

SEX EDUCATION IN YOUTH WORK:

Beyond preventing pregnancy & sexually transmitted infections

By Jamie Grilz

Sexuality is a part of who we are, a critical aspect of healthy youth development. It's everywhere we look, it's in the television shows and movies we watch, the magazines we read, and the websites we frequent. Ninety-five percent of Americans report that they engaged in sex before marriage, but nobody ever *talks* about it. This is the culture surrounding sex and sexuality in the United States. We live in a culture where sex is everywhere, but there is no discussion. This is reflected in the fact that sex education in schools has been a highly charged political issue for the past 50 years.

In 2010, \$110 million in federal funds were dedicated to support teen pregnancy prevention programming, resulting in the establishment of the Office of Adolescent Health (OAH). It was an exciting time in the field of youth development and sexual health because we finally had the federal government supporting and funding programs that were not abstinence-only education. Although this was certainly a step in the right direction for our field, the funding came with the requirement to faithfully replicate approved evidence-based interventions (EBIs). EBIs are models that have demonstrated impacts on key sexual behavioral outcomes that include reduction of teen pregnancy, sexually-transmitted infections (STIs) and associated sexual risk behaviors. Eventually, a list of 28 evidence-based program models was produced for organizations to select from when applying for these federal funds.

The federal government currently funds the majority of sex education programming targeted to youth in the United States through the use of an approved list of EBIs that are based on two outcomes: pregnancy prevention and STI/HIV prevention. Sex education programs for youth need more comprehensive approaches and should be based on more than just pregnancy and STI prevention alone.

A NEEDED CULTURAL SHIFT

Every day in America 1000 teens contract a sexually transmitted infection. One in three females become pregnant in their teens. These represent obvious public health concerns that sexual health education programs can help address.

The U.S. has the highest teen birth rate in the industrialized world. The teen pregnancy rate is almost three times that of France and Germany, and over four times that of the Netherlands. Though there isn't as much data from Europe on STIs, data from the Netherlands showed that the rate of incidence is considerably higher in the United States. When measuring use of highly effective hormonal contraception, condoms, or both, researchers found that German, French and Dutch youth were significantly more likely to use protection than were their U.S. peers (Advocates for Youth, 2011).

In a country where religion plays a huge role in the culture, most young people in the U.S. are told to abstain from sexual intercourse until they are married. End of conversation. In fact, the federal government backed this message for decades prior to the introduction of the Office of Adolescent Health in 2010. There are obvious flaws in telling youth to abstain from sex until marriage. Given that on average a young person has sex for the first time at about the age of 17 and the average marrying age for women is 26.9 and for men it's

29.8 (Taylor et al., 2011) this leaves a young person with about a decade of time to either abstain or to try to prevent an unintended pregnancy or contract an STI before “settling down.” Another major flaw is the majority of the states in our country also have laws where many of our young people aren’t able to legally marry due to their sexual orientation.

The abstinence-only-until-marriage message leaves out important conversations that young people need to have not just about protecting themselves, but about how to develop healthy relationships, how to communicate about sex in those relationships, how to establish boundaries and self-advocacy skills, etc.

A BRIEF HISTORY OF SEX EDUCATION IN THE UNITED STATES

Dating back to 1981, abstinence-only-until-marriage programs were funded by conservative policymakers during the Reagan administrations making these programs the first tax-payer-funded sex education programs. Under the George W. Bush administration, funding for these programs grew exponentially despite the fact that an overwhelming body of research proved that these programs were ineffective and that the programs failed to reach their stated goals.

Minnesota’s federally funded abstinence-only-until-marriage program called MN ENABL (Education Now and Babies Later) was administered to over 45,000 seventh and eighth graders. An evaluation during 1998-2002 found there was little impact of the curriculum on youth’s attitudes, sexual intentions, and behaviors after one year (Hauser, 2004). One significant quote from an author of the evaluation points out what all advocates for comprehensive sex education already knew “Based on the findings it appears that a comprehensive approach provides the most promising prevention of teen pregnancies and STDs” (Professional Data Analysts and Professional Evaluation Services, 2003). Advocates for comprehensive sex education programming finally had research to back up what they had known for years: abstinence-only education was not effective.

While the federal government had been supporting abstinence-only programs, growing evidence was emerging that more comprehensive approaches to sex education are effective in changing behavior and that broad support for these programs exist from not only medical and public health organizations, but also the majority of Americans, including parents and young people.

THE FEDERAL GOVERNMENT SUPPORTS ‘NEW ERA’ OF SEX EDUCATION

In 2010, the Obama Administration introduced a ‘new era’ of sex education into the United States. The administration eliminated two-thirds of the funding for the ineffective programs and provided \$190 million in funding that supported evidence-based teen pregnancy prevention and more comprehensive approaches to sex education. The Department of Health and Human Services launched the Teen Pregnancy Prevention (TPP) as a central focus of the newly established Office of Adolescent Health (OAH). The goals for the TPP program and its grantees involve implementation of the best prevention science available while also collecting new evidence for effective strategies. The TPP program has a strong emphasis on evaluation standards. Each grant applicant was required to:

1. Choose from the 28 evidence-based models.
2. Replicate them.
3. Use performance data to ensure fidelity to those program models.
4. Conduct rigorous evaluations.

Before awarding grants that replicated evidence-based programming, the Department of Health and Human Services (HHS) identified programs/curriculum that already existed that had proven positive impact on teen pregnancy and related factors. Given the desire to start funding programs quickly, HHS defined the evaluation standards necessary to be considered “effective based on rigorous evaluation” and reviewed literature on teen pregnancy, STIs, and sexual risk behaviors in a very short time period. This was the first time the federal government had released such a list and clearly defined the evidence base standards.

To determine this list of evidence-based program models, the Department of Health and Human Services contracted with Mathematica Policy Research and its partner, Child Trends. Their review identifies, assesses, and rates the rigor of program impact studies and describes the strength of evidence supporting different program models. Currently 31 models are on the list that can be found on the OAH website.

Identifying teen pregnancy and STI prevention as the two outcomes for these programs is understandable. Pregnancy and STI prevention are concrete health outcomes. Pregnancy and STI prevention for teens saves taxpayers money. An analysis by the Brookings Institution shows that effective teen pregnancy prevention models, such as the evidence based programs the federal government is funding, are cost effective and more than pay for themselves.

Sexual health educators have a deep understanding of the implications a young person faces when experiencing an unplanned pregnancy or STI. However, teen pregnancy and STI prevention are intrinsic outcomes of quality youth development sex education programming.

There are a few EBIs on the federally approved list that have flexibility in their programs, but most of the curriculum focus on abstinence, refusal/negotiation skills, methods of protection, and STI prevention/treatment. Programs should include these skill-building practices, but the power of quality youth development is often missing from these programs.

LISTENING TO THE YOUTH WORKERS: PERSPECTIVES ON DELIVERING EBIS

I partnered with current NorthStar fellow and sexual health colleague, Emily Scribner-O’Pray, to conduct a focus group with eight sexual health workers who had experience implementing four different EBIs that are funded under federal grants. The purpose of the focus group was to gather information on how EBIs are being used in the field, the autonomy a youth worker feels when implementing the EBIs, and gathering perspectives of what is missing from the programs.

Though there was some positive feedback about the overall program they were using, there was a general consensus that the programs were outdated, that implementing the curriculum with fidelity was a struggle, and there was a strong desire to adapt the curriculum to better fit the needs of the actual young people they were serving.

OUTDATED PROGRAMS

“Nothing has changed since the original curriculum was written in 1979.”

-Focus group comment, Minnesota sexual health worker

“[School] Teachers always adapt their curriculums from year to year. It doesn’t make sense that we are using programs that haven’t been updated in 20 years.”

-Focus group comment, Minnesota sexual health worker

Information on sexual health and our approaches change over time. A few of the youth workers stated that some of the videos that they are using with their programs have incorrect information. Best practices for how sexual health workers approach topics of sexual violence and orientation have changed dramatically over the years. Some EBIs still contain outdated messages on refusal skills that could lead to victim-blaming tendencies in the realm of sexual violence.

ISSUES WITH FIDELITY

"If you are implementing the program with non-talkers, it keeps things moving. For students who have a lot they want to say it can be harder to stay on track and the program doesn't work as well."

-Focus group comment, Minnesota sexual health worker

"I feel bound to fidelity, but when the youth want to talk, I let them talk."

-Focus group comment, Minnesota sexual health worker

Facilitators implementing EBIs are required to track the fidelity of their programs and have very little room for adaptation for the youth that they are working with. Tracking fidelity can start to become the focus of the program instead of keeping the focus on the youth. Curriculum should be used as a guideline for facilitators versus a script. With the fear of losing funding for their programs, facilitators feel restricted to stick to the program.

EBIs don't always account for the real, live youth involved during the implementation phase. The structure and time-allotment for lessons misses valuable pieces of youth development including youth having time to 'check-in' and discuss day-to-day issues that have come up or a young person having a question that expands on the topic, but the question is outside of what the curriculum addresses. When discussing intimate topics of sexuality, it is especially important to build a safe and supportive environment. It is problematic when a facilitator feels like there is not time to go outside the curriculum to address the needs of the youth they are working with.

DESIRE TO ADAPT

"We want to give [the youth] all of the information. We want them to make good choices, but [the programs] are all very limiting—we stick to HIV, STIs and condom use."

-Focus group comment, Minnesota sexual health worker

"We are boxed into thinking about the physical outcomes like STI and pregnancy prevention. [I] wish that EBIs would integrate healthy sexuality and pleasure into the outcomes."

-Focus group comment, Minnesota sexual health worker

All youth workers implementing EBIs through a federal grant undergo training on the specific curriculum they will use. These trainings often cover the rules of fidelity and adaptation. Table 1 gives a snapshot of the general adaptation guidance for EBIs delivered at the trainings (ETR Associates, 2012).

TABLE 1***Adaptation guidance for EBIs***

Green Light Adaptations	Yellow Light Adaptations	Red Light Adaptations
Updating and/or customizing statistics and other reproductive health information	Changing session order or sequence of activities	Shortening a program
Customizing role-play scenarios (using wording more reflective of youth being served)	Adding activities to reinforce learning or to address additional risk and protective factors	Reducing or eliminating activities that allow youth to personalize risk or practice skills
Making activities more interactive, appealing to different learning styles	Modifying condom activities	Removing condom activities
Tailoring learning activities and instructional methods to youth culture, developmental stage, gender and orientation	Replacing videos (with other videos or activities) or replacing activities with videos	Contradicting, competing with, or diluting the program's goals
	Implementing a program with a different population or in a different setting	Minimizing or eliminating strategies built into the curriculum that promote effective classroom management
		Replacing interactive activities with lectures or individual work

A new or inexperienced youth worker may not see where a green light adaptation is needed or feel experienced enough to go into the yellow light adaptations. For even the experienced youth worker, adaptations to curriculum take time and energy to implement. Without the guidance from a trainer or manager, many needed adaptations to these EBIs may not take place. Having outdated statistics and scenarios that don't represent the culture/orientation/gender/etc. of the youth with whom you are working with can prove harmful.

When youth workers were asked what they would add or change in the EBI they were implementing, they all had the desire to make the program more comprehensive in nature. Supplemental topics mentioned were:

- Drug and alcohol information
- Team building
- Sexual orientation
- Respect & empathy
- Pornography
- Sexual violence
- Healthy relationships
- Sexual pressure
- Peer education
- Technology & communication
- Gender roles
- General sexuality
- Pleasure

A MISSED OPPORTUNITY

With the introduction of this federal funding into our field we had a huge opportunity to implement youth development programming in a much larger capacity. Limiting this programming to the use of EBIs was a missed opportunity to create and deliver programming that included a more comprehensive, holistic approach.

I work at an organization that supports programs that require the use of an EBI and are funded through the use of both non-federal and federal funds. When facilitators of youth programs are adequately trained in the field of youth development and sexuality education, they are able to design and deliver programming targeted to the youth they are serving, and are able to deliver on more outcomes than reduction of teen pregnancy and STIs alone.

Youth development programming in sexual health should include pregnancy and STI prevention, but programs should also include outcomes that are based on, but not limited to:

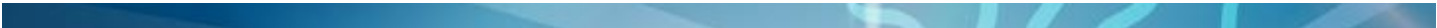
- Promoting human rights, including sexual and reproductive rights
- Increasing pride and accountability of a young person
- Increasing confidence, empowerment, and engagement of a young person
- Increasing comfort communicating about sexuality with an adult (parents and/or caregivers), as well as peers and sexual partners
- Increasing opportunities for quality relationships with peers and adults
- More favorable attitudes towards use of condoms and contraception

MORE THAN PREGNANCY & STI PREVENTION

After numerous conversations in the field, the general consensus is that we need EBIs. There is a strong desire to have research and evidence to back up the work we are doing. We need this to convince policymakers and the American public so that we can continue providing a more comprehensive approach to sex education. A strong point in identifying that programs prevent pregnancy and STI prevention is the money it saves the taxpayer. Unplanned pregnancy and sexually transmitted infections cost Americans millions every year. It is much harder to sell policymakers and the American public on the idea that we need to base these programs on building healthy relationships/communities, building leadership and communication skills, etc. because it's harder to prove that these outcomes save money.

I also found that many people in the field share my views that we want more for our youth than just pregnancy and STI prevention. We want our youth to have healthy relationships and the ability to establish boundaries and speak up for themselves. We want our youth to become leaders and have all sexual health knowledge available to them in order to make empowered decisions. We need to trust our sexual health youth workers to adapt curriculum accordingly to the youth that they are working with on any given day, and we need more training for new sexual health youth workers and teachers providing sexual health education.

Youth workers in sexual health education that are not under the constraints of federal funds are more empowered, given the freedom and creativity they are able to put into their work. They have the flexibility in their programs to adapt curriculum to fit the needs of their audience. The facilitators of programs are given



a great amount of autonomy in their work by being able to adjust to the participants that they were working with from day to day, giving them the freedom to focus on a true youth development style of programming.

When you provide a young person with quality youth development programming, including a safe and supportive environment where they establish a sense of belonging and a connection to a trusted adult, pregnancy and STI prevention become intrinsic outcomes.

ABOUT THE AUTHOR

Jamie Grilz, is the community education manager at Planned Parenthood Minnesota, North Dakota, South Dakota. As a student at University of Minnesota Duluth, Jamie interned with the local Planned Parenthood, igniting her passion for working with youth and reproductive health. In her tenure at Planned Parenthood, Grilz has worked with over a dozen peer education programs and taught hundreds of sexuality education presentations in the community to diverse audiences. Grilz has been involved in establishing Planned Parenthood peer education programs in North Dakota and has most recently been involved with establishing education and parent-child programs in the St. Cloud area.

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