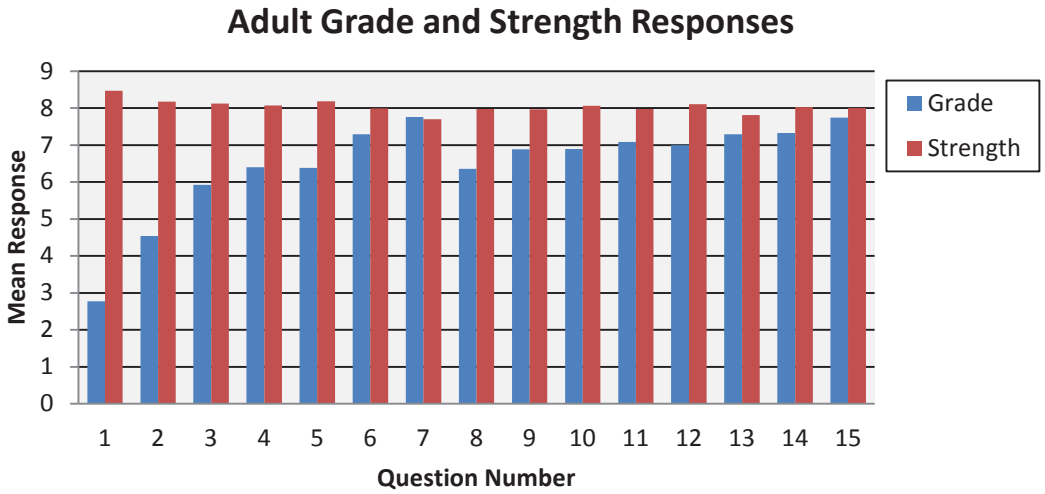
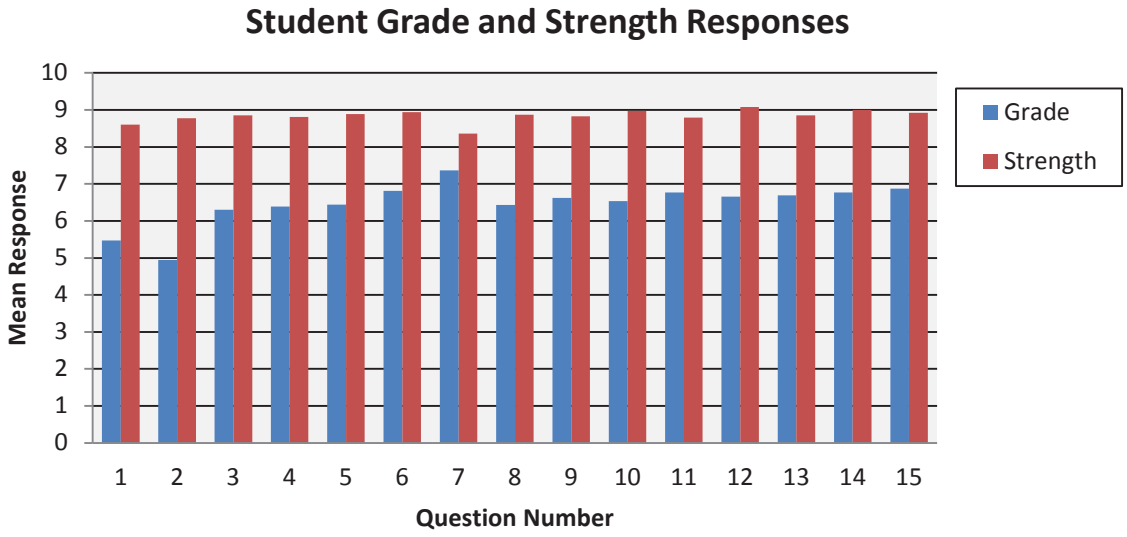


Figure 3



Chapter V

Discussion

Introduction

The Union City Area School District maintained the second highest rate of teenage pregnancy in the county over the last several years. To address this concern the Modern Living class teacher developed an elective class which incorporated many components of comprehensive sex educations topics. The class was also designed to develop Peer Educators who received specific training to disseminate medically-accurate information to their peers and the community. The mandatory middle school health programs restricted the sex education content to abstinence-based programs. These offerings were an attempt to address the high rate of pregnancies while maintaining controversy to a minimum in the community. During the evolution of the classes, peer educators and staff encountered many students seeking advice regarding very serious issues related to sexual abuse, eating disorders, sexually transmitted infections, drug and alcohol parties, physical abuse and relationships. It became obvious that further expansion of the curriculum was required to address the student concerns.

While the incidence rate of pregnancy slowly declined, feedback from the Task Force comprised of peer educator students and staff caused this researcher to question whether the community would support comprehensive sex education topics in the middle school health curriculum. Establishing the threshold for sensitive topics was critical for creating content for a new health curriculum which could address the range of factual information needed by students to make informed decisions for positive life choices. To

accomplish this goal surveys were created to seek community and student feedback on how early sensitive information could be introduced into the health curriculum.

Support for the Hypothesis

As indicated in the results section (Figure 1 of Chapter IV), responses to nine of the fifteen survey questions indicated a trend of parent choice of higher grade levels for comprehensive sex education content than what students would choose. The reliability of the test scores were indicated by the measure of Cronbach's alpha for both the questions and strength indicators. All scores were within the ranges of $\alpha = .90$ or above. This is highly satisfactory for a measure of internal consistency.

Survey questions had been developed using content endemic in comprehensive sex education curricula gleaned from evidenced-based programs and peer reviewed research articles. Fifteen questions were developed that ranged from addressing benign instructive information to highly sensitive content debated in many communities (Table 1 in Chapter II). Seven questions were reflective of controversial, medically-accurate content often restricted to grades 9 through 12. Four questions focused on relationship information, two questions reflected information typically introduced at the elementary level, and the remaining questions involved decision making and self-management. Question number fifteen was related to information about breast and testicular health, which is a national concern. Many people are aware of the high incidence of breast cancer in our nation. Few are knowledgeable about the facts that approximately 50% of testicular cancer diagnoses occur for men in the age group between 20 and 34 and 6% under the age of 20. This health concern necessitates the inclusion of this factual

information within the health curriculum for students, but is typically not found in comprehensive sex education curriculum.

The results of the survey clearly indicated that the threshold for introducing sensitive information could be at the middle school level. While adult responses for nine of the fifteen questions indicated a parent choice of higher grade levels than student choice, results clearly fell within the elementary to middle school range for the inclusion of comprehensive sex education content in the health curriculum (Figure 1 in Chapter IV). The means of the responses did not exceed the threshold of the range between seventh and eighth grade. These results disclosed that the community is comfortable with the inclusion of sensitive comprehensive sex education content at the middle school levels.

The inclusion of the strength question portion of the survey was to measure how strongly the participants of the survey felt about their grade level choices. Participants chose a response from numbers ranging from one (weakest) to ten (strongest). Results reflected a high ceiling effect, with means between eight and ten. This reveals that participants were not ambivalent about their grade level choice; rather they were highly committed to their response. The decisive responses to the survey questions validated the degree of community readiness for health curriculum change.

The school administration was concerned about the possibility of local Christian churches challenging the inclusion of comprehensive sex education within the health curriculum. Based on the outcome of this survey, it would seem as if the local churches would experience minimal pressure in supporting the changes in the health curriculum, as 75% of the adult participants indicated their participation in a Christian faith. There are

many churches in Union City and the local ministerium greatly influences community endeavors. Approximately 80% of the adult responders fell within the range of 30 to 50+ years of age with almost an equal distribution for the three oldest age ranges. This multi- generational distribution would indicate that the equivalent cross section of representation did not oppose the middle school level of comprehensive sex education content. This inference will further support future health curriculum changes within the school district.

Gender comparisons of the responses of participants were not significantly different. Student gender responses, with the exception of questions pertaining to the consequences of choices (question #1) and puberty (question #2), which indicated a fourth to fifth grade range and family planning (question #7), indicating a seventh grade range, fell within the sixth grade range. Although there was a higher female response rate for adults, male and female responses for students were not significantly different, except for question number two regarding puberty, where females indicated a lower grade level choice than males. This commonality between female and male responses may further signify common acceptance for future comprehensive sex education content within the school district's health curriculum.

A high percentage of adult respondents when asked to reply to the demographic questions regarding the "number of female and male children in school" (demographic questions #7 and #8) reported zero children in their household, yet the survey was sent exclusively to parents with children registered in the school district. Statistically, the percentages were recalculated to deduct the zero responses, but it is uncertain as to why many parents chose to respond in such a manner (Table 9 in Chapter IV).

The adult and student responses for question number one (consequences for choices) differed greatly. The grade level mean for students reflected fifth grade, while adults chose introduction at second grade. Perhaps the adults viewed the question more generally and students' interpreted the question on a contextual level specific to comprehensive sex education. Further refinement of the question may be necessary in any future surveys.

Implications of the Research

Participants of the Union City survey resoundingly indicated an acceptance for comprehensive sex education content in the health curriculum of the school district. Furthermore, while adults indicated a preference for a higher grade level introduction for sensitive content, all participants indicated acceptance for content within the middle school grades except for the consequences of choices (question #1) and puberty (question #2), (Table 14 in Chapter IV). Adult respondents indicated a preference for question #1 (consequences of choices) in the second grade range vs. the student respondents' preference for a fifth grade range. Adult and student respondents chose a fourth grade range for puberty (question #2).

The responses for this survey far exceeded the expectation of this researcher. Once this doctoral dissertation is completed and approved by the University, the research will be presented to the Union City Area School Board for review. Once permission is received from board members, the survey results will provide the framework for the initiation of a health curriculum review and revision. Rewriting the curriculum to include comprehensive sex education content will become a priority for the school district.

Further exploration into the new National Sexuality Education Standards may also yield additional topics for content consideration.

School districts interested in considering inclusion of comprehensive sex education content into their health curriculum may benefit from surveying their community for input and support. The results of this survey would indicate that a conservative rural school district may not experience as much resistance to such sensitive topics as once was perceived. If national perceptions are changing toward health curriculum content, school administrators should investigate the possibilities for their students. Creating a curriculum that provides medically accurate information for students to assist them in making positive life choices will help them secure a healthy lifestyle. Furthermore, a reduction in teenage pregnancies and sexually transmitted infections will enhance our nation's economic future by reducing the associated costs. Preparing students to enter a society that is rapidly changing and presenting future uncertain economic challenges is daunting for school districts. Presenting students with relevant and important health information should be a priority in all schools. A focus on core content for curriculum development should not be the sole objective within our schools. Providing important health information relevant to healthy lifestyles must also be a goal for schools.

Recommendations for Future Research

The National Sexuality Education Standards were not published until after the survey questions for this dissertation were developed (Future of Sex Education Initiative, 2012). The Union City survey encompassed questions relevant to the needs of students

within its district as described by the peer educators and school staff. It also reflected elements of the national standards. If a community wanted to survey their constituents regarding favorability towards a comprehensive sex education curriculum, the entire content of the national standards could be utilized to gain a common national perspective. A next logical step in advancing a national agenda for comprehensive sex education would be to develop a more extensive survey aligned with the full scope of the national standards. This would provide a national perspective beyond a rural viewpoint.

Currently, many schools have begun to incur questions from students related to gender identity and sexual orientation. I would recommend questions be developed to seek participant input in any future surveys.

I would also recommend that question number one in this survey be revised to reflect more detailed information regarding choices associated with puberty and adolescent development. This may explain why the adult and student grade level means were so disparate.

Summary

Schools are responsible for preparing students to become productive citizens in our society. Demands for more rigorous educational standards are rife within our present culture. Focusing solely on core academic content can only inhibit the impact on society by limiting the information needed by students to make serious life altering decisions. This survey explores the limitations of our health curriculum within public schools, particularly in a rural school burdened by poverty.

Surveys conducted in a community can provide powerful feedback and impetus for change. This survey provided compelling input which situates the district in a position to infuse the health curriculum with important information needed by students, but often shunned by communities.

The participants' responses to the survey questions provided significant support for health curriculum change and the inclusion of sensitive comprehensive sex education content. The overwhelming support of middle school thresholds for such content exceeded the expectations of this researcher and the results may galvanize other communities to explore changes in a curriculum area previously considered taboo.

The objective of the survey was met and the hypothesis supported, but the most valuable aspect of the endeavor was the outcome of the community response. While the 50 percent response rate from the adult responders may present some limitations on claiming firm representation of community views, it is a reasonably high response rate for a survey such as this. Clearly, this study shows ample support from both adults and students for giving teenagers accurate information and asking them to make healthy decisions. Any revision of curricula in the school district includes opportunity for community members to review changes and provide input.

Students from the Union City Area School District will significantly benefit from receiving the information needed to make positive life choices, and hopefully the teenage pregnancy rate in the school district will continue to diminish. Supported by the outcomes of this survey and with a tenacious focus and commitment, the staff and Peer Educators of the school district will move the district forward toward achieving that goal.

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APPENDIX A

PARENT SURVEY

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey

Exit this survey

11%

Welcome To Our Survey,

Teen pregnancy is a national issue that needs to be addressed. Teenage pregnancy correlates to increased dropout statistics, intergenerational poverty, and life stressors for adolescents, placing them at risk for further social challenges. While the national incidence of teenage pregnancy and sexually transmitted diseases has declined recently, Erie County incidence rates still surpass the state average. This necessitates the concern for reproductive education in American schools.

Unfortunately, our community has a serious problem with a high rate of teenage pregnancy. We must all work together to provide our teens with the important information they need to address reproductive health issues and assist them in making positive life choices.

Union City Area School District currently offers an elective modern living class that provides students with accurate and relevant information that assists them in making informed decisions regarding reproductive health and positive life choices. We are presently reviewing our curriculum topics, want to extend this information to enrich our health classes for all students, and would appreciate your input.

Voluntary Participation: Completion and submission of this survey implies your consent to participate in this research. You must be 18 years or older to consent to take part in this research study.

***1. Consent**

- ○ I consent to take this survey.
- ○ I decline to take this survey.

Next

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey Exit this survey

22%

We value your interest in our school district and thank you for taking the time and effort to participate in our survey. It will help us to develop a curriculum that will provide all of our students with the pertinent information needed to make positive life choices.

Please fill in the following demographic information. This information is vital to the survey. All items will be confidential.

***2. Gender:**

***3. Age Range:**

***4. Race/Ethnicity:**

***5. Education:**

***6. Religious Preference:**

Prev Next

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey Exit this survey

33%

***7. Number of children in school: Female**

***8. Number of children in school: Male**

***9. Ages of children in school: check all that apply Female**

☐ none ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19

***10. Ages of children in school: check all that apply Male**

☐ none ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19

Prev Next

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey

Exit this survey

44%

The survey is designed to solicit your preference for the appropriate grade level to introduce a variety of topics.

Directions: Each topic requires a response. Please indicate your preference for the earliest grade level the topic should be taught. If you feel a topic should not be discussed, please indicate this by selecting the specific box (never). Each grade level selection requests that you indicate a strength factor for your choice. The strength factor is numerically ranged from weakest to strongest.

What is the earliest grade students should be taught that their personal choices or actions could produce consequences that could hurt themselves or others?

***11. The earliest grade students should be taught that their personal choices or actions could produce consequences?**

Range is Never → grade 12

***12. Strength Factor: (How strongly do you feel that this is the earliest grade this should be taught?)**

Range is 1- weakest → 10 strongest

What is the earliest grade that facts about puberty should be taught?

***13. The earliest grade that facts about puberty should be taught?**

***14. Strength Factor:**

What is the earliest grade the benefits of abstinence and self-restraint or self-denial should be taught?

***15. The earliest grade that benefits of abstinence and self-restraint or self-denial should be taught?**

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey Exit this survey

56%

What is the earliest grade that the differences between myths and facts about pregnancy should be taught?

***17. The earliest grade that the differences between myths and facts about pregnancy should be taught?**

***18. Strength Factor:**

What is the earliest grade that negative consequences of teen pregnancy should be taught?

***19. The earliest grade that negative consequences of teen pregnancy should be taught?**

***20. Strength Factor:**

What is the earliest grade that birth control options should be taught?

***21. The earliest grade that birth control options should be taught?**

***22. Strength Factor:**

Prev Next

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey Exit this survey

67%

What is the earliest grade that information on family planning services should be taught?

***23. The earliest grade that information on family planning services should be taught?**

***24. Strength Factor:**

What is the earliest grade that methods to avoid unwanted sexual behaviors should be taught?

***25. The earliest grade that methods to avoid unwanted sexual behaviors should be taught?**

***26. Strength Factor:**

What is the earliest grade that facts about dating violence and sexual abuse should be taught?

***27. The earliest grade that facts about dating violence and sexual abuse should be taught?**

***28. Strength Factor:**

Prev Next

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey Exit this survey

78%

What is the earliest grade that the difference between love, lust, and infatuation should be taught?

***29. The earliest grade that the difference between love, lust, and infatuation should be taught?**

***30. Strength Factor:**

What is the earliest grade that information about harmful intimate relationships should be taught?

***31. The earliest grade that information about harmful intimate relationships should be taught?**

***32. Strength Factor:**

What is the earliest grade that information on preventative behaviors versus high-risk behaviors for contracting Sexually Transmitted Diseases (STDs) or Human Immunodeficiency Virus (HIV) should be taught?

***33. The earliest grade that information on preventative behaviors versus high-risk behaviors for contracting Sexually Transmitted Diseases (STDs) or Human Immunodeficiency Virus (HIV) should be taught?**

***34. Strength Factor:**

Prev Next

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey Exit this survey

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***33. The earliest grade that information on preventative behaviors versus high-risk behaviors for contracting Sexually Transmitted Diseases (STDs) or Human Immunodeficiency Virus (HIV) should be taught?**

***34. Strength Factor:**

Prev Next

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey Exit this survey

89%

What is the earliest grade that lessons on how to locate medically accurate on-line information regarding pregnancy, birth control, and STDs should be taught?

***35. The earliest grade that lessons on how to locate medically accurate on-line information regarding pregnancy, birth control, and STDs should be taught?**

***36. Strength Factor:**

What is the earliest grade the signs and symptoms of common STDs should be taught?

***37. The earliest grade the signs and symptoms of common STDs should be taught?**

***38. Strength Factor:**

What is the earliest grade that medically accurate facts related to symptoms of breast and testicular health problems should be taught?

***39. The earliest grade that medically accurate facts related to symptoms of breast and testicular health problems should be taught?**

***40. Strength Factor:**

Prev Next

Reproductive Health and Positive Life Choices Survey

Reproductive Health and Positive Life Choices Survey Exit this survey

100%

Thank you for your time!

Prev Done

APPENDIX B

STUDENT SURVEY

Reproductive Health and Positive Life Choices Student Survey

Reproductive Health and Positive Life Choices Student Survey

Exit this survey

11%

Welcome To Our Survey,

Teen pregnancy is a national issue that needs to be addressed. Teenage pregnancy correlates to increased dropout statistics, intergenerational poverty, and life stressors for adolescents, placing them at risk for further social challenges. While the national incidence of teenage pregnancy and sexually transmitted diseases has declined recently, Erie County incidence rates still surpass the state average. This necessitates the concern for reproductive education in American schools.

Unfortunately, our community has a serious problem with a high rate of teenage pregnancy. We must all work together to provide our teens with the important information they need to address reproductive health issues and assist them in making positive life choices.

Union City Area School District currently offers an elective modern living class that provides students with accurate and relevant information that assists them in making informed decisions regarding reproductive health and positive life choices. We are presently reviewing our curriculum topics, want to extend this information to enrich our health classes for all students, and would appreciate your input.

Voluntary Participation: Completion and submission of this survey implies your assent to participate in this research. You must have parent consent to take part in this research study.

***1. Assent**

- ○ I assent to take this survey.
- ○ I decline to take this survey.

Next

Reproductive Health and Positive Life Choices Student Survey

Reproductive Health and Positive Life Choices Student Survey Exit this survey

22%

We value your interest in our school district and thank you for taking the time and effort to participate in our survey. It will help us to develop a curriculum that will provide all of our students with the pertinent information needed to make positive life choices.

Please fill in the following demographic information. This information is vital to the survey. All items will be confidential.

***2. Gender:**

***3. Age Range:**

***4. Race/Ethnicity:**

***5. Grade Level:**

***6. Religious Preference:**

Prev Next

Reproductive Health and Positive Life Choices Student Survey

Reproductive Health and Positive Life Choices Student Survey Exit this survey

33%

***7. Number of children in school:**
Female

***8. Number of children in school:**
Male

***9. Ages of children in school: check all that apply**
Female

☐ none ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19

***10. Ages of children in school: check all that apply**
Male

☐ none ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19

Prev Next

Reproductive Health and Positive Life Choices Student Survey

Reproductive Health and Positive Life Choices Student Survey

Exit this survey

44%

The survey is designed to solicit your preference for the appropriate grade level to introduce a variety of topics.

Directions: Each topic requires a response. Please indicate your preference for the earliest grade level the topic should be taught. If you feel a topic should not be discussed, please indicate this by selecting the specific box (never). Each grade level selection requests that you indicate a strength factor for your choice. The strength factor is numerically ranged from weakest to strongest.

What is the earliest grade students should be taught that their personal choices or actions could produce consequences that could hurt themselves or others?

***11. The earliest grade students should be taught that their personal choices or actions could produce consequences?**

***12. Strength Factor: (How strongly do you feel that this is the earliest grade this should be taught?)**

What is the earliest grade that facts about puberty should be taught?

***13. The earliest grade that facts about puberty should be taught?**

***14. Strength Factor:**

What is the earliest grade the benefits of abstinence and self-restraint or self-denial should be taught?

*

Reproductive Health and Positive Life Choices Student Survey

15. The earliest grade that benefits of abstinence and self-restraint or self-denial should be taught?

***16. Strength Factor:**

Prev Next

Reproductive Health and Positive Life Choices Student Survey

Reproductive Health and Positive Life Choices Student Survey Exit this survey

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Reproductive Health and Positive Life Choices Student Survey

Reproductive Health and Positive Life Choices Student Survey Exit this survey

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***28. Strength Factor:**

Prev Next

Reproductive Health and Positive Life Choices Student Survey

Reproductive Health and Positive Life Choices Student Survey Exit this survey

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Prev Next

Reproductive Health and Positive Life Choices Student Survey

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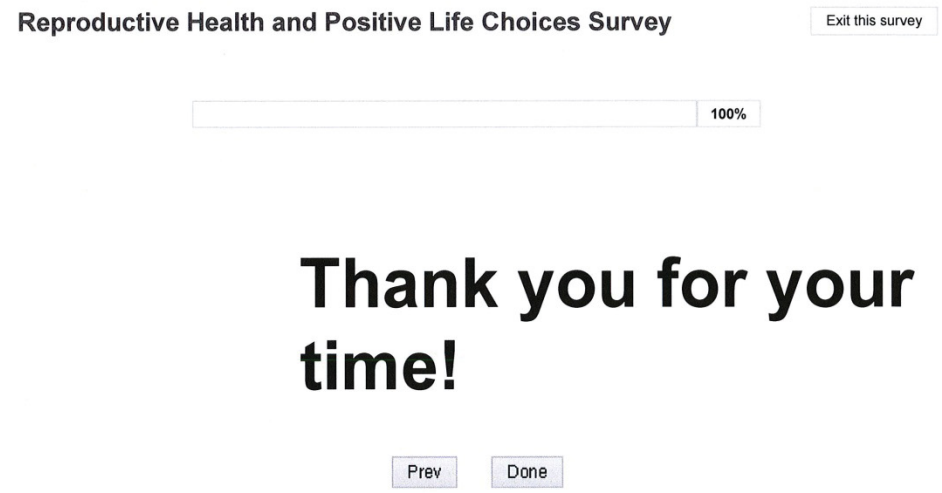
***40. Strength Factor:**

Prev Next

Reproductive Health and Positive Life Choices Survey



https://www.surveymonkey.com/s.aspx?sm=kzxWj0d4zNGE%2f6LfPmqy0A%3d%3d 2/15/2012

APPENDIX C

PARENT SURVEY LETTER NOTICE

Union City Area School District

107 Concord Street
Union City, Pennsylvania 16438
www.ucasd.org
(814) 438-3804
Fax: (814) 438-2030

Alisa A. Willey
Assistant Superintendent
awilley@ucasd.org

Sandra K. Myers
Superintendent
smyers@ucasd.org

Rebecca J. Stuart
Business Manager
rstuart@ucasd.org

[Date]

Mr. & Mrs. [Last name/s] Address
Address

Dear Mr. & Mrs. [Last name/s]:

We are asking the parents within our district for your help with a very important survey. Your responses will provide important health information at the appropriate time to students in our school district health classes. As a parent or guardian within our district, we value and need your input. While the incidence of teenage pregnancy and sexually transmitted diseases has declined recently, Erie County incidence rates still surpass the state average. Students are expressing the need for medically accurate health information to assist them in making important life choices.

We request your participation in this survey by logging online to the link on our webpage (www.ucasd.org) or by contacting our middle/high school office at 814-438-3804, ext. 5400, to request a paper questionnaire. The link on our website will be available [insert dates]. The survey asks you to address 15 questions regarding topics related to puberty, pregnancy, relationships, and medically accurate reproductive health information.

We guarantee anonymity and confidentiality of individual responses. We will only report summarized group data and not individual responses. If you are interested in learning the survey results, they will be available via an internet link on our webpage at: https://www.surveymonkey.com/sr.aspx?sm=8SP5smoAW_2fneYGxWJnnRS4WHieYp0xaV5GjS536Kbp0_3d with the code "bears" or if you prefer, we will mail to you a hard copy of the results upon request.

Thank you for helping us with this important effort in educating our children. The answers you provide will assist us in updating our district health curriculum.

Sincerely,

Sandra Myers
Superintendent

An Equal Rights and Opportunities Agency

APPENDIX D

PARENT PERMISSION SLIP

STUDENT PARTICIPATION LETTER

Union City Area School District

107 Concord Street
Union City, Pennsylvania 16438

www.ucasd.org

(814) 438-3804
Fax: (814) 438-2030

Alisa A. Willey
Assistant Superintendent
awilley@ucasd.org

Sandra K. Myers
Superintendent
smyers@ucasd.org

Rebecca J. Stuart
Business Manager
rstuart@ucasd.org

[Date]

Mr. & Mrs. [Last name/s]
Address
Address

Dear Mr. & Mrs. [Last name/s]:

We are asking the parents within our district to allow their students in grades 10-12 to participate in this very important survey. Their responses will provide important health information at the appropriate time to students in our school district health classes. We value our students perspectives and feel that their input will provide valuable feedback. While the incidence of teenage pregnancy and sexually transmitted diseases has declined recently, Erie County incidence rates still surpass the state average. Students are expressing the need for medically accurate health information to assist them in making important life choices.

If you would like to preview the survey prior to granting permission, please contact our middle/high school office at 814-438-3804, ext. 5400, to request a paper questionnaire. The survey asks participants to address 15 questions regarding topics related to puberty, pregnancy, relationships, and medically accurate reproductive health information. It should take no longer than 15-20 minutes to complete.

We guarantee anonymity and confidentiality of individual responses. We will only report summarized group data and not individual responses. If you are interested in learning the survey results, they will be available via an internet link on our webpage at: https://www.surveymonkey.com/sr.aspx?sm=8SP5smoAW_2fneYGxWJnnRS4WHieYp0xaV5GjS536Kbp0_3d with the code "bears" or if you prefer, we will mail to you a hard copy of the results upon request.

Thank you for helping us with this important effort in educating our children. The responses our students provide will assist us in updating our district health curriculum.

Sincerely,

Sandra Myers
Superintendent

APPENDIX E

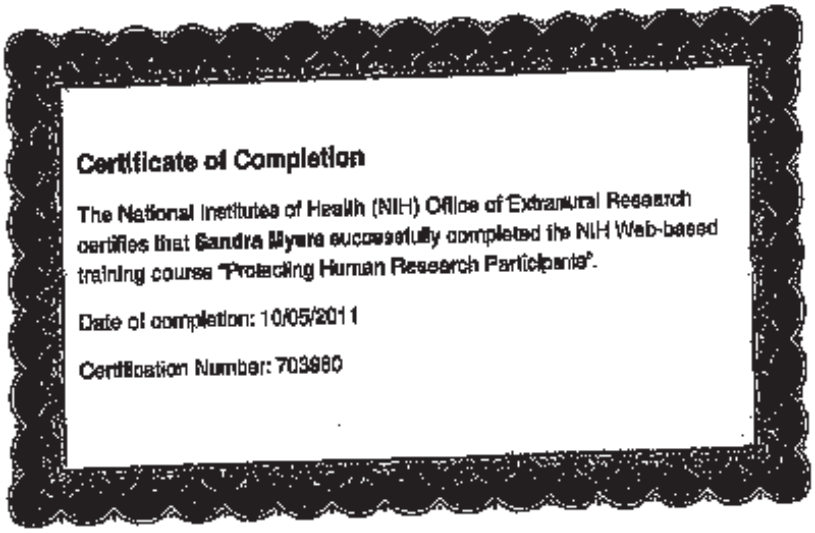
POWER SCHOOL REPORT
STUDENT INFORMATION SYSTEM

Enrollment Summary: as of 03/18/2013 District Office

Grade Level	Total in Grade	Asian / Pacific Islander	African-American	Hispanic	American Indian	Multi-Racial	Caucasian	Unclassified
-1	84 45 / 39	0 0 / 0	0 0 / 0	0 0 / 0	0 0 / 0	2 1 / 1	82 44 / 38	0 0 / 0
0	118 47 / 71	0 0 / 0	0 0 / 0	0 0 / 0	0 0 / 0	0 0 / 0	118 47 / 71	0 0 / 0
1	91 48 / 43	0 0 / 0	0 0 / 0	2 0 / 2	0 0 / 0	0 0 / 0	89 48 / 41	0 0 / 0
2	80 37 / 43	0 0 / 0	1 0 / 1	0 0 / 0	0 0 / 0	2 1 / 1	77 36 / 41	0 0 / 0
3	86 47 / 39	0 0 / 0	1 0 / 1	2 1 / 1	0 0 / 0	1 0 / 1	82 46 / 36	0 0 / 0
4	88 43 / 45	0 0 / 0	1 1 / 0	0 0 / 0	0 0 / 0	0 0 / 0	87 42 / 45	0 0 / 0
5	88 46 / 42	1 0 / 1	0 0 / 0	2 0 / 2	0 0 / 0	0 0 / 0	85 46 / 39	0 0 / 0
6	104 51 / 53	0 0 / 0	1 0 / 1	4 2 / 2	1 0 / 1	1 1 / 0	97 48 / 49	0 0 / 0
7	91 46 / 45	0 0 / 0	4 2 / 2	1 0 / 1	0 0 / 0	0 0 / 0	86 44 / 42	0 0 / 0
8	79 32 / 47	0 0 / 0	4 1 / 3	2 1 / 1	0 0 / 0	0 0 / 0	73 30 / 43	0 0 / 0
9	91 41 / 50	0 0 / 0	0 0 / 0	2 1 / 1	1 1 / 0	0 0 / 0	88 39 / 49	0 0 / 0
10	75 36 / 39	0 0 / 0	1 0 / 1	0 0 / 0	0 0 / 0	0 0 / 0	74 36 / 38	0 0 / 0
11	83 37 / 46	0 0 / 0	0 0 / 0	1 0 / 1	0 0 / 0	1 0 / 1	81 37 / 44	0 0 / 0
12	83 40 / 43	0 0 / 0	0 0 / 0	1 0 / 1	0 0 / 0	0 0 / 0	82 40 / 42	0 0 / 0
Total	1241 596 / 645	1 0 / 1	13 4 / 9	17 5 / 12	2 1 / 1	7 3 / 4	1201 583 / 618	0

APPENDIX F

NIH - Protecting Human Rights Research Certificate



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Sandra Myers** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 10/05/2011

Certification Number: 703980

APPENDIX G

INSTITUTIONAL REVIEW BOARD APPROVAL

Sandra Myers< smyers@ucasd.org>

FW: YSU IRB Protocol 126-12
1 message

Cathy Bieber Parrott < cbieberparrott@ysu.edu> Wed, Apr 25, 2012 at 4:34 AM
To: Sandra Myers <smyers@ucasd.org>, "Dr. Robert Beebe" <rjbeebe@ysu.edu>
Cc: Cheryl Coy <ckcoy@ysu.edu>

Dear Investigators,

The IRB has received the required permission letter and has completed the review of your project, protocol # 126-12. The permission letter will be appended to your original IRB submission and the supplemental documents provided by you via email on 3/27/2012.

The IRB fully approves your project with the condition that the children be informed in writing that participation is completely voluntary even though parents have provided consent. In our phone conversation yesterday, you verbally responded you will adhere to this condition by providing written assent information at the time students pick up the computer room entrance card and the IRB accepts this methodology as meeting the condition.

The IRB also approves the waiver of documentation of consent for both the parents and children because the signed document would be the only record linking the subject and the research and the principal risk of your project is potential harm resulting from a breach of confidentiality. Further, the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. Thus, your project meets the needed criteria for allowing waiver of documentation of consent.

The principal investigator will receive a letter in the mail regarding approval. However, while awaiting this letter, you may begin recruitment for your project based on this email notification. Please use the protocol number 126-12 for all future communications about this protocol. Best wishes for successful completion of your project.